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Editorial

Ayushman program in India: Everyone is a hero

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Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) is often discussed like a ledger: Packages, pre-authorizations, claim ratios, and budgets. However, at the bedside, it behaves like a social promise — that illness should not automatically translate into personal bankruptcy. In July 2025, government reporting noted that more than 41 crore Ayushman cards had been created, with over 9.84 crore hospital admissions authorized and spending/authorization reported at over Rs 1.40 lakh crore.[1] These numbers represent a real and meaningful change in the lives of families, often involving the sole earning member. They represent families who did not have to sell land or take predatory loans or forgo critical medical treatment.

A scheme at this scale will never be friction-free. The realistic choice is between two failures: Cynicism that weakens trust and participation versus denial that normalizes harm. The better path is honest improvement — seeing AB-PMJAY as a living public project that needs continuous calibration. The crux is simple: Everyone is a hero when the program is made to work honestly — beneficiaries, frontline staff, administrators, auditors, and even responsible critics.

THE INVISIBLE WORKFORCE BEHIND "CASHLESS"

In public imagination, "cashless" sounds like magic: Show a card and the bill disappears. In reality, cashless care is manufactured — not by slogans, but by people. Eligibility must be verified, identity details matched, clinical notes documented, packages selected, and pre-authorisations obtained within appropriate timelines - a process rigor that cannot take into account the tempo of emergencies.

Hospital desk staff and Ayushman Mitras explain eligibility, fix Aadhaar or name mismatches, guide families through forms, and absorb frustration that is really directed at illness. Residents and nurses deliver care while being pulled into "one more signature" or "one more upload." Medical records teams and coders know that one missing field can convert a genuine case into a rejected claim. This labor is not incidental — it is implementation.

WHERE IMPLEMENTATION STRAINS: RECURRING PROBLEMS (AND WHY THEY PERSIST)

The problems are not mysterious. They recur because AB-PMJAY sits at the intersection of medicine, technology, public finance, regulation, and federalism — domains with different rhythms and different failure modes.

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Awareness and usability gaps at the last mile

Coverage protects only when people know it exists, know they are eligible, and know how to use it. Studies have found uneven awareness of PM-JAY and awareness of one's own eligibility across socio-demographic groups.[2] Field work has similarly highlighted that awareness and knowledge are not uniformly high even among entitled households.[3] Low awareness translates into delayed care, avoidable conflict, and a false sense that the system is "unreliable" even when benefits are real.

Documentation friction that becomes a moral injury

In medicine, small delays can become big clinical events. Yet a spelling mismatch, an ID linkage issue, or a missing document can turn into hours of waiting. For families already terrified by illness, procedural hurdles are frustrating. A humane scheme must be operationally strict without being socially cruel — which means simplification, multilingual communication, and empowered on-site problem-solving.

Package rates versus real costs: the public-private tension

Provider payment is the central tension: rates must be affordable to the common man but realistic for modern healthcare delivery. Hospitals argue some packages – especially complex cases – can be under-priced, while administrators worry about over-billing and "upcoding." The government is proactive, open to suggestions, and has a good track record of periodic revisions of the health benefit package (HBP), including a revised HBP with 1,961 procedures and rate increases for hundreds of packages.[4] Revisions are necessary — but it is transparency: how costing is done, and where pain points persist.

Payment delays and deductions that poison goodwill

Even a morally sound scheme struggles if payments are unpredictable. When reimbursements are delayed or deductions feel arbitrary, hospitals experience cash-flow stress, and frontline staff become the face of a problem they did not create. Parliamentary documents have explicitly discussed delayed payments and reimbursement issues under AB-PMJAY.[5,6] On the ground, this has periodically spilled into public conflict — including announcements by private hospitals in Haryana to suspend services citing large pending dues and reimbursement disputes.[7]

Where there is a will, there is a way. In August 2025, services reportedly resumed after negotiations and assurances on clearing pending claims and improving processes.[8] A mature system should not require a crisis to trigger routine administrative hygiene. Predictable settlement timelines are not a "provider demand–" they are a vital component to ensure continued patient access.

