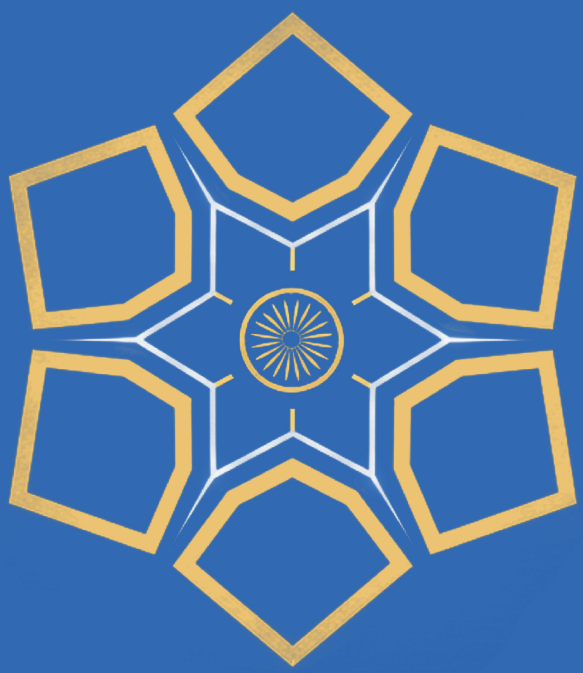
Road to Viksit Bharat

From Achieving Universal Health Coverage to Attaining Universal Health Assurance



INDIAN SCHOOL OF PUBLIC POLICY

CENTRE FOR UNIVERSAL HEALTH ASSURANCE

PREFACE

From Achieving Universal Health Coverage to Attaining Universal Health Assurance examines the evolving landscape of health systems and highlights the need to move beyond notional coverage towards true access and effective coverage. While coverage ensures that individuals are formally included in a health programme, access underscores their ability to actually utilize services that are affordable, equitable and of high quality.

This report embodies the vision of Viksit Bharat (Developed India) thriving in a healthy society where multi-sectoral initiatives align the various determinants with the developmental imperatives of promoting health and wellbeing in the population, preventing disease and restoring health where it is compromised. This is the 'health assurance' a developed India must give the people as it confidently moves towards Viksit Bharat by 2047.

The document presents the key elements of India's programme for universal health coverage based on extensive research, analysis and dialogue with experts. It outlines the challenges and opportunities confronting efforts to strengthen health systems with inclusivity and resilience. It is intended to serve as a resource for policymakers, practitioners, researchers, and all stakeholders committed to advancing health equity.

It is our hope that this report will stimulate further discussion, inform decision-making, and encourage collaborative action towards building systems that guarantee not just enumerated coverage, but meaningful access to effective and equitable health for all.

We acknowledge the contributions of colleagues, institutions, and communities whose insights and experiences have shaped the perspectives presented here. Their dedication to improving health outcomes in India continues to inspire our work

TABLE OF CONTENTS

Abbreviatons

A

AAM: Ayushman Arogya Mandir

ABHA: Ayushman Bharat Health Account

ABDM: Ayushman Bharat Digital Health Mission

AB-HWCs: Ayushman Bharat – Health and Wellness Centres

AB-CCs: Ayushman Bharat Counselling Centres

ACA: Affordable Care Act

AGCA: Advisory Group on Community Action

ANC: Antenatal Care

ANM: Auxiliary Nurse and Midwife

ArK: Arogya Karnataka

ART: Anti-retroviral Therapy

ASHA: Accredited Social Health Activist

AYUSH: Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy

B

BPHUs: Block Public Health Units

BPL: Below Poverty Line

C

CAH: Community Action on Health

CAPFs: Central Armed Police Forces

CCBs: Critical Care Blocks

CCM: Chronic Care Model

CE: Community Engagement

CHC: Community Health Centres

CHE: Current Health Expenditure

CHO: Community Health Officer

CHWs: Community Health Worker

CGCR: Central Gateway Control Room

CGHS: Central Government Health Scheme

CINs: Clinically Integrated Networks

CoCM: Collaborative Care Model

COPD: Chronic Obstructive Pulmonary Disease

CSOs: Civil Society Organizations

D

DH: District Hospitals

DIUs: District Implementation Units

E

EAG: Empowered Action Group (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand)

EBAIS: Equipos Básicos de Atención Integral de Salud

EMRs: Electronic Medical Records

ENT: Ear, Nose and Throat

EPW: Economic and Political Weekly

ESIC: Employees & State Insurance Corporation

F

FBS: Fasting Blood Sugar

FRP: Financial Risk Protection

G

GATS: Global Adult Tobacco Survey

GBV: Gender- Based Violence

GDP: Gross Domestic Product

GIS: Geographic Information Systems

GPs: General Practitioners

GSDP: Gross State Domestic Product

H

HBPs: Health Benefit Packages

HBNC: Home-based Newborn Care

HIV: Human Immunodeficiency Virus

HLEG Report: High-level Expert Group Report on UHC

HR: Human Resource

HRH: Human Resource for Health

HMIS: Health Management Information System

HTA: Health Technology Assessments

HTP: Health Transformation Programme

I

ICS: Integrated Care System

ICT: Information and Communication Technology

IDSs: Integrated Delivery Systems

IMIH: Indian Model of Integrated Healthcare

IMR: Infant Mortality Rate

IPAs: Independent Practice Associations

IPCs: Integrated Care Pathways

IPHL: Integrated Public Health Labs

IPHS: Indian Public Health Standards

IT: Information Technology

ITN: Insecticide-treated Nets

J

JAS: Jan Arogya Samitis

M

MAS: Mahila Arogya Samiti

MCH: Maternal and Child Health

MMR: Maternal Mortality Ratio

MMU: Mobile Medical Units

MoHFW: Ministry of Health and Family Welfare

MoSPI: Ministry of Statistics and Programme Implementation

MPW: Multi-purpose Worker

MSGPs: Multispeciality Group Practices

N

NCDs: Non-communicable Diseases

NGOs: Non-governmental Organization

NHA: National Health Authority

NHCX: National Health Claim Exchange

NFHS: National Family Health Survey

NFSA: National Food Security Act

NHA: National Health Accounts

NHM: National Health Mission

NHSRC: National Health Systems Resource Centre

NRHM: National Rural Health Mission

NSSO: National Sample Survey Office

NUHM: National Urban Health Mission

NQAS: National Quality Assurance Standards

O

OOP: Out-of-Pocket

OOPE: Out-of-Pocket Expenditure

OPD: Outpatient Department

P

PCMH: Patient-Centered Medical Home

PFHI: Publicly Financed Health Insurance

PHC: Primary Health Centre

PHOs: Physician-Hospital Organizations

PLA: Participatory Learning and Action

PM-JAY: Pradhan Mantri Jan Aarogya Yojana

PM-ABHIM: Pradhan Mantri Ayushman Bharat Health Infrastructure Mission

PPBS: Postprandial Blood Sugar

PPP: Public Private Partnership

PPSA: Patient Provider Support Agency

PRI: Panchayati Raj Institutions

Q

QCI: Quality Council of India

QoC: Quality of Care

R

RBS: Random Blood Sugar

RKS: Rogi Kalyan Samiti

RSBY: Rashtriya Swasthya Bima Yojana

S

SHA: State Health Agency

SCI: Service Coverage Index

SDGs: Sustainable Development Goals

SDH: Social Determinants of Health

SDHs: Sub-district Hospitals

SEAR: South East Asian Region

SECC: Socio-Economic and Caste Census

SHAs: State Health Agencies

SHSRC: State Health Systems Resource Centre

SLA: Service Level Agreement

SSI: Social Security Institution

STGs: Standard Treatment Guidelines

SMS: Short Message Service

T

TB: Tuberculosis

TFR: Total Fertility Rate

THE: Total Health Expenditure

TPAs: Third-Party Administrators

U

UNICEF: United Nations Children's Funds

UNFPA: United Nations Population Fund

UHA: Universal Health Assurance

UHC: Universal Health Coverage

ULBs: Urban Local Bodies

UPHC: Urban Primary Health Centre

U5MR: Under-5 Mortality Rate

V

VHSNC: Village Health, Sanitation and Nutrition Committees

W

WASH: Water, Sanitation and Hygiene

WHO: World Health Organization

FOREWORD

It gives me great pleasure to present this flagship report on behalf of Centre for Universal Health Assurance (CUHA) at the Indian School of Public Policy. CUHA was established with a singular purpose: to generate robust, policy-relevant evidence that can guide India's transition from Universal Health Coverage (UHC) to Universal Health Assurance (UHA); a shift from counting entitlements to guaranteeing dependable, high-quality care for every individual. This vision aligns closely with India's national aspiration of Viksit Bharat @ 2047, where health is not merely a service but a foundational pillar of human development and economic strength.

This report brings together a timely systems analysis on the architecture of UHA. It examines the four pillars of Ayushman Bharat: ***Ayushman Arogya Mandirs, PM-JAY, PM-ABHIM and Community engagement*** as core instruments for reorienting India's health system towards people-centred, primary care-led assurance. A unique contribution of this report is the construction of a State-level Universal Health Coverage Index, offering a comparative assessment of how states are progressing on commonly used indicators of service coverage and financial protection.

