Challenges of Policy Implementation for PM-JAY in Rural Uttar Pradesh: A Governance Perspective

Sona Ojha[1], Prof. Gopal Prasad[2]
Research Scholar[1], Professor[2]
Department of Political Science, Deen Dayal Upadhyaya, Gorakhpur University
Email id- sonaojhaa@gmail.com[1] drgopalprasad@gmail.com[2]

Abstract:

The Pradhan Mantri Jan Arogya Yojana (PM-JAY), launched under the Ayushman Bharat scheme, aims to provide financial protection to over 500 million vulnerable Indians by offering health insurance coverage of up to ₹5 lakhs per family per year. Despite its transformative potential, the implementation of PM-JAY in rural regions such as Uttar Pradesh reveals critical governance-related challenges. This paper examines these challenges through the lens of public policy and health governance, focusing on issues such as administrative coordination, frontline awareness, digital infrastructure, beneficiary identification, and healthcare provider participation. Drawing on a governance framework, the paper argues that institutional fragmentation, lack of local capacity, and inadequate inter-departmental coordination significantly hinder effective delivery.[1] Moreover, limited health insurance literacy among rural populations, coupled with social exclusion due to caste and gender, further exacerbates access barriers.[2] By analyzing secondary data, policy reports and theoretical literature, the study illustrates the need for context-sensitive implementation strategies, capacity building at the grassroots level and stronger accountability mechanisms. The findings contribute to the broader discourse on health policy reform and the viability of large-scale public insurance models in low-resource rural settings.

Key words: PM-JAY, Policy Implementation, Health Governance, Healthcare.

Introduction:

A simple access to quality healthcare in rural India has been a challenge for years due to structural inequities, financial pressure and poor public health infrastructure. To overcome these challenges, the Government of India implemented the Pradhan Mantri Jan Arogya Yojana (PM-JAY) in the year 2018 as part of the Ayushman Bharat initiative. PM-JAY is the world's largest public funded health insurance which provides an annual cover of Rs. 5 lakh per family to over 10 crore poor and vulnerable families for secondary and tertiary care hospitalization, including This scheme assures financial risk protection, better health results, including reduction of out-of-pocket expenditure (OOPE), with the accent particularly on the rural population which is more affected by the cost of health care.[3]

Although the policy ambitions and intentions of PM-JAY are grand and inclusive, operationalization in rural areas, particularly in states like UP, has been faced with serious governance-related hurdles. Uttar Pradesh, with the largest rural population in India, presents a crucial test case for evaluating the practical effectiveness of PM-JAY. Reports and field studies indicate that despite the formal availability of benefits, issues such as poor beneficiary awareness, infrastructural gaps, ineffective monitoring, weak institutional coordination, and social exclusion continue to impede the program's success.[4] This study also aims to contribute to broader debates on universal health coverage (UHC), rural health equity, and the role of state capacity in welfare

[1] Lahariya C. (2018). 'Ayushman Bharat' Program and Universal Health Coverage in India. Indian pediatrics, 55(6), 495–506
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[3] Lahariya C. (2018). 'Ayushman Bharat' Program and Universal Health Coverage in India. Indian pediatrics, 55(6), 495–506
[4] Prinja, S. et. al., (2022). Impact of India's publicly financed health insurance scheme on public sector district hospitals: a health financing perspective. *The Lancet regional health. Southeast Asia*, *9*, 100123. https://doi.org/10.1016/j.lansea.2022.100123

delivery. It also identifies critical gaps and recommends governance reforms that could enhance the efficiency, inclusivity, and accountability of PM-JAY in rural settings.

PM-JAY and Rural Healthcare in Uttar Pradesh:

PM-JAY is a centrally sponsored health insurance initiative launched in September 2018 administered by the National Health Authority under the Ayushman Bharat Yojna. It is the largest publicly funded health assurance program in the world, covering approximately 10 crore (100 million) families, which is roughly 500 million individuals; across India. The scheme provides cashless hospitalisation coverage of ₹5 lakh per family annually, covering secondary and tertiary care, and includes all pre-existing conditions from day one[5]. Benefits include treatment, diagnostics, hospitalization, medicines, along with post-hospitalisation for provision of wide-range services to decrease the catastrophic out-of-pocket expenditure for hospitality care.[6] Eligibility for the same is based on the 2011 Socio-Economic Caste Census (SECC); in particular, rural families meeting six deprivation criteria (D1–D5, D7) and urban families in occupation that would be categorized as D1–D5 (such as ragpickers, rickshaw pullers, street vendors, and, in some states, "hawkers"), with the additional inclusion of automatically included families, such as those that are homeless, and include "manual scavenger" families. This ensures the poorest 40% of rural households are included.[7]