Fraud control: Necessary, but easily weaponized

Any large payer system attracts misuse: unnecessary procedures, inflated billing, duplicate claims, and identity manipulation. Ethical analyses in India have documented typologies of unethical provider practices and the reputational harm they inflict.[9] The Comptroller and Auditor General's performance audit of AB-PMJAY also documented governance and process gaps and emphasized the need for tighter controls.[10] But fraud control and healthcare are two sides of the same coin. The goal should be smart scrutiny: Data-driven flags, rapid review lanes for routine claims, and decisive penalties for proven fraud — without punishing legitimate care with endless uncertainty.

Federalism and patchwork realities

AB-PMJAY's experience varies across states because implementation capacity and administrative culture vary. A beneficiary's illness does not respect state boundaries, so portability matters — but it requires sustained center-state coordination. Even when national metrics improve, a few local failures can dominate public perception if they become the only story that gets amplified and what people hear, especially through social media.

Media: The double-edged scalpel

A public insurance scheme is built not only on budgets and IT platforms, but also on belief. Positive reporting – credible stories of lives saved and catastrophic spending avoided – increases trust and early utilization, and helps frontline workers feel seen. Negative reporting is also essential when it exposes fraud, denial of care, or abuse. The risk is not criticism; the risk is cynicism without context.

In August 2025, a report highlighted how delayed reimbursements and operational fragility can push private hospitals to suspend services – a legitimate alarm bell that forces governance attention.[11] However, when every operational hiccup is framed as proof that "nothing works," beneficiaries hesitate, hospitals become defensive, and implementation turns adversarial.

A CONSTRUCTIVE FRAME: ACCOUNTABILITY WITH SYSTEMS LITERACY

The healthiest public narrative combines human stories with systems literacy. It distinguishes fraud from delay, error from deception, and design limitation from malpractice. It asks hard questions — and also reports corrective actions, such as

package revisions and process upgrades, so that improvement becomes visible and trust stays rational.[4]

SO WHO IS THE HERO?

AB-PMJAY succeeds when different kinds of heroism happen simultaneously: The beneficiary who persists through documentation barriers; the nurse who stays late to complete records so a poor patient is not denied; the doctors who deliver appropriate care within the available framework and logistic challenges; the administrator who fights for claim clearance while insisting on ethical billing; the auditor who catches a fraud ring; the journalist who reports responsibly; and the policymaker who keeps funding and reforming a program that is constantly tested.

The moral of "everyone is a hero" is not sentimental — it is strategic. A scheme that depends on cooperation cannot survive a culture of contempt. If beneficiaries assume hospitals are cheating, hospitals assume the payer is hostile, and administrators assume clinicians are careless, the system becomes expensive, slow, and emotionally brutal. This is what has happened in the USA. We are doing better!

A REALISTIC GOAL FOR THE NEXT PHASE

Ayushman's next phase should be defined by reliability: predictable claim settlement timelines and transparent deduction logic; routine rate recalibration grounded in costing; user-friendly beneficiary support in local languages; and strengthened but humane anti-fraud systems. Government updates in late 2025 continued to report expansion in card issuance and scheme scale.[12] Scale is necessary, but reliability is what converts scale into dignity.

This also means protecting the people who run the system. Hospitals need adequate staffing for documentation and pre-authorization work so clinicians are not forced to choose between care and compliance. Beneficiaries need clear, fast grievance channels (online and offline) that resolve "small" issues – name corrections, eligibility confusion, and unjustified deductions – before they become viral scandals. And states should publish simple performance dashboards (turnaround times, rejection reasons, grievance outcomes) so trust is built on transparency rather than rumors.

Finally, the scheme must keep its ethical compass visible: Zero tolerance for proven fraud, but equally zero tolerance for denial of clinically necessary care through procedural games. Training for hospital teams and payer teams should focus not only on rules, but on shared intent — that documentation exists to protect patients and public money, not to exhaust honest providers. When the intent is shared, compliance stops feeling like punishment.

No public program can cater to every problem. But a good program can listen to problems, prioritize the most harmful frictions, and keep improving without losing its soul. AB-PMJAY remains a remarkable effort by the government, the public, and the healthcare workforce. When we speak about it – in hospitals, in parliament, and in the media – we should be honest about shortcomings without erasing daily successes. Because in the quiet moments where a poor family receives timely care without financial ruin, the scheme is not a policy – it is compassion made operational.

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