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Effectiveness of Ayushman Bharat Yojana in Northeast Delhi: A Case Study of Seelumpur and Seemapuri Districts

Ms. Sofiya Ali

Independent Research Scholar, Political Science, University Of Delhi

ABSTRACT

Since India got its independence, it has focused on state funded welfare schemes to mitigate various deficiencies and problems of a post-colonial society. One such sector full of lacunas is Indian medical infrastructure and its functionaries.

This article tries to study the domain of effectiveness of Ayushman Bharat -Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) policy, which acts as an overarching national program by the government to fill the loopholes within existing national medical structures. AB PM-JAY officially became operational in NCT-Delhi from 10th April,2025. Since then, the number of its beneficiaries sore up.

This article tries to evaluate the effectiveness of the policy within the area of north east Delhi. The highest density of population with a weak socio-economic background nature of trans Jamuna habitat makes it a conducive ground for study of policy's operationality. The article focuses on two specific districts of northeast Delhi- Seemapuri and Seelampur. The major aim of this article is to access the ground level efficiency of the policy, examine the improvement in health care domain and accessibility of medical assistance to the needful ones.

As far as methodology is concerned, I'll be adopting a post positivist approach which tries not only to quantify the number of beneficiaries of the policy but also it tries to understand the qualitative insight of the population regarding the policy and its functioning. My research will be based on a prospective study design, for which I'll be conducting cross sectional surveys within specified districts.

KEYWORDS: Welfare state, state funded programs, health infrastructure

INTRODUCTION

The concept of welfare of the citizens and welfare state was intrinsic to ancient Indian political philosophy. Time and again from ancient to medieval period, Indian notion of state was seen as a sole flag bearer of citizens' wellbeing. In contemporary period, ever since India started drafting the very ideals of the constitution, the notion of public assistance through welfare policies gained popular consensus. In order to mitigate the deficiencies due to colonial legacy in education, sanitation and health sector, to harness the ever-growing socio-economic vulnerabilities in the society, the notion of state assistance steps in.

For instance, article 47 of DPSP, instructs state to raise level of nutrition in population along with improving public's health by providing standard of living. Article 21 of fundamental rights of Indian constitution directs state to provide timely medical assistance to the citizens in the pursuance of right to life. (*Durga Das Basu, 2024*)

From time and again various political parties who won electoral majority, irrespective of their ideologies tried to uphold this gist of public welfare. Rashtriya Swastha Bima Yojana (RSBY) was introduced by UPA govt in 2008, which was later absorbed into AB PM-JAN by NDA govt in 2018. Ayushman Bharat encompasses two complementary schemes, Health and Wellness Centres and National Health Protection Scheme. Health and Wellness Centres are envisioned as a foundation of the health system to provide comprehensive primary care, free essential drugs and diagnostic services, whereas National Health Protection Scheme is envisaged to provide financial risk protection to poor and vulnerable families arising out of secondary and tertiary care hospitalization. (*Sanjay Zodpey , Habib Hasan Farooqui, 2018*)
This same policy became operational in Delhi. AB PM-JAY in Delhi focuses on developing capacities of health system across primary, secondary and tertiary health care levels. Along with this, an additional 5 lakh cover up is given by Delhi govt through its funds
Within the extends of Delhi, the local demography of trans Jamuna suggests it to be the prominent area to gage the efficiency of safety nets as being promised by the policy. My, article will be focusing on districts of Seemapuri and Seelampur in order to understanding how the migrant population of urban slums of these areas who are specifically employed in informal sector of economy, interact with ABPM-JAY. Furthermore, my article tries to comprehend the efficiency of the policy through four major analyses. First, beneficiary enrolment number of the patients; second, reduction in out-of-pocket expenditure (OPE); third, quality of health care services; fourth, awareness of the policy among population.

