

Original Research

Received 15 June 2026

Revised 30 July 2026

Accepted 12 Aug 2026

Natural Resources for Human Health 2026, Vol. 6 (16s): 704–714

KEYWORDS:

Ayushman Bharat; PM-JAY; CHIRAYU Haryana; healthcare access; consumer behaviour; out-of-pocket expenditure; catastrophic health expenditure; universal health coverage.

Assessing the Impact of Ayushman Bharat (PM-JAY) on Healthcare Access and Consumer Behaviour: An Exploratory Study in Haryana

¹Monika Dahiya, ²Dr. Neelam Maggu,

¹Research Scholar, Department of Commerce, Baba Mastnath University, Rohtak, Haryana.

Email id- monikadahiya6002@gmail.com

²Research Supervisor & Professor, Department of Commerce, Baba Mastnath University, Rohtak, Haryana.

Email id- neelam.maggu5@gmail.com

ABSTRACT: This study examines how Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), India's publicly funded health assurance scheme, has altered access to hospital care and the health-seeking behaviour of households in Haryana. The analytical concern is not the number of cards issued, but whether a cashless entitlement of ₹5 lakh per family per year changes the decisions that patients actually make: whether to seek treatment, when to seek it, where to go, what they still pay, and whether they trust the scheme enough to use it again. The study adopts an exploratory, secondary-data and policy-analysis design. Evidence is drawn from National Health Authority (NHA) and Ministry of Health and Family Welfare releases up to September 2026, the National Family Health Survey (NFHS-4, NFHS-5 and NFHS-6), the National Health Accounts, the Haryana State Health Authority, audit and media records on claim settlement, and peer-reviewed impact evaluations, including a recent case-control study from Haryana. Nationally, PM-JAY had funded 13.25 crore hospital admissions worth about ₹2.03 lakh crore by 31 August 2026, and more than 48.5 crore Ayushman cards had been created. Haryana has widened eligibility beyond the national criteria through the state-funded CHIRAYU extension linked to Parivar Pehchan Patra (PPP). The Haryana evidence shows that beneficiaries incur direct medical out-of-pocket expenditure about 65% lower than non-beneficiaries, and a much lower incidence of catastrophic health expenditure (13.3% against 45.9%). Similarly, indirect costs are not covered, and conflicts over delayed insurance payments, including unpaid claims totaling ₹1,200 crore and a 24-hour shutdown of private hospitals in September 2026, undermine consumer confidence in PM-JAY. Analysis in this paper suggests that PM-JAY has encouraged earlier and more use of formal and private-sector health care facilities among consumers, but sustaining these improvements will require addressing issues related to timely payments to providers and coverage of outpatient and indirect costs.

1. INTRODUCTION

Illness has both health and financial costs for households. In India, financial costs associated with illness are traditionally paid by households. In 2013-14, 64.2% of health spending by households in India was out-of-pocket spending. Hospitalization was one of the main reasons households sold assets or took other high-cost actions to finance health care. A program that

provides direct payments to hospitals for care received by poor patients has benefits beyond simply providing cash assistance . It affects the price poor patients pay for health care and may change their behavior .

AB PM-JAY was launched on 23 September 2018 to provide cashless cover of up to ₹5 lakh per family per year for secondary and tertiary hospitalisation at empanelled public and private hospitals. Eligibility was based on factors related to deprivation and occupation in the Socio-Economic Caste Census of 2011 . The program was later extended to frontline workers . In September 2024, the Cabinet approved free insurance coverage for senior citizens 70 years and older, regardless of income, under the Ayushman Vay Vandana card program . As of September 2026—the eighth year of the program—more than 600 million people had been enrolled in the program . Over 485 million Ayushman cards have been issued, and more than 1,961 health procedures in 27 service categories have been provided .

Haryana provides a good example for analysis of the program . It is a high-income state with significant private hospital activity in areas near the National Capital Region and rural areas where patients primarily use public hospitals . Haryana has also implemented policy changes beyond the national standards . Through CHIRAYU Haryana, launched in November 2022, it extended PM-JAY-equivalent cover to families with verified annual income up to ₹1.80 lakh in the PPP database, and later opened contributory enrolment for families with income between ₹1.80 lakh and ₹3 lakh. Haryana is an example of a program with broad target population coverage and diverse service providers that relies heavily on state funding .