Equally important are the dedicated chapters on strengthening rural and urban primary care, each outlining context-specific challenges and pathways for integrating comprehensive, continuous, community-anchored care within state health systems. The section on health financing charts long-term trends in government spending, out-of-pocket expenditure and catastrophic health expenditure, situating India's performance alongside comparable economies. Additionally, our chapters on PM-JAY and community engagement highlight how responsive purchasing, grassroots stewardship and citizen participation can together build trust and accountability in the system.

The report is intended to serve as a resource for policymakers, administrators, researchers and practitioners committed to shaping India's health trajectory over the next two decades. As the country advances toward the promise of UHA, evidence-driven action and collaborative governance will be indispensable.

I commend the CUHA team for producing this valuable and timely work.

Dr. Parth J Shah
Co-founder and Dean
Indian School of Public Policy

ACKNOWLEDGEMENTS

This report is the culmination of extensive research, collaboration and expert guidance. We are grateful to Mr. Luis Miranda, Co-founder, Indian School of Public Policy (ISPP) and Dr. Parth J. Shah, Co-founder and Dean, ISPP, whose guidance and unwavering support continue to shape the Centre for Universal Health Assurance (CUHA) and its mission to reimagine health systems for India's future.

The report has been made possible through the generous support of our key institutional funders - Indegene Limited, Manipal Foundation and Windlas Biotech Limited – whose continued commitment energizes our work. We are equally grateful to our individual supporters - Basant R. Agrawal, Nirmala Kapil Hetamsaria, Vishal Sharma, Lakshmi Ananthamurthy, Lini Jeby Cherian and Venkata Giridhar Inumella - for their steadfast dedication to advancing CUHA's mission.

Our heartfelt thanks to the distinguished public health leaders, policymakers and practitioners who generously shared their time and expertise. Our appreciation goes to Dr. Ajay Tandon, Dr. Ashish Shrivastava, Maj (Gen) Atul Kotwal, Dr. Devaki Nambiar, Dr. Girija Vaidyanathan, Dr. Grace Achungura, Mr. Himanshu Burad, Dr. Indrani Gupta, Dr. J. N. Srivastava, Dr. Manohar Agnani, Shri Manoj Jhalani, Ms. Mirai Chatterjee, Dr. Muraleedharan V. R., Dr. Nirmala Nair, Dr. Prashanth N., Mr. Rajeev Sadanandan, Ms Sandhya Venkateswaran, Dr. Shridhar M. Kadam, Dr. Swaroop N., Dr. T. Sundararaman and Dr. Yogesh Jain. Their perspectives have greatly enriched the analytical depth and practical relevance of this report.

We also extend our thanks to Arohan Partners for drafting two key sections of this report and for their valuable analytical inputs. This report reflects the dedication and hard work of the CUHA writing team, whose commitment to rigour, detail and clarity has shaped its final form. We extend special gratitude to Ms. Omita Goyal for her meticulous editing; to Startech Consulting & Solutions and Facet Design for their creative visualisation in bringing the report's narrative to life. We are also grateful to Sreyoshi Mitra and Himansh Raj Bhatia for preparing the style sheet for this report which shaped its visual coherence and readability.

To all who contributed directly or indirectly, we extend our heartfelt gratitude. Your support strengthens our shared commitment to building a health system that truly delivers assurance, dignity and equity for every citizen.

Executive Summary

As India charts its course towards Viksit Bharat, the transformation of its health sector is a strategic imperative. This journey requires moving beyond the globally accepted goal of UHC to a more profound and ambitious paradigm - UHA. This report examines the critical shift required in global health systems—moving beyond the assurance of coverage to ensuring meaningful access. While UHC has been a cornerstone of health policy worldwide, it often focuses on financial protection and service inclusion without adequately addressing barriers that prevent individuals from utilizing care. UHA emphasizes equity, quality and timeliness of services, ensuring that health systems deliver care that is not only available but accessible to all. At the same time, adverse social and environmental factors which undermine health must be countered through multi-sectoral policies which are fully aligned to population health.

The shift from 'Coverage' to 'Assurance' re-centres the health system on the constitutional right to health for every individual, especially the marginalized.

Key Insights

Coverage vs. Access: Coverage alone does not guarantee utilization. Geographic, socio-economic and cultural barriers often prevent people from accessing services.

Equity and Inclusion: Vulnerable populations—including rural communities, women, migrants and marginalized groups—remain underserved despite formal coverage.

Strengthening of Health Systems: Achieving UHA requires investments in infrastructure, workforce, financing and governance to ensure resilience and responsiveness.

Financial Protection: Out-of-pocket expenditures continue to push households into poverty, highlighting the need for stronger risk protection mechanisms.

Acting on the Social, Environmental and Commercial Determinants of Health: It is essential to address the adverse social, environmental and commercial factors through multi-sectoral policies that promote, protect and preserve the health of the population. These determinants require collaboration across government, civil society and the private sector to ensure environments support rather than undermine health equity and outcomes.

Integration with SDGs: UHA aligns closely with the Sustainable Development Goals, particularly SDG 3 (Good Health and Wellbeing), and supports broader social development.

Recommendations

Redefine Policy Goals: Shift from measuring coverage rates to evaluating actual access, quality and utilization of services.

Strengthen Primary Health Care: Expand community-based services and empower frontline health workers.

Address Social Determinants: Integrate health strategies with education, housing and social protection policies.

Prevent Adverse Environmental and Commercial Factors from Eroding Health: Develop and enforce multi-sectoral policies to counter environmental threats (such as pollution and unsafe living conditions) and commercial risks (such as marketing of unhealthy products), ensuring that all policies support and promote the health and wellbeing of the population.

Enhance Equity Monitoring: Develop indicators that capture disparities in access and outcomes. Moving from monitoring to supportive supervision in true spirit and outcome- linked result framework.

Promote Partnerships: Foster collaboration between governments, civil society and private sector to close access gaps.

Conclusion

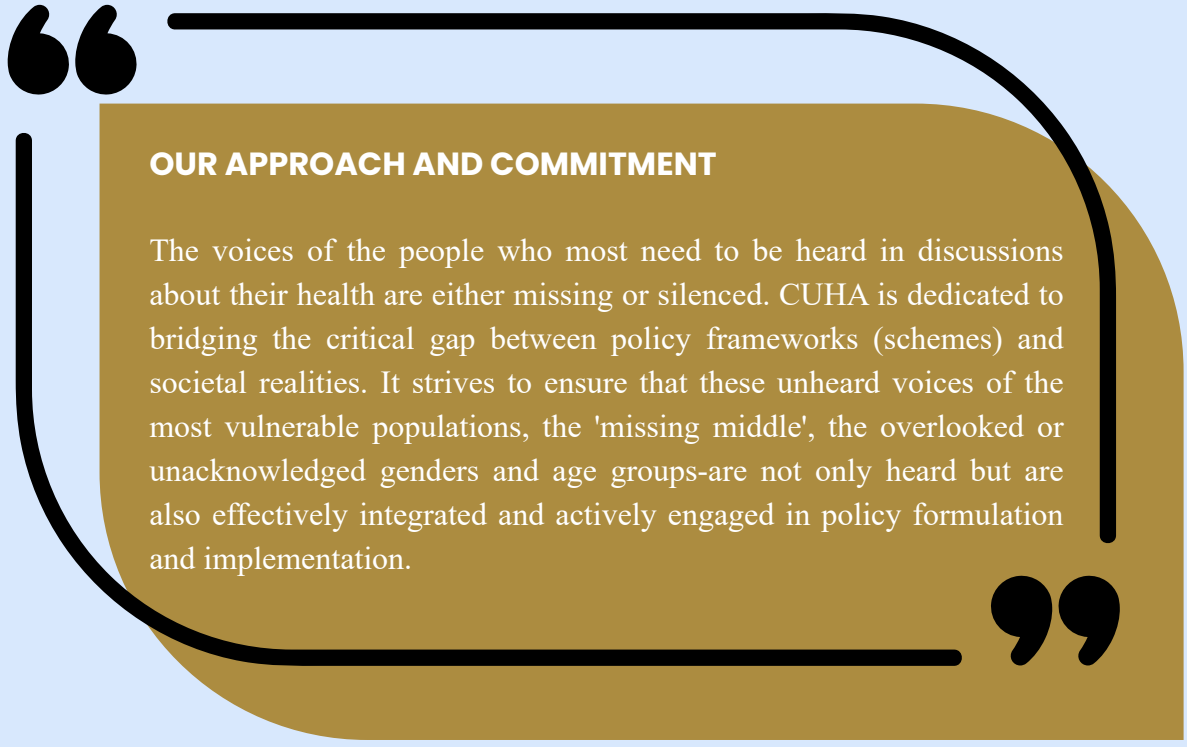
The transition from UHC to UHA represents a paradigm shift in health policy. It calls for a holistic approach that not only protects populations financially, but also ensures that services are equitable, timely and of high quality. By embracing UHA, health systems can move closer to the vision of health for all, leaving no one behind.

Introducing CUHA

The **Centre for Universal Health Assurance (CUHA)** at the Indian School of Public Policy (ISPP), New Delhi, was officially launched on May 23, 2025. Our vision is unequivocally simple: "Health is a human right, not a privilege to be purchased" .