LITERATURE REVIEW

ACCORDANCE WITH UNIVERSAL HEALTH COVERAGE

India being the member state of UN, actively tries to line its national policies and programmes in accordance with the idea of sustainable and quality living. UHC views the idea of healthy living as an indispensable part of holistic human development. It not only focuses on protection from health risk with the help of government funded health assistance, but also focus on prevention of health risk through all-inclusive rehabilitation and care. Similarly in this reference India came up with the notion of National Health Policy (NHP)-2017. It was initiated by the Union Cabinet. NHP aims to deliver quality health services at affordable cost by increasing public health expenditure to 2.5 per cent of the GDP. To translate the vision of the NHP-2017 into reality, the Government of India has approved Centrally Sponsored Ayushman Bharat-National Health Protection Mission (AB-NHPM). (*Sanjay Zodpey , Habib Hasan Farooqui,2018)*
Specifically talking about Delhi, the state government has allocated ₹13,034 crore to the healthcare sector for the 2026-27 financial year. This represents roughly 12.57%of the overall ₹1,03,700 crore state budget. This budgetary proportion that is dedicated to health coverage includes the operation of government hospitals, Mohalla Clinics, and universal health insurance schemes. To be more precise in respect to ABPM-JAY government has allocated ₹2,144 crore**.** (*Government of Delhi, planning department*,2025)

PERSISTENCY OF OOPE

One of the major provisions of ANPM-JAY is to reduce the out-of-pocket expenditure which often turns out to be more expensive than the treatment per se. however, OOPE majorly depends on implementation quality, hospital participation, and reimbursement systems. (*Sharma, A.,2026*). ABPM-JAY tries to reduce the health expenditure of an individual by providing government funded hospitalization, regardless this OOPE sustains itself due to limited benefit packages, medicine purchases outside hospitals, transport costs, outpatient care, repeated purchase of medicines, and treatment for chronic illnesses. (*Khokhar, A.,*

Gupta, S., Nathe, P. C., Yadav, G., & Kumar, S.,2026) Hospitalization is just one aspect of health treatment, overhead financial burden often generates from above mentioned factors which acts as a hinderance to the wider acceptance of a policy.

EMPANELED HOSPITALS

Another prominent provision of ABPM-JAY, is empanelment of large number of hospitals and health infrastructures to increase the domain of health assistance. This empanelment works at three major levels. Firstly, all public hospitals within state territory which has operationalized the policy, are considered empanelled. Secondly, Hospitals belonging to Employee State Insurance Corporation (ESIC) may also be empanelled based on their bed occupancy ratio. Thirdly, private hospitals are empanelled through HEM (Hospital Empanelment Management) Portal. (*National Health Authority. Hospital Engagement Module (HEM): Empanelled Hospitals Search.)*

In context to Delhi, the Official reports by NCT of Delhi indicated that more than 200 hospitals had been empanelled in Delhi, including over 150 private hospitals. (*Government of the National Capital Territory of Delhi,2025).*

Hospitals are considered the backbone of overall health coverage but if the situation is arising where hospitals are hesitating to actively participate in welfare of the population, it'll make policy fell flat on its face. the effectiveness and sustainability of private-sector participation depend on timely reimbursement of claims, transparent claim-settlement mechanisms, and efficient administrative processes. All these altogether discourage private hospitals from actively participating hence potentially limiting service availability and beneficiary access (*Joseph et al., 2021*). This clearly indicates that large number of private hospitals with more advanced infrastructure are stepping back from the policy implementation.

AWARNESS &BENIFICIARY ENROLLMENT

Within democracy, the policy with greater enrolment ratio fulfils the parameter of a successful policy. High number of public enrolments and public participation reflects high amount of policy legitimization as well. Beneficiary enrolments ratio plays an eminent role in reflecting the real median between what is being promised and what is being delivered. Hence, beneficiary enrolments directly reflect the quality of a policy.

However, popular participation towards a policy directly depends on public education and awareness. If public lacks awareness regarding a policy, then that public policy remains ineffective. Specifically, in Delhi the government established an online beneficiary registration through the National Health Authority portal. (*Government of NCT of Delhi, Department of Health & Family Welfare,2026*). As per the scheme there are 36 lakh eligible beneficiary of the policy, however, only 7.2 lakh Ayushman cards were published. This clearly suggest lack of awareness campaign and lack limited extends of the beneficiary rate. (*Press Information Bureau, 2025*)

All the above-mentioned scholarly work and data clearly show the gap within the existing study.

METHODOLOGY

For this article I adopted post positivist approach where I tried to quantify data on public participation as well as qualitative insight of population concerning their general views and awareness on policy benefits. My research is limited to Seelampur and Seemapuri area of Northeast Delhi. Both the areas comprise of migrant population from eastern parts of India in general and UP, Bihar and West Bengal in particular. A proper demographic understanding of the area was taken into account before determining the sample size.

My sample size consists of 100 people from both the districts. Within my sample size my targeted population was people from rural households with vulnerable socio-economic background, manual scavenger backward caste and landless rental wage laborers and those who are mostly employed in informal sector.