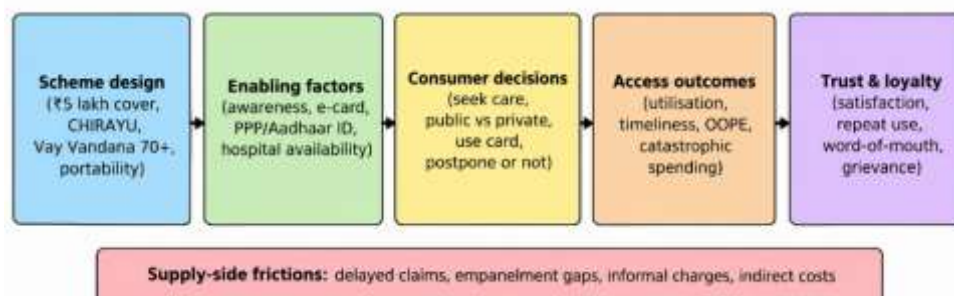
This paper has three main contributions . It views beneficiaries as patients seeking health care and examines how the PM-JAY program affects their decision-making process regarding selection and payment for services . It uses the latest available national and state-level data on Haryana, including 2026 program releases, which have not previously been analyzed in academic studies . It explores the relationship between financial protection and provider performance, showing that slow payments to hospitals under PM-JAY can affect patient behavior in addition to creating other challenges . This paper does not attempt to identify causal effects using secondary data but seeks to assess the consistency of secondary evidence with expected effects of PM-JAY on access to care and suggest measures to include in future studies .

2. CONCEPTUAL FRAMEWORK: PRICE, ACCESS AND HEALTH-SEEKING BEHAVIOUR

Three theories guide our analysis . Grossman's (1972) theory of health as a form of human capital suggests that, when the price of medical care declines, individuals will increase their investment in health care . Arrow (1963) and Pauly (1968) argue that insurance can reduce the price of medical care and increase consumption of medical care, including overconsumption of medical care that would not occur without insurance (moral hazard) . Andersen's (1995) behavioral model of health care use indicates that other factors affecting health care use, such as predisposing factors (age, education, attitudes) and enabling factors (income, insurance coverage, provider availability), also play a role . PM-JAY is an enabling factor affecting health care use, though its impact depends on other factors, including knowledge of the program and proximity to empaneled hospitals .

From a consumer behavior standpoint, there are five main benefits of the scheme . The payment channel lowers or eliminates copayments for procedures covered under the scheme . The choice channel increases the number and types of providers available, including private hospitals that were previously unaffordable to participants . The time channel reduces delays in treatment by eliminating the need to save for hospital costs . The information channel includes outreach by Ayushman Mitras and other services, such as e-cards and helplines, to provide information on benefits and reduce other information barriers . The repeat use channel affects whether households that have used the scheme in the past continue to use it or return to self-financing . These benefits are not guaranteed . Informal charges, uncovered medicines and diagnostics, travel and wage loss, denial of admission and delayed provider payments can each weaken the chain.

Figure 1. Conceptual framework: how PM-JAY shapes healthcare access and consumer behaviour



Source: Authors' construction based on Grossman (1972), Andersen (1995) and PM-JAY operational guidelines.

3. OBJECTIVES AND RESEARCH METHODOLOGY

The study pursues four objectives:

- (i) to trace the evolution and current scale of PM-JAY nationally and in Haryana;
- (ii) to assess changes in healthcare access and financial protection associated with the scheme in Haryana;
- (iii) to examine how the scheme has influenced consumer behaviour, including provider choice, timing of care and trust; and
- (iv) to identify the institutional constraints that limit the scheme's impact and suggest policy responses.

The design is exploratory and descriptive, relying on secondary data and documentary analysis. Four categories of sources were used. The first comprises official scheme data from the National Health Authority, Press Information Bureau releases and replies in Parliament up to September 2026. The second is household survey evidence from NFHS-4 (2015-16), NFHS-5 (2019-21) and the NFHS-6 (2023-24) national fact sheet released on 29 May 2026. The third is financing data from the National Health Accounts (NHA) estimates for 2021-22. The fourth is peer-reviewed evaluation research, selected where it reported comparative outcomes (beneficiaries against non-beneficiaries, or before against after), with priority given to studies from Haryana and north India. Official statements from the Haryana State Health Authority and reports on the claim-settlement dispute between the state and the Indian Medical Association (IMA) were used to assess supply-side reliability. Figures were cross-checked across at least two sources where possible, and all ratios reported in the study are the authors' calculations from the cited figures. Because the data are secondary and drawn from different periods, the findings are interpreted as indicative associations rather than causal effects.

4. POLICY ARCHITECTURE: PM-JAY AND ITS HARYANA EXTENSIONS

The architecture relevant to Haryana households combines the centrally sponsored PM-JAY with state-funded extensions that use the same IT platform, hospital network and card. Table 1 summarises the principal components. The common economic logic is that the state purchases hospital care on behalf of the household through pre-defined package rates, so that the patient faces a zero price for listed procedures at empanelled facilities.