Coverage Increase in Uttar Pradesh**:** In Uttar Pradesh (UP), based on SECC and RSBY data, about 1.17 crore families were deemed eligible for PM-JAY.[8] As of early 2022, roughly 39% of these eligible families were formally covered under the scheme.[9] While this might seem limited, national studies estimate that PM-JAY exposure led to a 3.4 percentage-point increase in non-PMJAY public health insurance (NPHI) coverage in rural UP, and 4.2 pp in urban UP, between NFHS-4 and NFHS-5 periods.[10]

Rural Health Infrastructure in Uttar Pradesh**:** Uttar Pradesh remains one of India's most populous and economically challenged states, hosting nearly 240 million people; most of them living in rural setting and grow up with high level of poverty and multidimensional deprivation. The public healthcare infrastructure, which consists of SPHCs, PHCs, and CHCs, is fairly well distributed but poorly resourced PM-JAY empanells (public or private) hospitals, subject to infrastructure requirements, but rural UP is under-empanelled, so that local cashless care is limited.[11]

Awareness and Utilisation Gaps: Evidence from recent studies shows very low awareness of PM-JAY among rural beneficiaries. In field surveys, only 18.8% of rural interviewees (n = 112) were aware of scheme benefits, and just 14.3% knew how to avail services; utilisation was even lower, with only 15.2% of rural respondents having actually used the scheme[12]. Notably, health workers, Arogya Mitras, and special drives accounted for most registrations, underscoring the importance of frontline outreach.[13]

Governance and Health Policy Implementation

A governance lens is needed for better comprehension and examination of how health policies such as PM-JAY are operationalised, especially in rural areas such as those in Uttar Pradesh. Governance in public health is more than just administrative capacity; it encompasses the institutions, processes, accountability structures, and relationships through which health policies are formulated and executed.[14] This section outlines the

[5] https://nha.gov.in/img/pmjay-files/Malti-Jaswal-Technical-session-4_Opening-presentation_AM3-Final.pdf
[6] https://nha.gov.in/PM-JAY
[7] https://nha.gov.in/img/pmjay-files/Policy-Brief-13-Projecting-Updated-Eligibility.pdf
[8] https://nha.gov.in/img/pmjay-files/State-factsheet-for-September-2021/Uttar-Pradesh-state-factsheet-september-2021-26.pdf
[9] https://nha.gov.in/img/pmjay-files/December-2021-state-factsheet/Uttar-Pradesh-December-2021-state-factsheet-26.pdf
[10] https://pmc.ncbi.nlm.nih.gov/articles/PMC10462969/
[11] Srivastava, S., Bertone, M.P., Basu, S. *et al.* Implementation of PM-JAY in India: a qualitative study exploring the role of competency, organizational and leadership drivers shaping early roll-out of publicly funded health insurance in three Indian states. *Health Res Policy Sys* **21**, 65 (2023). https://doi.org/10.1186/s12961-023-01012-7
[12] Dixit R, Chauhan A, Juneja K. Awareness and Utilization of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-NHPM) among Beneficiaries of Gautam Buddha Nagar District: A Comparative Study. Indian J Community Med. 2025 Jan-Feb;50(1):213-219. doi: 10.4103/ijcm.ijcm_728_23.
[13] ibid
[14] Brinkerhoff, D. W., & Bossert, T. J. (2013). Health governance: principal–agent linkages and health system strengthening. *Health Policy and Planning*, 29(6), 685-693. https://doi.org/10.1093/heapol/czs132

conceptual framework used in this paper, focusing on three core elements: **institutional capacity**, **stakeholder coordination**, and **participatory accountability**. This includes how decisions are made, who holds power, how resources are allocated, and how transparency and accountability are ensured. Grindle (2004) introduced the concept of "good enough governance" to highlight that governance reforms must be realistic, context-sensitive, and focused on specific developmental outcomes, rather than idealized institutional benchmarks.