CUHA was established to serve as a pivotal hub for research, innovation, and policy dialogue. We convene multidisciplinary experts from across the health domain to reimagine India's health system, based on accessible evidence and accumulated real world experience, and devise strategies for making quality healthcare universally accessible and affordable. While India possesses a robust health system, and CUHA fully aligns with the pursuit of Universal Health Coverage (UHC), the Centre maintains that the quality of life from womb to tomb is paramount. Both life expectancy (LE) and healthy life expectancy (HLE) must rise to attain the targets set by the Viksit Bharat mission for 2047. Therefore, crucial health determinants—including social, commercial, and economic factors—must be given equal weight in designing a holistic health system. This comprehensive approach will ensure the system is effective, equitable, empathetic, and economically efficient. This is the very basis of "Universal Health Assurance". This ethos directly supports the goal of a "Viksit, Sashakt, and Swasth Bharat" (Developed, Empowered, and Healthy India), a nation that guarantees health as a fundamental right for every individual.

We believe that the voices of the people who most need to be centered in discussions about their health are often either missing or silenced. CUHA is dedicated to bridging the critical gap between policy frameworks (schemes) and societal realities. We strive to ensure that the unheard voices—the most vulnerable populations, the 'missing middle,' and overlooked genders and age groups—are not only heard but are also effectively integrated and actively engaged during policy formulation and implementation.

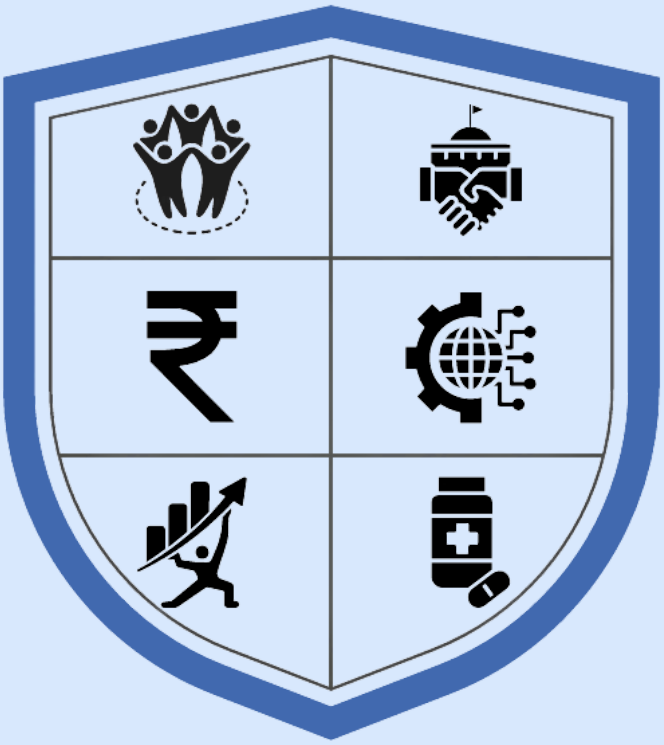


Institutional Visual Identity

In the visual language of institutional identity, a shield speaks to something profound: the commitment to defend, to preserve, to protect what is most vulnerable. The shield is a philosophical statement, a covenant between society and its commitment to ensure that health is not the privilege of a few, but a collective right for all.

The shield represents a core principle in public health ethics: that in societies of profound inequality, protection against health-driven catastrophe becomes a moral imperative. In India, a nation of vast social, economic and geographical differences, the shield symbolizes a singular desire that where one is born, what one can afford, or which community one belongs to should never determine one's access to healing.

This is not merely about healthcare delivery. It is about recognizing that ***health is fundamentally a social phenomenon*** shaped by the conditions in which people are born, grow, live, work and age. The shield underscores that health equity cannot be achieved through clinical interventions alone; it requires a fundamental reimagining of how society organizes itself, its power structures, its resource distribution, its capacity to imagine and act collectively and the alignment and convergence of all sectors around the shared goal of better health for all.



The Pillars of Collective Health Protection

The six pillars of the shield represent the integrated foundation upon which universal health assurance must be built. They are not separate domains but interconnected forces that must move in concert in the spirit of intersectoral convergence. Each pillar speaks to a dimension of what it takes to create health systems centred on equity, community and collective welfare and to the necessity of both effective governance within the health sector (governance *OF* health) and strong alignment across all other sectors (governance *FOR* health).

Community: People Joining Hands

At the foundation of any authentic health system lies the recognition that ***health emerges from the community.***

This pillar embodies the conviction that health assurance cannot be imposed from above; it must be built from below, rooted in the agency and participation of communities. It acknowledges that every community has knowledge about health, about disease, about healing practices that have served them across generations. It recognizes that real health progress occurs when institutions listen to communities, when communities have voice in decisions that affect their health and when health systems are accountable to the people they serve.

The image of people joining hands represents ***solidarity, mutual support and collective action***. It reminds us that health is ultimately a social achievement, something communities create together when they have the resources, knowledge and power to do so. This pillar reflects CUHA's commitment to research that honours community leadership, strengthens community capacity and sees communities as the true architects of health. It also highlights the need for enabling mechanisms within and beyond health systems, allowing communities to mobilize and shape wider determinants of health.

Parliament and Policy: The Architecture of Justice

Community aspiration, no matter how powerful, has to translate into policy and institutional action. Parliament and policymaking represent the formal mechanisms through which society makes collective choices about resources, priorities and protections. This pillar recognizes that health equity requires deliberate policy choices.

Policy is where values become concrete. It is the mechanism through which society can decide that health is a right, not a commodity; that financing should protect the poorest; that health workers should be valued and supported; that vulnerable populations should receive additional resources. Without policy grounded in evidence and commitment to justice, health remains fragmented and unequal.

This pillar embodies CUHA's commitment to ***evidence-informed policymaking***. It reflects the belief that rigorous research, when effectively translated into policy recommendations, can reshape the institutional structures that govern health. It acknowledges that achieving universal health assurance requires not just good intentions but tangible policy architecture like laws, regulations, financing mechanisms and governance structures designed with the explicit purpose of ensuring that everyone can access the health they need. The pillar of policymaking represents CUHA's role as a knowledge institution serving the wider project of health justice through informed advocacy and policy engagement.

Healthcare Financing: The Rupee Symbol

Health financing is ultimately about asking: ***Who pays for health and what are the consequences?*** The rupee symbol in the shield represents the material reality that health systems must be funded, that resources must flow smoothly without being obstructed by bureaucratic boulders and that a society's true commitment to health equity depends on how the resources are distributed. In India, the paradox of financing has been stark: where one can afford to pay determines whether one gets care. The cost of paying directly for health services can devastate families, pushing them into poverty and preventing them from seeking care even when desperately needed. This pattern perpetuates and deepens inequality and creates cycles of poverty and preventable disease.

This pillar underscores CUHA's commitment to understanding health financing both within the health sector and through leveraging investments and policies across sectors that impact health determinants. It represents the conviction that universal health assurance requires sustained financial commitment and deliberate choices about resource mobilization and distribution. It calls for research on sustainable financing models, on progressive taxation and on innovative mechanisms that ensure predictable, adequate funding for health systems.

Digital Technology and Health Information Systems

In an era of rapid technological change, digital systems make it possible to scale up knowledge about the health of a population.

When health data remains fragmented across disconnected systems and places, institutions fail to see disparities, are unable to track if interventions are reaching those most in need and cannot identify where resources should be directed. Interoperable digital systems are instrumental to intersectoral governance, driving accountability and coordination between all stakeholders.

This pillar signifies CUHA's commitment to examine how technology can strengthen health systems, improve access, enhance quality of care and enable evidence-informed decision-making at every level from frontline workers to policymakers, all the while recognising that data is valuable not for its own sake, but when it illuminates the conditions of those most marginalized, guides resources to those most in need and

enables accountability. It represents engagement with technological solutions, electronic health records, surveillance systems, digital tools for health communication, but always foregrounding the question: Does this technology serve justice?

Human Resources and Capacity: The Cornerstone of Care

Across India, health workers are distributed randomly and unequally. Those serving remote and marginalized communities often struggle with inadequate training, insufficient support and limited recognition. This results in health systems that cannot deliver quality care, that lose talented practitioners to migration and that fail to build the trust necessary for effective health relationships.

This pillar resonates with CUHA's commitment to understanding a health workforce as a justice issue. It calls for research on how to attract and retain health workers in underserved areas, how to provide training that equips people to serve diverse populations, how to create working conditions that enable health workers to practice with competence and compassion. It acknowledges that investing in human capacity is investing in the foundation of health systems. The pillar represents the conviction that true health assurance requires valuing health work and supporting those who do it and recognises that ***health systems are only as strong as the people who work in them.***

Medicines, Diagnostics and Technologies: The Tools of Healing

This pillar represents the ***material reality that health requires access to health technologies, medicines, vaccines, diagnostic tools and medical devices.***

It is a paradox in India and across the world that while cutting-edge medical knowledge exists, millions cannot access it. Lifesaving medicines are manufactured, yet remain unaffordable. Vaccines are developed, yet coverage remains unequal. Diagnostic tools for early detection of disease remain concentrated in urban centres.

This pillar relates to CUHA's commitment to examining access to medicines and diagnostics as a health equity concern. It represents the conviction that UHA requires ensuring that the tools of healing are accessible, affordable and available to all who need them. It acknowledges that this is not solely a clinical challenge but a policy and financing challenge-one that requires research on drug pricing, domestic manufacturing capacity, innovation models that prioritize affordability and on supply chains that can reach even the most remote populations.