Table 1. Components of the Ayushman Bharat architecture relevant to Haryana

Component	Eligibility / target	Benefit	Key behavioural concern
AB PM-JAY (2018)	SECC-2011 deprived and occupational categories; RSBY legacy families	₹5 lakh per family per year; cashless secondary and tertiary care; national portability	Awareness of entitlement; denial or informal charges at private hospitals

CHIRAYU Haryana (Nov 2022)	PPP families with verified income up to ₹1.80 lakh; contributory option for ₹1.80–3 lakh	Same ₹5 lakh cover and hospital network, funded by the state	Accuracy of PPP income data; sustainability of state financing
Ayushman Vay Vandana (2024)	All citizens aged 70+ irrespective of income	Additional ₹5 lakh top-up for senior members of eligible families	Uptake among elderly with multimorbidity; outpatient needs not covered
Frontline worker extension	ASHA, Anganwadi workers and helpers	₹5 lakh family cover	Workers as scheme ambassadors in villages
Ayushman Arogya Mandirs	Universal primary care	Free primary care, screening and referral	Linkage between primary care and PM-JAY hospitalisation

Source: Compiled from NHA, Ayushman Bharat Haryana Health Protection Authority and Government of Haryana notifications.

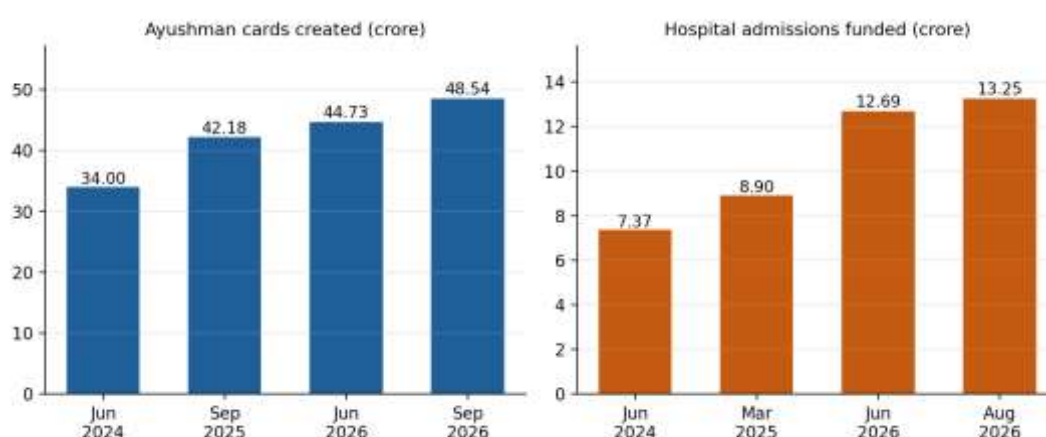
Two features distinguish Haryana. The first is the use of the PPP family database, which allows the state to determine eligibility on the basis of verified income rather than a 2011 census list, making coverage more current. The second is the degree of fiscal exposure: the state bears the full cost of CHIRAYU beneficiaries, who outnumber the original SECC-based PM-JAY beneficiaries. Early administrative data indicated that 74.33 lakh cards had been issued under CHIRAYU compared with 28.89 lakh under the original PM-JAY list, and national card-creation data place Haryana's cumulative total at over 1.36 crore, one of the highest among the states. The wider the eligibility, the greater the claims volume that the state must finance on time.

5. SCALE AND TRENDS: NATIONAL AND HARYANA EVIDENCE

5.1 National scale-up

PM-JAY has grown rapidly over the last two years. The number of Ayushman cards rose from about 34 crores in June 2024 to 48.54 crore by September 2026, and funded hospital admissions rose from 7.37 crore to 13.25 crore over the same period (Figure 2). Dividing the cumulative value of treatment by the number of admissions gives an average of roughly ₹15,300 per admission, which indicates that the scheme is used mainly for moderate-cost secondary procedures rather than exclusively for high-cost tertiary care. Table 2 reports the latest national indicators.

Figure 2. Growth in Ayushman cards and hospital admissions under AB PM-JAY, 2024–2026



Source: Authors' compilation from Ministry of Health and Family Welfare replies in Parliament (Aug 2024, Mar 2025, Jul 2026), NHA dashboard (Sep 2025) and eighth-anniversary releases (Sep 2026).