Three Dimensions of Governance Challenges

a) Institutional Capacity: Effective implementation will depend on the capacity and preparedness of the implementing institutions. It is important to consider efficiency of administration, staff training, technical infrastructure (PM-JAY IT platforms, for instance) and monitoring. Weak institutional capacity leads to delays in claim processing, poor empanelment of facilities, and inadequate response to grievances; challenges frequently reported in rural states.[15]

b) Stakeholder Coordination: Health policy governance is fundamentally multi-actor. The success of PM-JAY depends on the cooperation among central organisations (National Health Authority), SHAs, insurers or TPAs, hospitals and field health workers like ASHAs and Arogya Mitras.

c) Participatory Accountability: Those responsible for efforts in rural health delivery need to be participated in their accountability mechanisms. This includes community engagement, complaint mechanisms, local feed-back loops, and civil society monitoring. In rural Uttar Pradesh, low insurance literacy and weak civic engagement result in a lack of pressure on service providers, further limiting PM-JAY's impact.[16]

Implementation Challenges in Rural Uttar Pradesh

Despite its ambitious plan and focus from the national-level, PM-JAY has hit major challenges when it comes to rolling out in rural areas; some of it in places like Uttar Pradesh which suffer from a high levels poverty, poor health literacy, and a very weak public health system. This section analyse the core governance challenges across five dimensions, situated in the conceptual space of institutional capacity, coordination, and accountability. PM-JAY uses Socio-Economic Caste Census (SECC) 2011 data for beneficiary identification. But that dataset is aging and lacks a way to dynamically update itself. As a result; a large share of eligible households are either not being identified or are being wrongly classified, resulting in errors of exclusion.[17] Besides, the rural beneficiaries are not aware about their inclusion in the scheme and the biometric authentication through Aadhaar causes tech-based exclusion as well in low digital network connectivity regions and due to mismatch of fingerprints.[18] The local political and bureaucratic discretion involved in determining eligibility has led to geographically uneven access across caste and class categories, thus undermining the egalitarian aims of the scheme.

PM-JAY's operationalisation at district and block levels are connected through State Health Agencies (SHAs), insurance companies or TPAs and the local level functionaries. In rural UP, these fronts see them operate in silos, at times creating confusion on the ground about whose jurisdiction certain duties fell under. The implementation pipeline is also weakened by delay in empanelment of hospitals, biased claim settlement and poor monitoring.[19] The staff member many Arogya Mitras are given to assist the beneficiaries to navigate hospital systems are underqualified and over taxed and are often not there at all, especially in remote areas.[20]

[15] Bennett, S., Ozawa, S., & Rao, K. D. (2010). Which path to universal health coverage? Perspectives on the World Health Report 2010. *PLoS Medicine*, 7(11), e1001001. https://doi.org/10.1371/journal.pmed.1001001

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[18] Khera, R. (2019). *Aadhaar Failures: A Tragedy of Errors.* EPW Engage (April 6, 2019) OPEN ACCESS

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Lack of linkages between PHCs and the empanelled hospitals result in broken referrals and continuity of care is not maintained particularly for chronic diseases.

One of the most significant challenges in rural Uttar Pradesh is poor access to empanelled hospitals, especially secondary and tertiary hospitals of acceptable quality under PM-JAY. A significant number of rural blocks do not have even 1 empanelled private hospital, and the public ones are either under-equipped or unwilling to participate in the scheme due to low package rates and red tape.[21] During this time, patients often need to travel great distances and are increasingly faced with transport and out of pocket costs that undermine the plans objective to provide financial protection. Where services are present, lack of specialists, diagnostic equipment, and beds limits the provision of care.

Several field studies point out that the level of awareness about PM-JAY is very poor in rural UP. In a cross-sectional study, just 18.8% of rural respondents knew about the programme and fewer were clear on its benefits and how to gain them?[22] Women, Dalits and other disadvantaged communities are especially poorly informed about health insurance. Suspicions over free services, previous encounters with under-the-table payments and the absence of evident state efforts have combined to make the plan seem bizarre: ungainly and unreal. Close to the community health workers (ASHAs, ANMs) are rarely systematically included in the campaigns, a missed opportunity for trust building and mobilization.

Implementation Gap

The findings in the previous section reveal a concerning gap between the ambitious design of PM-JAY and its on-ground realities in rural Uttar Pradesh. This disconnect can be traced to deeper structural issues within governance and public administration, rather than mere technical or procedural shortcomings. This section reflects on those issues, interprets them in light of the conceptual framework, and identifies potential pathways for reform.

PM-JAY is an example of the top-down formulation of policy-making, centrally conceived but executed by state and district-level actors with varying capacities. This model frequently results in "policy drift" when it comes to local translation, particularly where there is weak institutional capacity or ill-coordinated actors.[23] Uttar Pradesh, despite having a large beneficiary base, suffers from historically weak state capacity, reflected in chronic human resource shortages, underfunded facilities, and limited monitoring infrastructure.[24] These deficiencies hinder effective coordination between key implementing bodies—State Health Agencies (SHAs), insurance companies, and district administrators. The lack of robust interdepartmental mechanisms further amplifies the administrative inertia. The disparity between the number of empanelled hospitals in urban vs rural areas also reflects spatial inequities embedded in India's health system.