Integration of the Shield

The six pillars do not function in isolation. They are interdependent, mutually reinforcing and together form the integrated foundation of UHA. The shield represents the conviction that achieving health equity requires simultaneous, coordinated action across all dimensions of health systems. Community participation without policy remains powerless. Policy without resources remains unfunded and unimplemented. Resources without skilled workers cannot translate into care. Technology without human connection becomes sterile. Medicines without access remain useless.

In a nation where health has historically been shaped by inequality, CUHA is committed to conducting research that strengthens each pillar, illuminates how they work together and contributes to building health systems in which every person, regardless of their circumstances, can access the health they need. The research is in service of justice, dedicated to understanding and advancing universal health assurance through community empowerment, evidence-informed policy, equitable financing, technology for equity, investment in human capacity and access to the tools of healing.

What is Universal Health Assurance

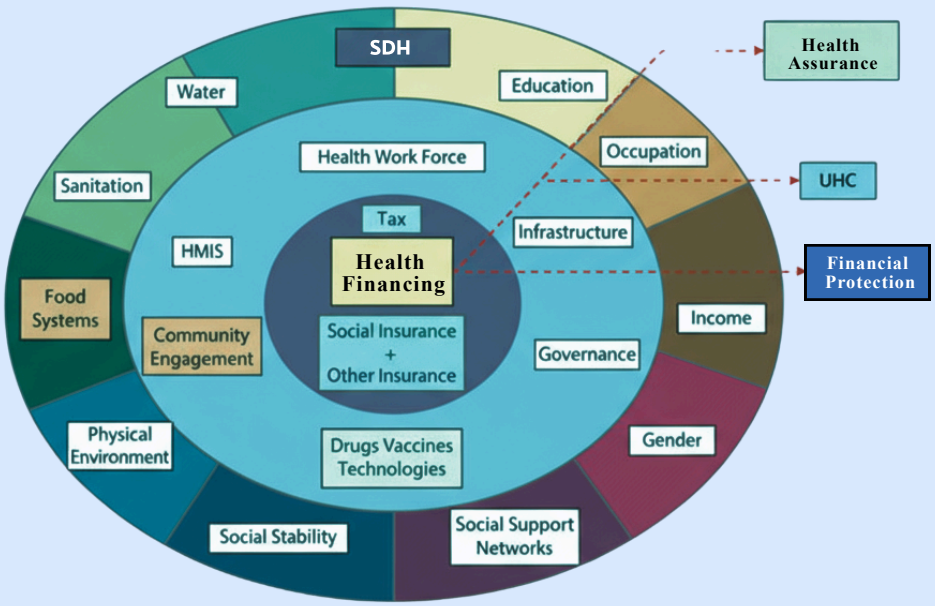


Figure 1 - Vision for Health Assurance

Universal Health Assurance (UHA) is a framework primarily conceptualized in the Indian context. It encapsulates financial protection and a defined package of services, emphasizing a guarantee that all citizens have a right to comprehensive, equitable and quality healthcare, primarily delivered through a strong public system. The shift from 'Coverage' to 'Assurance' re-centres the health system on the constitutional right to health for every individual, especially the marginalized.

The preference for UHA over UHC centres on the remissness of 'coverage' in equitable health. What are the reasons for this?

Exclusionary focus: Insurance-based coverage schemes, while vital, often focus on defined / vulnerable populations. This leaves out a large segment of the population just above the poverty line, the missing middle, who are equally susceptible to impoverishment from a health crisis, thereby violating the tenet of universality.

Gaps in care: Coverage models typically prioritize inpatient (hospitalization) care. However, most healthcare needs and financial burden come from outpatient care and diagnostics, which are frequently excluded from insurance packages. This leaves the poor with high out-of-pocket expenditure (OOPE), even if they have 'coverage'.

Low quality and access: Coverage does not "guarantee" access to quality care. The marginalized often rely on understaffed, under-financed public facilities, or are confronted with fragmented and unregulated services in the private sector. The lack of quality and timely accessibility nullifies the financial benefit of the coverage, denying them the highest attainable standard of health.

Rights vs. commodity: By emphasizing 'assurance', UHA explicitly links health access to an enforceable fundamental human right. When health is treated as a commodity to be covered (bought via insurance or subsidized payment), it fails to protect the most vulnerable who lack awareness, agency, or social power to navigate complex, fragmented systems and demand accountability.

Universal Health Assurance: A Progressive Vision (2030-2047)

As India charts its course towards Viksit Bharat, the transformation of its health sector is a strategic imperative. This journey requires moving beyond the globally accepted goal of UHC to a more profound and ambitious paradigm, UHA.

Health assurance within the universal health coverage framework must align with the 2030 Sustainable Development Goals, ensuring that every individual receives timely, appropriate, quality-assured and affordable healthcare without financial hardship. This vision goes beyond treating illness—it requires that social determinants of health are addressed so that populations are not only cured when unwell but are supported to remain healthy throughout their lives.

UHA is conceived as a progressive model that builds on the achievements of the SDGs and accelerates them. It represents an upward, integrated and networked movement that not only guarantees UHC entitlements but also fully incorporates social (education, WASH, nutrition), commercial (marketing of unhealthy products) and environmental (pollution and unsafe living conditions) determinants of health into the design and functioning of health systems. Achieving such integration will require that financing, service delivery and monitoring mechanisms evolve in a coordinated and interconnected manner by 2047.

The overarching ambition of UHA is to establish fully integrated, resilient health systems that are interlinked with other key sectors and aligned with broader population/health objectives. Sectors such as agriculture, food systems, transport and road infrastructure, urban planning and commerce must embed health goals within their mandates. Only through such cross-sectoral collaboration can health assurance be realized as a shared responsibility and a national development priority.

Universal health assurance for the 2030 milestone and beyond is a construct built on trust and confidence in the health systems.

As one analysis puts it, assurance is about: 'Confidence that medicines will be available at the primary health centre, that skilled providers will be present, that referral systems will work seamlessly, that families will not fall into poverty due to health shocks and that the system will remain resilient in future emergencies.'

This definition elevates the objective from simply providing access to services to being accountable for outcomes and responsive to people's needs. Further, what cannot be emphasized enough is trust: lack of trust and confidence in health systems often results in forgone care, which will be discussed later.

We are at a point of time when the right decisions in terms of policies have to be taken to move from UHC to UHA.

Measuring UHC

- UHC Index Methodology
- UHC Index Results

Need for More Granular UHC measurement

Global monitoring frameworks for UHC, most notably those developed by the WHO and World Bank, track progress through two core dimensions:

Service coverage; measured through tracer indicators of RMNCH+A (reproductive, maternal, newborn, child and adolescent health), infectious diseases, non-communicable diseases (NCDs) and service capacity.

&

Financial risk protection; assessed through out-of-pocket expenditure (OOPE) and the incidence of catastrophic health expenditure (CHE).

These metrics have played a crucial role in harmonizing global reporting, enabling comparability across countries and informing SDG monitoring. However, several limitations arise when these frameworks are applied uniformly across diverse country contexts.

While global UHC indicators are useful for macro-level comparison, they are not always representative of local realities. Health systems differ markedly in epidemiology, service delivery architecture, benefit entitlements and patterns of care-seeking. A uniform set of indicators may therefore under- or overestimate performance in countries with pluralistic systems like India, where public, private, formal and informal providers all play major roles.

To emphasize:

The global indicator for service capacity counts doctors, nurses and midwives, but in India, AYUSH (Allopathy, Ayurveda, Yoga, Unani, Siddha and Homeopathy) providers and allied health professionals constitute a large segment of the functional primary-care workforce.

Similarly, the indicator on hospital beds does not account for India's reliance on district hospitals or the massive heterogeneity in public–private infrastructure across states.

Given such limitations, direct adoption of global metrics can reflect an incomplete picture of India's UHC readiness.

Another major blind spot in global financial protection metrics is that they exclude people who avoid or delay care due to cost, distance or mistrust, also defined as forgone care. We will come back to this later in the report. Since OOPE and CHE are calculated only among those who actually use health services, a high level of unmet need can falsely signal strong financial protection.

To simplify, suppose:

- In State A, only 10% of people seek care because healthcare is unaffordable. Among them, 5% incur CHE.
- In State B, 70% seek care and 15% incur CHE.

Global UHC metrics would classify State A as having better financial protection, even though far more people are silently bearing the burden of untreated illness. This dynamic is particularly relevant in rural and tribal regions of India where barriers to care like distance, discrimination, informal payments or lack of functional facilities remain substantial.

Therefore, CHE without unmet need is an overestimation of financial protection; CHE with unmet need is a more accurate signal of system performance.

These limitations highlight the need for contextualized, India-specific contextualization of global UHC indicators. The UHC Index developed in this report retains the conceptual structure of the WHO–World Bank framework but introduces customized modifications to better capture India's system architecture, data availability and policy priorities. These include:

- Expanding the human resources indicator to incorporate AYUSH providers and specialists, reflecting India's mixed workforce.
- Adjusting service delivery metrics to align with Indian Public Health Standards (IPHS).
- Adding indicators such as insurance coverage under any government scheme and non-experiencing catastrophic expenditure at the state level.
- Incorporating Indian data sources (NFHS, NSS, disease-specific annual reports, etc.) that provide state-level granularity.