Table 2. Key national indicators of AB PM-JAY (latest available)

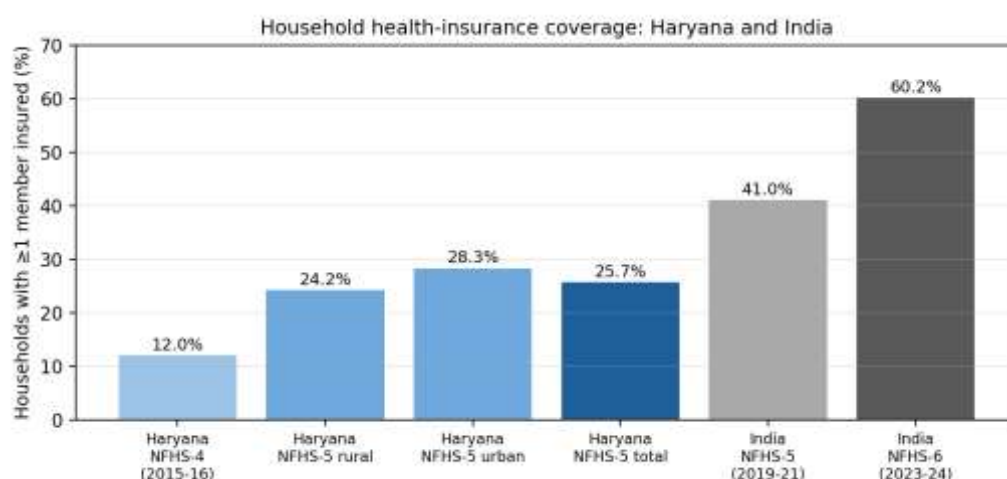
Indicator	Value	Reference date
Population covered	More than 60 crores	23 Sep 2026
Ayushman cards created	48.54 crore	Sep 2026
Hospital admissions funded	13.25 crore	31 Aug 2026
Value of treatment funded	≈ ₹2.03 lakh crore	31 Aug 2026
Average value per admission (authors' calculation)	≈ ₹15,300	31 Aug 2026
Empanelled hospitals	More than 38,000	Aug–Sep 2026
Health benefit package	1,961 procedures in 27 specialties	2026
Ayushman Vay Vandana cards (70+)	More than 1.36 crore	21 Sep 2026
Union Budget allocation for PM-JAY	₹9,406 crore	2025-26

Source: Ministry of Health and Family Welfare / NHA releases; Union Budget 2025-26.

5.2 Coverage and financing context

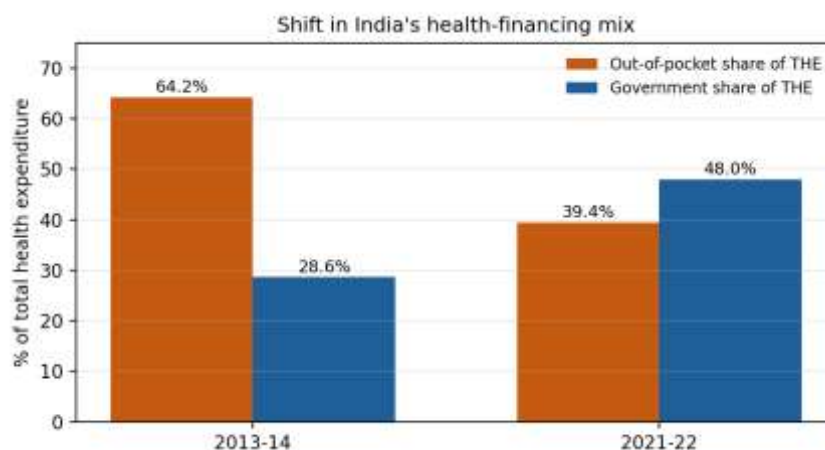
Household survey data show how far the insurance landscape has changed. In NFHS-4 (2015-16) only 12% of Haryana households had any member covered by a health insurance or financing scheme. NFHS-5 (2019-21) recorded 25.7% (28.3% urban and 24.2% rural), but the survey itself notes that PM-JAY had not been fully rolled out at the time of fieldwork. The NFHS-6 (2023-24) national fact sheet shows the proportion of insured households in India rising from 41.0% to 60.2%, with coverage now higher in rural (62.0%) than urban (56.4%) areas, a reversal that is largely attributed to publicly financed schemes (Figure 3). At the aggregate level, National Health Accounts estimates show the OOPe share of total health expenditure falling from 64.2% in 2013-14 to 39.4% in 2021-22, while the government's share rose from 28.6% to 48.0% (Figure 4).

Figure 3. Households with at least one member covered by health insurance or a financing scheme



Source: NFHS-4 Haryana; NFHS-5 Haryana State Fact Sheet; NFHS-5 and NFHS-6 India Fact Sheets (IIPS & MoHFW). Haryana-level NFHS-6 estimates were not available in consolidated form at the time of writing.