For sampling technique, simple probability sampling was used, where every respondent got fair and equal chance to be a part of survey. Research questions were prepared in advance. The sequence of the questions moved from general to specific. The language of questions was easy to understand. Standard questions about policy and procedure to obtain benefits from the policy outnumbered other questions. Special attention was given to map how many beneficiaries got treatment from private hospitals under ABPM-JAY. Apart from standard questions certain subjective questions like how were the quality of treatment that the recipient received through this policy was also included in the survey. Rigorous unstructured surveys were conducted for my study so that it can provide greater flexibility to touch other factors as well that hinders public from actively attaining greater benefit from the public policy. The nature of my surveys was based on cross sectional study. Holistic perspective was also given importance, where education, assets, health and overall well-being were also considered. Similarly, interactions were held at micro relational levels. One to one interaction and conversations were given preferences. However, to ensure greater participation by the population, focused groups were also created with 5 to 6 participants. And in-depth interviews of focused groups were conducted. Mostly the surveys and the interviews that were conducted were highly flexible and oral responses were recorded. Apart from this a general naturalistic observation method was also used. Through this method I tried to gauge the effectiveness of ABPM-JAY.

RESULT & DISCUSSION

The data that has been collected during my research clearly showed that there's a huge gap between what can be achieved through utilization of policy at its fullest capacity and what is being actually utilized at the ground level.

The data highlights that only 30% of the population that was considered, is able to avail the benefits of the policy. And out of 30% only 5% of the recipient testify the effectiveness of the policy at the same time they expressed their satisfaction towards to quality of the treatment that they received.

The results shows that even after a huge chunk of money that is being spend on the policy and its implementation, the health infrastructures and various other fundamental health technologies & instruments are at verge of total collapse condition. The less empanelled private hospitals further deteriorate the effectiveness of the policy. the research clearly shows that within the districts of Seelumpur and Seemapuri the number of private hospitals that participates in the policy also lacks advance healthcare systems. Hence, again creating cracks for policy effectiveness.

According to research the vulnerable households who are major recipient of the policy still faces the burden of out-of-pocket expenditure. According to my research the recipients continuously faced the financial burden of outpatients, which lead them to fall in the loop of out-of-pocket expenditure. Only 1% out of 30% were able to manage both treatment and outpatient financial burden through the concerned policy.

Further the research highlights that out of 200 approximately 20% are the Ayushman card holders. However, they haven't used it even once. This clearly reflects the problems that lies at two levels; first, even after one year of policy implementation people don't have Ayushman cards, which clearly shows

lack of awareness among people. This lack of awareness in turns hampers the public participation in the public policy, which altogether creates question of policy legitimization. As per the data that is being collected even people with little bit of knowledge of the policy, fails when it comes to policy registration and availing its benefits. This highlights another level of the problem that is complex registration process. As my population is coming from the darkest and poorest section of the society, digital registration is never an option available to them. In specific reference to on-site registration booth, mostly which are established outside medical care centres remain closed or remain open as per the discretion of booth officer.

CONCLUSION

The findings of my research certainly shows that the level of efficiency of ABPM-JAY in the urban slum areas like seelumpur and seemapuri is questionable. Despite repeated attempts by the government to expand the public funded health care coverage in India the situation at the ground level hardly makes any difference. Major lacunas are not inadequacy of the policy, but the way policy is being operationalized at grassroot level. Various provisions of the policy are wide ranging in nature. The spirit of the policy is definitely citizen centric. However, its implementation has many loopholes. the study reveals the policy made for public, has left many people out of its spectrum. The major cause is unawareness among citizens regarding both the policy and beneficiary arenas of the policy. Proper campaigns and programs need to be organised where illiterate masses could made to comprehend the real essence of the policy. Similarly, the notion of digital divide in Indian society need to be considered. Most of the policy registration and card generation process is limited to online platform hence eliminating of vulnerable section of the society. There is need of establishing and maintaining physical booths near or within the premises of hospitals, which acts in providing assistance to the masses regarding the policy. Proper functioning of these booths must be emphasised and they must persuade masses to avail the policy benefits. More empanelment of hospitals should be given emphasis in general and in urban slums like Seelumpur and Seemapuri in particular. Outpatient financial requirements must also be considered in this policy in order to reduce out of pocket expenditure. Similarly, the process to applying for treatment under policy must be made simple and time saving.

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