These adaptations are intended to produce a more realistic, state-sensitive index of service coverage and financial protection; one that aligns with India's policy ambitions towards UHA.
Finally, the index presented here is not a final product. It is a work in progress, shaped by iterative consultation with experts and will be refined further as new data sources, analytical methods and stakeholder inputs become available. The intent is to create a robust, evolving instrument that can guide India's roadmap to UHC by 2030 and UHA by 2047.

State-level Universal Health Coverage Index

Conceptual Framework

The Universal Health Coverage Index (UHC-I) for Indian states was developed in line with the monitoring framework of the WHO and the World Bank. UHC-I has two parts:

1. The Service Coverage Index (SCI) 4 domains, 14 indicators
2. The Financial Risk Protection (FRP) 2 indicators

Similar to the global UHC monitoring reports, the Index includes domains representing service coverage, access and financial protection, but was adapted for the state level and contextualized for the Indian health system.

The UHC Index is composed of five domains and 16 tracer indicators:

1. RMNCH+A - 4 indicators
2. Infectious Diseases - 4 indicators
3. NCDs - 3 indicators
4. Service Delivery and Access - 3 indicators
5. Financial Risk Protection - 2 indicators

Each domain reflects critical components of UHC and the indicators were chosen based on their policy relevance, alignment with WHO - World Bank tracer indicators and availability of reliable state-level data. Where direct measurement was constrained by data gaps, proxies and local benchmarks defined by IPHS were used to ensure contextual validity.

Each indicator is measured on a scale from 0 (no coverage) to 100 (full coverage). Where feasible, thresholds appropriate to Indian standards (not WHO global values) were applied. For example: hospital beds and human resources for health (HRH). Indicators that reflected deficits (e.g., smoking prevalence, CHE) were transformed into their complements to align with the directionality of the SCI (higher values = better performance).

Data sources

We relied exclusively on publicly available, state-representative, secondary data sources:

- National Family Health Survey (NFHS-4, 2015 - 16; NFHS-5, 2019 - 21): RMNCH+A, NCDs, sanitation, ITN use, insurance coverage.
- National TB Reports & India HIV Estimations: TB treatment and ART coverage.
- National Sample Survey[i]: health expenditure.
- Rural Health Statistics, National Health Profile and Ministry of Health reports: service delivery and workforce indicators.

Index Construction Process

Transformation: All indicators normalized to a scale of 0 - 1, higher being better coverage. Directionality is positive and consistent across all domains.

- Aggregation: Geometric mean was used to combine indicators within domains, minimizing distortion from outlier values. Indicators carry equal weight, consistent with prior research.
- Within each domain, the geometric mean of all constituent indicators was calculated. This ensures that poor performance on one indicator cannot be fully compensated by better performance on another.
- Across domains, the SCI was computed as the geometric mean of the five domain scores. This gives equal weight to each domain, consistent with global UHC monitoring.
- Additionally, SCI can be disaggregated as needed into service coverage and financial protection subcomponents.

Handling of Missing Data

- Where state-level estimates were missing, proxy indicators or nearest available year estimates were used.
- Consistency checks were applied to minimize bias.

Benchmarking

Indicator definitions, data sources and selection were validated by cross-referencing national standards and triangulation with scientific literature. The Index is presented on a common 0–1 scale to facilitate cross-state comparison and higher SCI values reflect better progress towards primary UHC goals.

Output

- The SCI produces a state-level score between 0 and 1, enabling:
- Comparison of overall UHC progress across states.
- Disaggregation by domain to identify strengths and gaps.
- Trend analysis (2015 - 2019) to highlight improvements and declines.

Index Strengths

- Indicators are robust and cover all essential UHC domains per national and global guidance.
- For internal validity and actionable policy focus, expanded workforce and sanitation indicators are retained in keeping with high-level expert group (HLEG) and NITI Aayog recommendations.

Index Limitations

- Domain 2 (Infectious Diseases): ITN coverage is less relevant in non-endemic states. We may consider malaria case management coverage (treatment-seeking + ACT use) if data is available.
- Domain 3 (NCDs): Instead of 'normal random blood glucose', 'proportion of diabetics on treatment' would have been a better indicator for UHC. 'Control' assessment may need HBA1c or FBS + PPBS measurements, unless only self-reported status is accepted.
- There are no indicators on 'quality of services' which is a crucial part of UHC.

RESULTS

Table 1: Detailed Results

Summary of States for the Composite UHC Index (2015-2019)

Sl. No.	States	2015 Rankings				2019 Rankings				Comments
		SCI	FRP	UHC	UHC-I Values	SCI	FRP	UHC	UHC-I Values	
1	Haryana	14	16	14	0.277	11	12	8	0.323	Improved overall
2	Himachal Pradesh	9	7	5	0.451	2	11	4	0.469	Improved in SCI and overall ranking
3	Jammu & Kashmir	7	20	15	0.272	16	21	18	0.118	Deteroriated overall
4	Punjab	6	15	6	0.442	10	13	7	0.326	Deteroriated in SCI and overall rankings
5	Rajasthan	17	11	17	0.196	17	2	16	0.228	Improved overall
6	Uttarakhand	12	9	11	0.328	15	4	14	0.272	Deteroriated in SCI and overall rankings
7	Chhattisgarh	16	1	16	0.266	14	6	13	0.272	Improved in SCI and overall ranking
8	Madhya Pradesh	13	12	12	0.301	13	9	10	0.307	Improved in FRP and overall ranking
9	Uttar Pradesh	18	19	19	0.128	19	19	19	0.086	No change
10	Bihar	21	17	21	0.046	21	17	21	0.053	No change
11	Jharkhand	20	13	20	0.081	20	15	20	0.084	No change
12	Odisha	11	5	9	0.394	12	18	12	0.281	Deteroriated overall
13	West Bengal	15	10	13	0.295	9	14	9	0.314	Improved in SCI and overall ranking
14	Assam	19	14	18	0.146	18	3	17	0.150	Improved overall
15	Gujarat	10	8	8	0.407	6	7	5	0.437	Improved overall
16	Maharashtra	8	18	7	0.418	8	16	11	0.306	Improved overall
17	Andhra Pradesh	5	4	4	0.513	1	8	1	0.544	Improved in SCI and overall ranking
18	Karnataka	3	6	2	0.531	3	10	3	0.472	Deteroriated overall
19	Kerala	1	21	10	0.385	5	20	15	0.233	Deteroriated in SCI and overall rankings
20	Tamil Nadu	2	3	1	0.550	7	5	6	0.402	Deteroriated overall
21	Telangana	4	2	3	0.524	4	1	2	0.535	Improved overall

The UHC rankings reveal significant shifts between 2015 and 2019, driven largely by variations in service coverage improvements and the evolving landscape of public financial protection schemes across states. The State's patterns of health-seeking behaviour, baseline demographic and epidemiological characteristics have also played a key role in determining the final scores in UHC index.

States with Major Overall Improvements

Several states register meaningful upward movement in overall UHC ranking, most notably Telangana, Himachal Pradesh, Gujarat, Assam, Rajasthan, West Bengal, Chhattisgarh and Andhra Pradesh.

- Telangana maintains top-tier FRP performance (rank 1 in 2019) while showing stable SCI performance, consolidating its place among the best-performing UHC states.

- Himachal Pradesh and West Bengal rise sharply in SCI rankings, propelled by strong primary care investments and improved maternal-child health indicators.
- Rajasthan makes a dramatic jump in FRP rank (from 11 → 2) owing to widespread insurance expansion under Mukhyamantri Chiranjeevi Swasthya Bima Yojana and increased public provisioning, making it one of the strongest FRP performers despite modest SCI progress.
- Andhra Pradesh achieves the top SCI rank in 2019, reflecting systematic primary care strengthening, wide coverage under YSR Aarogyasri and strong district health system reforms.

States with Declining Overall Performance

A cluster of states see consistent deterioration: Kerala, Karnataka, Tamil Nadu, Punjab, Odisha, Jammu & Kashmir and Uttarakhand. Kerala's paradox stands out: excellent SCI (rank 1 in 2015 → rank 5 in 2019) but persistently poor FRP performance (rank 21 → 20).

This could be explained by:

- High health service utilisation (especially outpatient care), which mechanically raises OOPE even when public facilities are strong.
- High burden of NCDs, requiring continuous long-term expenditure.
- Preference for private providers, with ~70% of outpatient care delivered by private sector, leading to high OOPE despite better service availability.
- Limited depth of financial protection for outpatient medicines and diagnostics which are major drivers of impoverishment expenditure.

In short, Kerala's high utilisation magnifies private spending, lowering FRP scores despite high-quality service coverage.

- Tamil Nadu, historically high-performing, slips in SCI and FRP due to plateauing indicators, higher chronic disease prevalence and growing utilisation of private facilities for diagnostics and outpatient care.
- Punjab, Odisha, Uttarakhand and Jammu & Kashmir show SCI declines due to stagnation or dip in reproductive and child health indicators, vaccination coverage, and chronic disease control.

States with Little or No Change

Uttar Pradesh, Bihar and Jharkhand remain consistently low-performing across SCI, FRP and overall UHC ratings. This stagnation could possibly be driven by:

- low baseline public health spending
- persistent supply gaps in PHC
- high unmet need for care and low service utilisation
- low insurance penetration
- continued reliance on out-of-pocket payments

These states represent India's largest population burden and their stagnation significantly impacts national UHC averages.