Figure 4. Share of out-of-pocket and government spending in India's total health expenditure (THE)



Source: National Health Accounts Estimates for India 2021-22, MoHFW (2024).

5.3 Implementation in Haryana

Haryana's hospital network and claim volumes have expanded with eligibility (Table 3). In late 2022 the state had 715 empanelled hospitals (539 private and 176 public); by early 2025 about 1,300 hospitals were empanelled, around 600 of them private. The Comptroller and Auditor General reported 4.99 lakh settled claims worth ₹589.24 crore up to November 2022, an average of about ₹11,800 per claim. By August 2025 the State Health Authority reported that more than ₹3,050 crore had been disbursed since inception and that hospitals were registering about 2,500 pre-authorisations a day. The rising volume indicates strong consumer uptake, but it also explains why payment arrears have become recurrent.

Table 3. Selected implementation indicators for Haryana

Indicator	Earlier value	Recent value	Interpretation
Empanelled hospitals	715 (539 private, 176 public), 2022	≈1,300 (≈600 private), 2025; ≈650 private in IMA claims dispute, 2026	Network nearly doubled; private sector central to access
Cards issued	28.89 lakh PM-JAY + 74.33 lakh CHIRAYU (early phase)	Over 1.36 crore (national card-creation data, 2026)	Eligibility far exceeds SECC-based list
Claims settled	4.99 lakh; ₹589.24 crore (to Nov 2022)	Over ₹3,050 crore disbursed since inception (Aug 2025)	Claims value grew more than five-fold
Daily pre-authorisations	—	≈2,500 per day (Aug 2025)	High and regular consumer demand
Pending dues to private hospitals	≈₹400 crore (early 2025)	≈₹1,200 crore, >6 months old (Sep 2026)	Payment reliability deteriorating

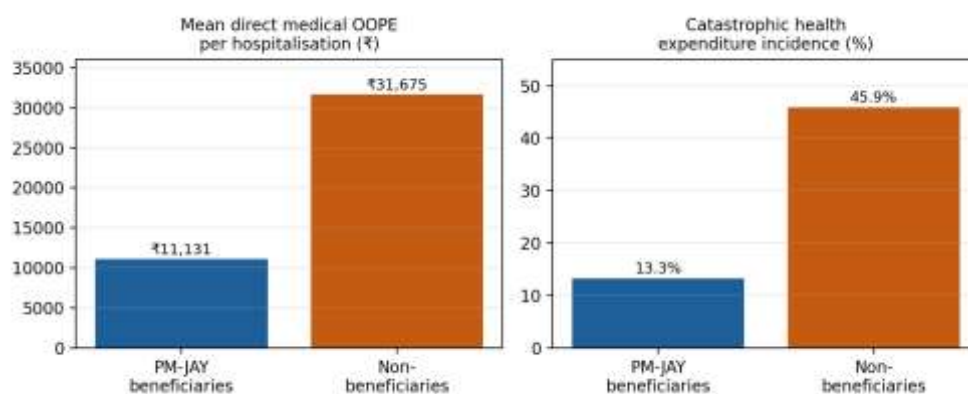
Source: Government of Haryana; CAG audit as reported in The Tribune (2023); Haryana State Health Authority (2025); IMA Haryana statements reported in The Tribune (2025, 2026).

6. IMPACT ON HEALTHCARE ACCESS AND FINANCIAL PROTECTION

The most direct evidence for Haryana comes from a case-control study by Kumar et al. (2025), which used stratified random sampling of hospitalised PM-JAY beneficiaries and comparable non-beneficiaries. After controlling for caste, housing, family type, morbidity, facility type, length of stay, distance and travel time, direct medical expenditure per hospitalisation was 65%

lower for beneficiaries (₹11,131) than for non-beneficiaries (₹31,675). The incidence of catastrophic health expenditure was 13.3% among beneficiaries against 45.9% among non-beneficiaries (odds ratio 7.15). Crucially, the difference was concentrated in private empanelled hospitals, where non-beneficiaries paid about three times as much; in public hospitals out-of-pocket costs were similar for both groups (Figure 5).

Figure 5. Out-of-pocket and catastrophic expenditure among PM-JAY beneficiaries and non-beneficiaries in Haryana



Source: Kumar et al. (2025), BMJ Open, 15(9), e093304.