Recommendations:

To address the implementation constraints of PM-JAY in rural Uttar Pradesh requires a governance-oriented reform strategy that is not confined to policy financing and technology, but includes building the institutional capacity, social accountability, and local adaptability. The recommendations are based on policy analysis, in-service training and evidence of lessons learned in other states. A key priority is the reform of beneficiary identification and enrollment systems. The dependence on the inadequate SECC 2011 list is leading to exclusion errors in the masses, with a preference for excluding the rural poor. To address this, there should be a dynamic inclusion mechanism, using block-level evidence along with regular field verification by field

[21] Choudhury, M., & Mohanty, R. K. (2019). Utilisation of PM-JAY by public and private hospitals: Emerging evidence and policy implications. *NIPFP Working Paper*.

[22] Awareness of the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana among beneficiaries in India. (n.d.). *PMC*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11927863/

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workers like ASHA, ANM.[25] Decentralized verification and recourse mechanisms can play a role in addressing exclusion in real time and enhance transparency.

Developing the institutional strength at the district level is equally important. PM-JAY is currently based on State-level Health Agencies (SHAs) and Third-Party Administrators (TPAs), however, in UP, many rural districts still lag behind in terms of personnel, technology systems, and decision-making authority that are needed for management efficiency.[26] Assignment of some of the operational powers – empanelment of hospitals, local audits and claim verification, to district authorities and targeted training of nodal officers and Arogya Mitras, would facilitate implementation and cut down bureaucratic delays.[27] The problem of insufficient availability of rural health providers in rural blocks needs to be addressed through a targeted rural provider policy. Many private hospitals prefer urban centers due to profitability and logistical ease, while public hospitals face empanelment challenges due to infrastructure and documentation shortfalls. The government can also explore performance-based incentives for private facilities to establish satellite facilities in underserved areas and provider grants to public hospitals for building capacities to meet empanelment criteria.[28] District-level health access mapping is useful for determining where such interventions are needed most.

Finally, establishing multi-channel accountability mechanisms is essential for citizen-centered implementation. Rural residents often face technological and literacy barriers in accessing toll-free helplines or online grievance redress systems. Therefore, in-person help desks at PHCs, community feedback sessions, and independent social audits should be institutionalized.

Conclusion:

The Pradhan Mantri Jan Arogya Yojana (PM JAY) is one of India's boldest policies in public health, targeting universal health coverage and reducing out-of-pocket spending amongst its poorest populations. Yet, the current study has revealed that, in rural Uttar Pradesh, the operationalization of PM-JAY is limited not by intention or by resources, but by the complexity of governance-related challenges. From weak identification of the beneficiaries and health infrastructure to poor coordination among various stakeholders and low awareness among the rural populace, the distance from the policy concept and its ground implementation is gaping. The governance weaknesses exposed as: institution fragility, delegation disconnectedness, exclusion access, which have a negative impact on the potential of the scheme to provide income protection and accessible health services benefiting to those who need these the most. The findings confirm that technology and finance are not sufficient by themselves. Local governance reform, genuine community involvement and respect for socio-economic and cultural conditions of rural people are essential to ensure fair and successful implementation. States such as Uttar Pradesh need to spend not just on hospital infrastructure or IT systems but also on capacity building, decentralized decision-making and frontline engagement.

As India continues towards Ayushman Bharat and Universal Health Coverage, it is important that learning from contexts as rural as UP should actually guide future reforms! An implementation scheme that is more bottom-up, equity-conscious, and governance-sensitive is key to not only for the success of PM-JAY but also to the rebuilding of public confidence in state's commitment to inclusive and accountable healthcare delivery.

[25] Karan, A., Selvaraj, S., & Mahal, A. (2017). Moving to universal coverage? Trends in the burden of out-of-pocket payments for health care across social groups in India, 1999–2000 to 2011–12. *PLOS ONE*, 12(1), e0170110.

[26] Prinja, S. et. al., (2022). Impact of India's publicly financed health insurance scheme on public sector district hospitals: a health financing perspective. *The Lancet regional health. Southeast Asia*, *9*, 100123. https://doi.org/10.1016/j.lansea.2022.100123

[27] Choudhury, M., & Mohanty, R. K. (2019). Utilisation of PM-JAY by public and private hospitals: Emerging evidence and policy implications. NIPFP Working Paper

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