Understanding the Divergence Between SCI and FRP

The rankings highlight an important structural insight: good service coverage does not automatically translate to good financial protection. The possible reasons they move differently across states could be-

1. Utilisation effect: States with higher utilisation, particularly of private providers (Kerala, Punjab, Karnataka), often show higher OOPE, lowering FRP scores.
2. Baseline gaps and scope for improvement: States with poor SCI in 2015 (Assam, Rajasthan, Chhattisgarh) often show larger jumps due to greater "room to grow."
3. Insurance penetration vs. depth of coverage: States with expanded insurance coverage (Rajasthan, Telangana, Andhra Pradesh) perform better on FRP, especially when schemes include tertiary care.
4. Nature of disease burden: NCD-heavy states spend more on outpatient medicines, reducing FRP scores even when in-patient coverage is high.
5. Urbanisation and private sector dominance: States with heavy private sector use (Kerala, Karnataka, Tamil Nadu, Punjab) show comparatively poorer FRP outcomes.

States that Stand Out

Top UHC Performers (2019): Telangana, Andhra Pradesh, Gujarat, Himachal Pradesh.
They combine strong insurance penetration, improvements in SCI and robust PHC strengthening.
States Requiring Targeted Attention: Uttar Pradesh, Bihar, Jharkhand, Jammu & Kashmir, Odisha.
They show stagnation or deterioration, reflecting systemic bottlenecks in health financing, workforce distribution and service access.

Unique Cases

- Kerala exemplifies the utilisation-vs-protection paradox.
- Rajasthan showcases how large-scale insurance reforms can rapidly improve FRP even without dramatic SCI gains.
- Assam shows one of the biggest FRP improvements due to state insurance expansion and improved public sector provisioning.

The UHC rankings reveal a complex story: some states progress despite low baselines, others stagnate despite historical advantages, and a few like Kerala and Tamil Nadu face the challenge of rising costs amid high utilisation. These results reinforce the need for: deeper primary care reforms, expansion of outpatient benefits packages, state-specific strategies reflecting disease burden and care-seeking behaviour, stronger public expenditure on medicines and diagnostics, and targeted investment in historically lagging regions.

Table 2: Performance Summary of States for the Composite UHC Index (2015-2019)

Index	2015		2019	
	Best Performers	*Worst Performers*	*Best Performers*	*Worst Performers*
Service Coverage (SCI)	Kerala (76.5)	Assam (12.2)	Andhra Pradesh (54.8)	Uttar Pradesh (9.5)
	Tamil Nadu (54.0)	Jharkhand (5.8)	Himachal Pradesh (47.7)	Jharkhand (6.6)
	Karnataka ((52.9)	Bihar (3.0)	Karnataka (47.5)	Bihar (3.8)
Financial Risk Protection (FRP)	Chhattisgarh (73.6)	Uttar Pradesh (8.9)	Telangana (86.5)	Uttar Pradesh (5.9)
	Telangana (60.0)	Jammu & Kashmir (2.8)	Rajasthan (86.2)	Kerala (2.4)
	Tamil Nadu (58.8)	Kerala (2.5)	Assam (81.6)	Jammu & Kashmir (2.4)
Universal Health Coverage (UHC)	Tamil Nadu (55.0)	Uttar Pradesh (12.8)	Telangana (64.0)	Bihar (8.6)
	Karnataka (53.1)	Jharkhand (8.1)	Andhra Pradesh (53.8)	Uttar Pradesh (7.5)
	Telangana (52.4)	Bihar (4.6)	Tamil Nadu (52.0)	Jammu & Kashmir (6.5)

Between 2015 and 2019, India's progress toward Universal Health Coverage has been mixed. While a few states like Telangana, Andhra Pradesh, Himachal Pradesh and Rajasthan showed measurable improvement, the historically disadvantaged States like Uttar Pradesh, Bihar, Jharkhand and Jammu & Kashmir remained persistently below the national median.

The results demonstrate three clear messages:

1. Service coverage advanced modestly in some high-performing states but plateaued or declined elsewhere.
2. Financial protection improved more sharply in select states due to expanded insurance schemes and free-entitlement policies.
3. The composite UHC Index continues to favour states with both supply-side and financial-risk-protection reforms, primarily in the south and a few reform-oriented middle-income states.

i. **Interpretation for SCI:**

- Regional persistence of southern advantage.
  Kerala, Tamil Nadu, and Karnataka led in 2015, consistent with their mature public-health systems and higher density of health workers. Although Kerala's SCI declined from 76.5 to ~41 amongst the leading peers, these states still outperform the national mean (estimated 30–35 points).
- Emergence of Andhra Pradesh and Himachal Pradesh as 2019 leaders.
  Andhra Pradesh's SCI (54.8) reflects the expansion of Ayushman Arogya Mandirs and a sharp rise in primary-care utilisation. Himachal Pradesh's 47.7 score highlights the payoff from rural retention strategies and near-universal immunisation [ii].
- Chronic under-performance of EAG states.
  Bihar (3.8), Jharkhand (6.6), and Uttar Pradesh (9.5) continue to struggle, with values significantly lower than southern states. These deficits mirror low facility density, 40–60 % staff vacancies at sub-centres, and weak supply-chain reliability. [iii]
- Relative decline of Kerala's score.
  Kerala's 2015 lead (76.5) gives way to other states by 2019, suggesting possible methodological convergence (scores normalised) or plateau in service gains as health focus shifts to quality rather than coverage.

National comparison: NFHS-5 shows near-universal institutional delivery (>95 %) and ANC 4+ in southern states versus <60 % in Bihar/Jharkhand. NITI Aayog's Health Index (2020) ranks Kerala & Tamil Nadu 1st-2nd and Uttar Pradesh last, consistent with this SCI gradient.

ii. Interpretation for Financial Risk Protection (FRP):

- Sharp improvements in selected reform states.
  1. Telangana increased FRP from 60 → 86.5 (+44 %), leading all states. The Aarogyasri insurance scheme's expansion and early integration into PM-JAY likely explain this jump.
  2. Rajasthan rose from below 60 to 86.2, reflecting the adoption Chiranjeevi Swasthya Bima Yojana and free drug/diagnostic initiatives that aimed at reducing the out-of-pocket expenditure (OOPE).
  3. Assam's improvement to 81.6 suggests rising financial protection through state-funded drug distribution and improved primary-care availability.
- Persistent low FRP in high-coverage states.
  1. Kerala, despite high SCI, continues to have extremely low FP (~2.4 %), showing that strong service coverage does not automatically translate to financial risk protection when private sector use dominates. [iv]
  2. Uttar Pradesh's FRP fell from 8.9 → 5.9 (−33 %), reinforcing evidence from NSS 75th Round that the state has one of India's highest incidences of catastrophic health expenditure. [v]
  3. Southern and reform-minded central states improve FRP, whereas populous northern and eastern states remain exposed to high OOPE. The inter-state FRP gap widened from roughly 65 points in 2015 to ~80 points by 2019.

iii.Interpretation for Composite UHC Index:

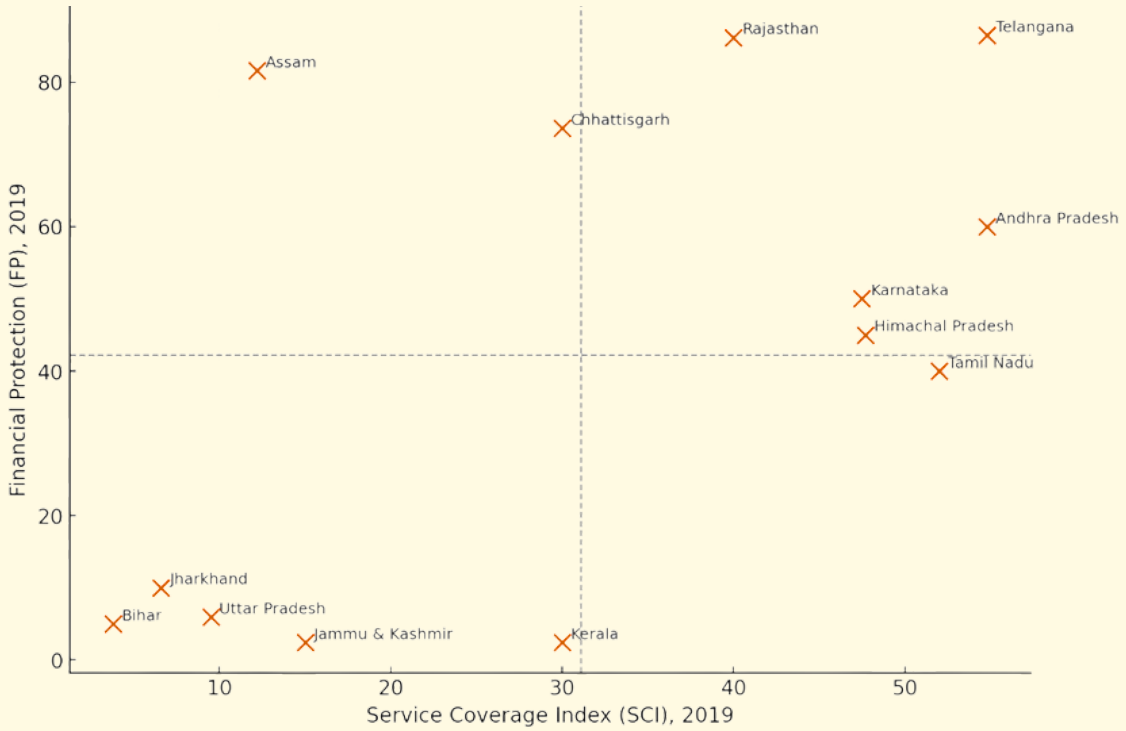
- Overall improvement in leading states.
  Telangana and Andhra Pradesh (maintained scores > 50) reflect sustained efforts in both coverage and protection. Tamil Nadu's decline may stem from data normalisation or slowed incremental gains after high baseline achievements.
- Persistent lag in Bihar and Uttar Pradesh.
  Scores remain under 10, highlights structural inequities in access, human resources and household affordability. The double deficit of low SCI (<10) and low FP (<6) makes these the highest-priority states for targeted interventions.
- Convergence of mid-tier states.
  Several mid-performers (Rajasthan, Chhattisgarh, Himachal Pradesh) cluster around 40–50, indicating catch-up potential if current trajectories continue.
- National alignment.