The Haryana results are consistent with a six-state household survey by Parmar et al. (2023), which found that PM-JAY did not raise the overall number of hospitalisations but raised the probability of using a private facility by 4.6 percentage points, and reduced OOOE by 13% and catastrophic expenditure by 21%, with the reduction driven entirely by private facilities. However, the literature is not uniform. Garg et al. (2024) found in Chhattisgarh that, four years after roll-out, enrolment was not associated with lower OOOE, and over 70% of enrolled patients using private hospitals still incurred catastrophic expenditure at the 10% threshold. Earlier reviews of publicly financed insurance in India likewise reported consistent gains in utilisation but mixed evidence on financial protection (Prinja et al., 2017; Reshmi et al., 2021). Table 4 summarises the evidence.

Table 4. Synthesis of selected evidence on PM-JAY and related schemes

Study	Setting / design	Key finding	Relevance to Haryana
Kumar et al. (2025)	Haryana; case-control, stratified random sample	Direct medical OOOE 65% lower; CHE 13.3% vs 45.9%	Strong protection, mostly in private hospitals; indirect costs persist
Parmar et al. (2023)	Six states; >57,000 eligible individuals	Private use +4.6 pp; OOOE -13%; CHE -21%	Scheme shifts demand toward private providers
Garg et al. (2024)	Chhattisgarh; repeated household surveys	No reduction in OOOE or CHE among enrolled; private overcharging	Protection depends on regulating provider behaviour
Prinja et al. (2023)	Public district hospitals	Scheme revenues strengthen public-hospital finances	Claims income can improve public-sector quality
Prinja et al. (2017); Reshmi et al. (2021)	Systematic reviews of Indian PFHI	Utilisation rises; financial-protection evidence mixed	Results sensitive to design and implementation

Source: Compiled by the authors from the cited studies.

Three conclusions about access follow. First, in Haryana the scheme appears to provide meaningful financial protection for hospitalisation, which is its core purpose. Second, the protection is largest precisely where the pre-scheme price barrier was highest, namely private hospitals; the scheme therefore expands the effective choice set of poorer households. Third, the

protection is incomplete. Kumar et al. (2025) report that indirect costs such as food, transport and lost wages were not covered and were sometimes higher for beneficiaries, reflecting longer journeys to empanelled hospitals. Outpatient care, which accounts for a large share of household health spending, remains outside the PM-JAY benefit.

7. CONSUMER BEHAVIOUR UNDER PM-JAY

Viewed as consumer behaviour, the evidence points to a reorganisation of the decision process rather than a simple increase in demand. Table 5 maps the main behavioural dimensions against the evidence and their implications.

Table 5. Behavioural dimensions of PM-JAY use in Haryana

Behavioural dimension	Observed pattern	Driver	Risk
Decision to seek care	Hospitalisation sought without first arranging funds	Zero price at point of use; cashless card	Care delayed if hospital refuses or asks for deposit
Choice of provider	Shift toward private empanelled hospitals	Perceived quality, shorter waits, proximity in urban belts	Supplier-induced demand; overcharging
Timing of care	Earlier admission for planned procedures	Removal of liquidity constraint	Outpatient follow-up still self-financed
Information search	Reliance on Ayushman Mitras, ASHA workers, helplines, e-card apps	PPP and Aadhaar-linked identification	Low awareness among elderly and migrants
Payment behaviour	Residual spending on medicines, tests, travel, food	Gaps in package coverage and indirect costs	Catastrophic spending not eliminated
Trust and repeat use	Positive word-of-mouth after cashless treatment	Satisfactory first experience	Suspensions and denials erode confidence

Source: Authors' analysis based on Kumar et al. (2025), Parmar et al. (2023), Garg et al. (2024) and Haryana SHA statements.

Three behavioural effects deserve particular attention. The first is the liquidity effect. For poor households, the main obstacle to using hospitals is upfront payment rather than overall cost. Cashless entitlements eliminate the upfront payment obstacle and can lead to increased use of hospital services even if overall costs do not decline substantially. A second effect is substitution of public for private care. From the consumer's perspective, advantages of private-sector care in urban Haryana include faster service and better attention. From the consumer's perspective, disadvantages include loss of regulation of hospital practices, as private hospitals may try to obtain informal payments or provide services that are not covered. A third effect is the information effect. A cashless entitlement program has value to consumers only to the extent that they expect to be able to use it. Negative experiences with cashless entitlements, such as being refused service, asked to pay a deposit, or having service denied or interrupted, can inform consumers that their entitlements are not absolute.

This is why the Haryana reimbursement row is important for consumer issues. The reimbursement program aims to have hospitals paid within 15 days of claim submission. In early 2025 the IMA's Haryana unit threatened to suspend services over dues of about ₹400 crore; in August 2025 private hospitals suspended PM-JAY services for a period until the State Health Authority released additional funds; and on 1–2 September 2026 roughly 650 private hospitals suspended new Ayushman admissions for 24 hours over about ₹1,200 crore in claims pending for more than six months. A threatened indefinite suspension from 16 September 2026 was withdrawn only after an assurance from the Chief Minister. Emergency admissions continued throughout, and public hospitals continued to serve card holders. Yet repeated disruptions of this kind are likely to make patients hedge—by keeping cash in reserve, returning to self-financed care, or delaying planned procedures—thereby undoing part of the liquidity effect.