The composite UHC rankings mirror those of the NITI Aayog Health Index (2019-20) and the Global Burden of Disease subnational analysis, both of which place southern states at the top and Bihar/Uttar Pradesh at the bottom. [vi]

Table 3

Cluster	States	Characteristics
High SCI + High FRP ("Integrated Performers")	Telangana, Tamil Nadu, Andhra Pradesh, Himachal Pradesh	Mature public systems + strong insurance or free-entitlement schemes
High SCI + Low FRP ("Service-Rich but Costly")	Kerala	Extensive private use; OOPE remains high
Low SCI + Improving FRP ("Insurance-led")	Rajasthan, Assam	Insurance expansion outpacing service readiness
Low SCI + Low FRP ("Double Deficit")	Bihar, Uttar Pradesh, Jharkhand	Weak supply + high private dependence

Figure 2: Quadrant Scatter of Service Coverage Index(SCI) vs Financial Protection(FP), 2019



These typologies are consistent with WHO's global observation that UHC progress must advance simultaneously on both the coverage and financial-risk-protection axes (WHO 2019).

Comparison with External Evidence:

1. NFHS-5 (2019-21): Confirms higher maternal, child and NCD service coverage in Kerala, Tamil Nadu, Telangana and Himachal Pradesh; poor coverage in Bihar and Uttar Pradesh. [ii]
2. NSS 75th Round (2017-18): Shows catastrophic health expenditure (CHE ≥ 10 % of consumption) ranging from 3 % in Telangana to > 20 % in Uttar Pradesh, directly mirroring our findings. [i]
3. NITI Aayog Health Index (2020): Ranks Kerala and Tamil Nadu highest; Uttar Pradesh lowest; composite correlation with our UHC index > 0.85. [vii]
4. Academic synthesis: Studies by Dandona et al. (2020) and Prinja et al. (2020) similarly report a strong south-north gradient in both service and protection dimensions.

Recommendations:

1. Focus on "double-deficit" states.
   Bihar, Uttar Pradesh, and Jharkhand require simultaneous investments in infrastructure, workforce and free entitlements. Rural-focused HRH pipelines, predictable primary-care financing and robust monitoring must be prioritised.
2. Close the service-finance gap in high-coverage states.
   Kerala and, to a lesser degree, Tamil Nadu should address cost barriers through tighter private-sector regulation and expansion of free secondary-care services.
3. Leverage states with good financial protection scores as learning laboratories.
   Telangana and Rajasthan illustrate the dividends of coherent insurance and drug-supply strategies. Cross-state knowledge transfer mechanisms can replicate these successes.
4. Institutionalise state UHC dashboards.
   Regularly updated SCI and FP indicators should be published annually to sustain accountability and peer learning.

Endnote:

[i] Ministry of Statistics and Programme Implementation (MoSPI), Key Indicators of Social Consumption: Health (NSS 75th Round 2017–18) (New Delhi: MoSPI, 2019).

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[iii] Anamika Karan et al., "Size, Composition and Distribution of Human Resource for Health in India," BMJ Open 9, no. 4 (2019): e025979.

[iv] Shankar Prinja et al., "Does PM-JAY Improve Financial Protection? Early Evidence and Research Agenda," Indian Journal of Public Health 64, no. 2 (2020): 87–92.

[v] Ministry of Statistics and Programme Implementation (MoSPI), Key Indicators of Social Consumption: Health, 18.

[vi] Lalit Dandona et al., "Measuring Universal Health Coverage in India: Evidence from District Level," The Lancet Regional Health – Southeast Asia 1 (2020): 100007.

[vii] NITI Aayog, Ministry of Health and Family Welfare, Healthy States, Progressive India: Report on the Ranks of States and Union Territories, Fourth Round, 2020–21 (New Delhi: NITI Aayog, 2021), https://www.niti.gov.in/sites/default/files/2021-12/NITI-WB_Health_Index_Report_24-12-21.pdf.

Estimates of Forgone Care: Who and Why?

Interlinkages Between Financial Protection, Service Coverage and Forgone Care

As shown, ***financial protection and service coverage are the two core dimensions of UHC***. Both determine whether individuals can access the health services they need without suffering financial hardship. Although these indicators are measured separately in global monitoring frameworks, they are deeply intertwined in practice, together shaping how health systems respond to population needs and influence the extent of forgone care.

Service coverage reflects the availability, accessibility and quality of essential health services across the continuum of care such as preventive, promotive, curative, rehabilitative and palliative. Financial protection, on the other hand, captures whether individuals can afford to use those services without catastrophic or impoverishing expenditure. Even where a service is physically available, it remains inaccessible if people cannot pay for it. Conversely, financial coverage mechanisms like insurance schemes lose meaning if adequate services are not reachable or functional.

The interlinkages between these two dimensions determines real access. Weak financial protection increases OOPE, forcing people to delay or forgo care due to cost. Similarly, poor service coverage such as understaffed facilities, stock-outs of medicines or long-distance travel also drives forgone care, as people perceive healthcare as unavailable or ineffective. Thus, inadequate progress in either domain reinforces the other's shortcomings, leading to unmet health needs and health inequities.

An important nuance is noted when interpreting forgone care alongside OOPE. As forgone care increases, measured OOPE may appear to decline, but this is a false signal of improved financial protection. Lower OOPE in this context does not reflect reduced financial hardship; instead, it indicates that people are avoiding care altogether because they cannot afford it or it is unavailable. Therefore, reduced OOPE amid rising forgone care represents suppression of demand and not genuine protection from financial risk. This underscores why UHC monitoring must jointly consider service coverage, financial protection and unmet needs to capture the true accessibility and equity of a health system.[i]

Forgone care is thus a revealing link between these two UHC pillars which demonstrates the lived consequences of inadequate service coverage and fragile financial protection. ***Strengthening both dimensions simultaneously is essential to ensure that no one is left out of the health system.***

Estimates of Forgone Care

India has a high level of forgone care, especially amongst the poor, less educated, rural, tribal and marginalized groups. This challenge is compounded by geographical diversity and a rapid shift in epidemiological burden towards chronic diseases alongside an aging population. Due to forgone care, there is a gap between healthcare needs and the utilization of services despite the need. Several national-level surveys have highlighted that a substantial share of the population does not access necessary medical care because of certain barriers, both physical and financial. Unmet healthcare needs not only undermine health outcomes but also lead to delayed diagnoses, financial distress due to serious health-related disability and preventable mortality. All these erode progress towards SDG 3 and national UHC commitments. With nearly one in five Indians reportedly foregoing critical treatment due to high costs and systemic inefficiencies, the crisis is both urgent and multifaceted.

Overview of Current Situation

Although there is improvement in institutional deliveries, the percentage of women who follow the recommended minimum of ANC visits is still very low.

Many children with illnesses such as fever, diarrhoea and acute respiratory infection don't receive timely treatment. NFHS-5 reports that about 25-30% children with such common illnesses were not taken to a healthcare facility. Additionally, there are coverage gaps in vaccination and nutritional interventions, contributing indirectly to forgone health care.

The current forgone care scenario, reflected in NFHS-5 (2019-21)[ii] and NSS 75th round (2017-18)[iii] data, reveals that inequality persists between urban and rural populations. NFHS-5 showed that 58% of pregnant women received four or more ANC visits, which is an improvement from NFHS-4, but still leaves nearly 42% of pregnant women without adequate ANC, especially in rural and low-income households. In urban India, around 68% of women received complete ANC, while the figure drops to 54% in rural areas, underscoring a persistent urban-rural divide. Similarly, although institutional deliveries increased to 88.6% nationally, the rate remains lower in rural regions (86.7%) compared to 93.8% in urban areas. This suggests that urban residents continue to benefit more from healthcare access, availability and quality.

Reasons for Forgone Care

NFHS-5 data shows that care is improving but forgone care persists among vulnerable groups. Analysing the reasons for this provides insights into the inefficiencies within the health system, guiding policymakers towards targeted interventions rather than generic solutions. The main reasons for forgone care are:

- **Financial Barriers**

  Out-of-pocket expenditure remains the most significant driver of forgone care in India. With total healthcare spending constituting approximately 3.84% of GDP (FY 2021-22) and limited insurance coverage reaching only about 41% of the population (NFHS-5) [iv], most Indians face substantial financial hardship when seeking care. The concentration index analysis from NFHS-5 data demonstrates that forgone care is systematically higher among economically disadvantaged groups, with poverty being the strongest predictor of service non-utilization. High medical costs force families to make difficult choices, often leading to delayed treatment or its avoidance altogether, especially in non-emergency conditions[v].