8. DISCUSSION

The Haryana experience suggests that PM-JAY works best as a financial-protection instrument when three conditions are met: the household knows and can prove its entitlement, a suitable empanelled hospital is within reach, and that hospital is confident of being paid on time. Haryana has made significant progress toward meeting the first requirement through PPP-based identification systems and the CHIRAYU program. Haryana has made moderate progress on the second requirement by doubling the number of hospitals. The third requirement has become the biggest barrier. Increased demand for services due to expanded eligibility creates greater fiscal exposure for Haryana with each eligible patient admitted. Delays in service use reduce the fiscal risk to Haryana's households and increase it for service providers, who may pass the risk on to patients by requiring deposits or other payments or denying service.

Another challenge is demand-side composition. Private hospitals help fill gaps in public services for many patients, but private-sector demand must be encouraged. The CAG report indicates that some private hospitals overstated patient occupancy relative to bed capacity. The SHA's use of unannounced inspections and patient photo verification at discharge are strategies to address fraud and quality concerns related to cashless hospital services. Another challenge is the scope of benefits provided under PM-JAY. Many chronic diseases, including diabetes, hypertension, and cancer, require long-term outpatient and other medical care. Patients with chronic diseases who receive inpatient care under PM-JAY but not outpatient care at Ayushman Arogya Mandirs pay out of pocket for other medical services. The inclusion of people aged 70 and older in PM-JAY services is particularly problematic, as older adults often have multiple chronic conditions.

9. POLICY RECOMMENDATIONS

- **Guarantee payment discipline.** Create a dedicated, ring-fenced claims fund for PM-JAY and CHIRAYU, publish monthly ageing of pending claims, and pay statutory interest on claims unpaid beyond the prescribed period.
- **Match eligibility with financing.** Any further extension of CHIRAYU to higher-income families should be accompanied by a costed premium or contribution structure and a multi-year budget commitment.
- **Strengthen strategic purchasing.** Use claims data analytics, random audits and patient feedback to identify overcharging, unnecessary procedures and denial of care; link hospital incentives to quality indicators.
- **Reduce residual consumer costs.** Enforce the cashless rule for medicines and diagnostics within packages, and explore transport support for patients referred to distant hospitals.
- **Integrate primary and hospital care.** Link Ayushman Arogya Mandirs with PM-JAY hospitals for pre- and post-hospitalisation follow-up, especially for elderly and chronic-disease patients.
- **Communicate entitlements clearly.** Use ASHA workers, Ayushman Mitras and SMS alerts to explain what is covered, how to complain and what to do if a hospital refuses a card, particularly during payment disputes.
- **Measure outcomes, not cards.** Annual district-level reporting should cover utilisation per 1,000 beneficiaries, OOPE, catastrophic expenditure, denial complaints and claim-settlement time.

10. LIMITATIONS AND FUTURE RESEARCH

The study has four principal limitations. First, secondary data from multiple sources and time periods make it difficult to compare the results and draw causal inferences. Second, administrative data on the number of cards issued and patients admitted are outcome measures and do not provide information on health impacts. Third, Haryana state and district-level data from NFHS-6 and PM-JAY use were not publicly available in a single source when this article was written. Fourth, media reports on the payment dispute include statements from the disputing parties and should be interpreted accordingly.

Future research could conduct a large survey of households in several Haryana districts to compare outcomes, including use and out-of-pocket spending, among program participants and eligible nonparticipants. Other survey questions could assess future program use intentions. Data from the survey combined with program and hospital payment information could be used

to examine direct evidence of the effects of delayed payments on program and informal payments. Difference-in-differences studies exploiting variations in the timing of CHIRAYU income eligibility cutoffs could help identify causal relationships.

CONCLUSION

Ayushman Bharat PM-JAY has had a significant economic impact on many households in Haryana. Direct payments to hospitals at admission have been eliminated, resulting in lower out-of-pocket healthcare expenditures and catastrophic health expenditures and increased use of private hospitals. Consumer responses to these policy changes include earlier hospital visits and greater use of formal and private healthcare providers. The same evidence, however, shows that the gains are fragile. Indirect and outpatient costs remain uncovered, private-sector behaviour requires active regulation, and repeated delays in paying hospitals have exposed card holders to the risk of disrupted services. The central policy implication is that the value of an entitlement lies in its reliability. For PM-JAY to deliver lasting improvements in healthcare access in Haryana, the next phase must focus less on enrolling more families and more on ensuring that every card is honoured, every hospital is paid on time and every beneficiary is protected from the costs that the scheme does not yet cover.

REFERENCES

- [1] Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36(1), 1–10. <https://doi.org/10.2307/2137284>
- [2] Arrow, K. J. (1963). Uncertainty and the welfare economics of medical care. *American Economic Review*, 53(5), 941–973.
- [3] Garg, S., Bebarta, K. K., & Tripathi, N. (2024). The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) after four years of implementation – is it making an impact on quality of inpatient care and financial protection in India? *BMC Health Services Research*, 24, 919. <https://doi.org/10.1186/s12913-024-11393-2>
- [4] Grossman, M. (1972). On the concept of health capital and the demand for health. *Journal of Political Economy*, 80(2), 223–255.
- [5] International Institute for Population Sciences & Ministry of Health and Family Welfare. (2021). *National Family Health Survey (NFHS-5), 2019-21: State fact sheet, Haryana*. IIPS.
- [6] International Institute for Population Sciences & Ministry of Health and Family Welfare. (2026). *National Family Health Survey (NFHS-6), 2023-24: India fact sheet*. IIPS.
- [7] Karan, A., Yip, W., & Mahal, A. (2017). Extending health insurance to the poor in India: An impact evaluation of Rashtriya Swasthya Bima Yojana on out of pocket spending for healthcare. *Social Science & Medicine*, 181, 83–92.
- [8] Kumar, A. P., Yerram, A., Chugh, Y., Rana, S., Mudgal, D., Prinja, S., & Muraleedharan, V. R. (2025). Impact of India's publicly funded health insurance scheme on financial risk protection: A case-control study from Haryana state in India. *BMJ Open*, 15(9), e093304. <https://doi.org/10.1136/bmjopen-2024-093304>
- [9] Ministry of Health and Family Welfare. (2024). *National Health Accounts estimates for India 2020-21 and 2021-22*. National Health Systems Resource Centre, Government of India.
- [10] Ministry of Health and Family Welfare. (2025, 2026). *Replies in Lok Sabha and Rajya Sabha on the progress of AB PM-JAY*. Press Information Bureau, Government of India.
- [11] National Health Authority. (2026). *AB PM-JAY: Eight years of implementation*. Government of India.
- [12] Parmar, D., Strupat, C., Srivastava, S., Brenner, S., Parisi, D., Ziegler, S., Neogi, R., Walsh, C., & De Allegri, M. (2023). Effects of the Indian national health insurance scheme (PM-JAY) on hospitalizations, out-of-pocket expenditures and catastrophic expenditures. *Health Systems & Reform*, 9(1), 2227430. <https://doi.org/10.1080/23288604.2023.2227430>
- [13] Pauly, M. V. (1968). The economics of moral hazard: Comment. *American Economic Review*, 58(3), 531–537.
- [14] Prinja, S., Chauhan, A. S., Karan, A., Kaur, G., & Kumar, R. (2017). Impact of publicly financed health insurance schemes on healthcare utilization and financial risk protection in India: A systematic review. *PLOS ONE*, 12(2), e0170996. <https://doi.org/10.1371/journal.pone.0170996>
- [15] Prinja, S., Kaur, G., Gupta, R., Rana, S. K., & Aggarwal, A. K. (2019). Out-of-pocket expenditure for health care: District level estimates for Haryana state in India. *International Journal of Health Planning and Management*, 34(1), 277–293.
- [16] Prinja, S., Singh, M. P., Aggarwal, V., Rajsekar, K., Gedam, P., Goyal, A., & Bahuguna, P. (2023). Impact of India's publicly financed health insurance scheme on public sector district hospitals: A health financing perspective. *Lancet Regional Health – Southeast Asia*, 9, 100123. <https://doi.org/10.1016/j.lansea.2022.100123>

- [17] Reshmi, B., Unnikrishnan, B., Rajwar, E., Parsekar, S. S., Vijayamma, R., & Venkatesh, B. T. (2021). Impact of public-funded health insurances in India on health care utilisation and financial risk protection: A systematic review. *BMJ Open*, 11(12), e050077. <https://doi.org/10.1136/bmjopen-2021-050077>
- [18] The Tribune. (2026, September 1). Haryana private hospitals suspend Ayushman services over delayed claim payments. *The Tribune*, Chandigarh.
- [19] The Tribune. (2026, September 15). Haryana IMA withdraws call to suspend Ayushman services from Sept 16 after CM's intervention. *The Tribune*, Chandigarh.