- **Geographic and Logistic Barriers**

  Distance from healthcare facilities and inadequate transportation infrastructure are formidable obstacles, especially in rural and remote areas. Many rural inhabitants must travel over 100 kilometres to access quality healthcare services, often on poorly maintained roads that make medical emergencies particularly challenging. The shortage of healthcare facilities in rural regions, combined with irregular public transport and lack of emergency medical services are challenges in accessing healthcare even when families recognize the need for care.

- **Healthcare System Inadequacies**

  Facility-level barriers to care include chronic shortage of essential medicines, inadequate healthcare staff, poor infrastructure and insufficient diagnostic equipment. In such conditions, even those who reach healthcare facilities may not receive appropriate care, leading to future avoidance of the formal healthcare system.

- **Socio-economic and Educational Factors**

  Maternal education levels and overall socio-economic status significantly influence healthcare-seeking behaviour[vi]. Women with higher education, professional employment, bank access and mobile phones are substantially less likely to experience barriers to healthcare access. Conversely, those from disadvantaged backgrounds face multiple intersecting barriers, including limited health literacy, reduced decision-making autonomy and cultural constraints that particularly affect women's healthcare utilization[vii].

Diversity, Equity, and Inclusion

Global experiences show that several countries have successfully tackled forgone care and unmet health needs through targeted health system reforms, financial protection strategies, social outreach and innovations in service delivery. They offer practical models for India to adapt, scale and contextualize, forging a path towards more inclusive, resilient and accessible health systems that actively minimize forgone health care.

Country	Notable Strategies
Brazil	Unified Health System (SUS) guaranteeing free public healthcare, Family Health Strategy (FHS) for active household outreach, mobile clinics for hard-to-reach populations and decentralized funding [viii].
Ghana	National Health Insurance Scheme (NHIS) with premium exemptions for vulnerable populations, reduction of OOPE payments and broad benefit packages [ix].
Indonesia	Expansion of JKN (social health insurance) with large government subsidies for premiums, mandatory registration and digital enrolment [x].
Rwanda	Community-based health insurance (CBHI), pro-poor targeted subsidies, strong local health leadership and integrating health financing with poverty-reduction strategies[xi].
Sri Lanka	Strong public health infrastructure, free essential services at point of delivery, empowered mid-level health workers and national outreach for maternal/child health[xii] .
Thailand	Universal Coverage Scheme (UCS)[xiii] providing comprehensive, tax-financed care; harmonized benefit packages across schemes; robust primary care network; 'no copayment' policies for basic and chronic care; efficient referral and gatekeeping [xiv].
Turkey	Health Transformation Programme harmonizing insurance schemes, expanding coverage and abolishing many co-payments; rigorous investment in primary care and human resources [xv].

Policy Implications and the Path Forward

Addressing forgone care in India requires a multi-pronged approach targeting both supply-side improvements and demand-side interventions. The Ayushman Bharat initiative, including PM-JAY and AAMs, is a significant step in reducing financial barriers and improving primary care access. However, these efforts must be complemented by enhanced rural health infrastructure, improved medicine supply chains and targeted interventions for marginalized populations.

The ABDM and telemedicine initiatives are promising solutions to overcome geographic barriers, particularly in remote areas where physical healthcare facilities remain scarce. Additionally, addressing social determinants of health through education, women's empowerment and poverty reduction programmes will be essential to create an enabling environment for healthcare utilization.

Ultimately, reducing forgone care in India requires a sustained commitment to strengthening the health system, equitable resource allocation and recognition that healthcare access is not merely about service availability but also about removing the complex web of barriers that prevent vulnerable populations from utilizing essential health services. Only through comprehensive reforms that address financial, geographic, social and systemic barriers can India achieve its goal of leaving no one behind in the journey towards universal health coverage.

Endnote:

[i] Rajaram Yadav, Jeetendra Yadav, and Chander Shekhar, "Unmet Need for Treatment-Seeking from Public Health Facilities in India: An Analysis of Sociodemographic, Regional and Disease-Wise Variations," PLOS Global Public Health 2, no. 4 (2022): e0000148, https://doi.org/10.1371/journal.pgph.0000148

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Financial Protection and Equity: Who is left Behind

Health financing and OOPE

Health financing is a critical determinant of UHC. A country's ability to generate, allocate and efficiently use financial resources ensures access to essential health services without causing its citizens financial hardship. In addition to resource generation and allocation, purchasing decisions play a vital role in the effectiveness of a health financing system. Moreover, how healthcare providers are reimbursed has implications for provider behaviour and service delivery outcomes. In India, healthcare financing is a pluralistic structure involving multiple sources. These include government funding at both central and state levels, OOPE by individuals, contributions from NGOs, corporate spending on employee health benefits, and various public and private health insurance schemes. Strengthening these mechanisms is crucial to reduce the financial burden on households and to advance towards the goal of UHC.

Current health financing situation

India's total health expenditure stood at 3.8% of GDP in 2021–22 [i]. The share of government health spending, which is crucial for improving healthcare access and utilization, was 1.84% of GDP and that of OOPE was 1.51% (Table 1). Public spending as a share of GDP has been low for a long time. Historically, this hovered around 1% per cent of GDP. However, in recent years it showed an upsurge due to increase in central government expenditure, especially on new initiatives like health infrastructure mission and expansion of medical education. It amounted to 1.89% in 2021–22, rising from 1.15% in 2013–14. Despite this, India's public spending is low compared with many countries, of South East Asia, especially Thailand, Singapore and China (at 3% each). It is also less than the average of South East Asian nations (3%). Many earlier reports, including the Planning Commission's High Level Expert Group Report on Universal Health Coverage for India, 2011, recommended that public expenditure on health be increased to 3% of GDP by 2022. Similarly, the National Health Policy 2017 suggested that public expenditure should be increased to 2.5% of GDP. Despite these recommendations, the current level of government spending in India falls short of the target resulting in higher OOPE at the point of care.

In recent years India has witnessed a rise in the share of social security expenditure. This component of health expenditure is crucial as it offers financial protection against hospitalization expenses. This includes government spending on premiums and payments for health insurance schemes—such as PM-JAY and state-specific programmes—as well as healthcare benefits or reimbursements to government employees. It also covers spending on other social health insurance programmes.

The share of private health insurance — including voluntary pre-payment schemes funded by households or jointly by employees and employers—has been rising steadily. Premiums are paid to insurance companies, which in turn reimburse medical costs in cases of hospital emergencies. Over the past nine years, the contribution of private health insurance to total health spending has almost doubled and now makes up about 7% of overall health expenditure.

Table 1: Health financing indicators for India

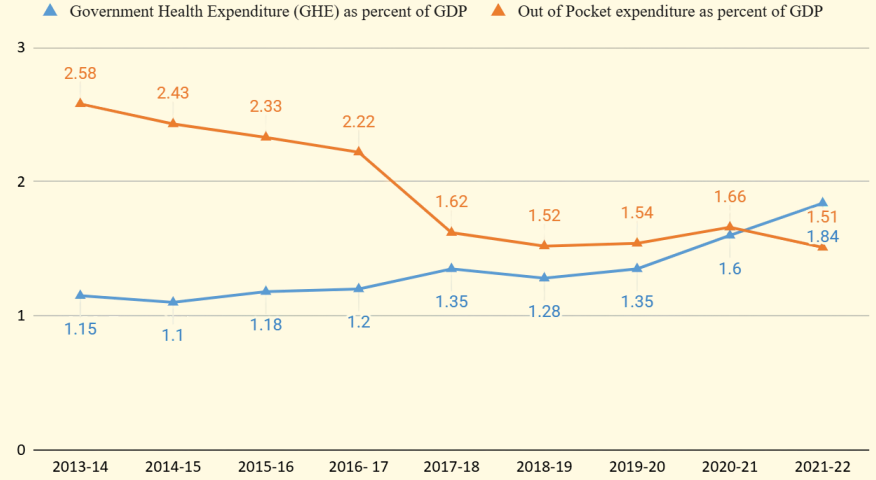
Indicators	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Total Health Expenditure (THE as per cent of GDP)	4	3.9	3.8	3.8	3.3	3.2	3.3	3.7	3.8
Government Health Expenditure (GHE) as per cent of GDP	1.15	1.1	1.18	1.2	1.35	1.28	1.35	1.6	1.84
Out of Pocket Expenditures (OOPE) as per cent of GDP	2.58	2.43	2.33	2.22	1.62	1.52	1.54	1.66	1.51
GHE as per cent of THE	28.64	29	30.63	32.4	40.8	40.6	41.4	42.8	48
OOPE as per cent of THE	64.2	62.6	60.6	58.7	48.8	48.2	47.1	44.4	39.4
Social Security Expenditure on health as per cent of THE	6	5.7	6.3	7.3	9	9.6	9.3	8.6	8.7
Private Health Insurance Expenditures as per cent of THE	3.4	3.7	4.2	4.7	5.8	6.6	7	7.3	7.4

Source: Ministry of Health and Family Welfare. (2023). National Health Accounts Estimates for India (2014–22)(National Health Systems Resource Centre, 2024) Government of India. https://nhsrcindia.org

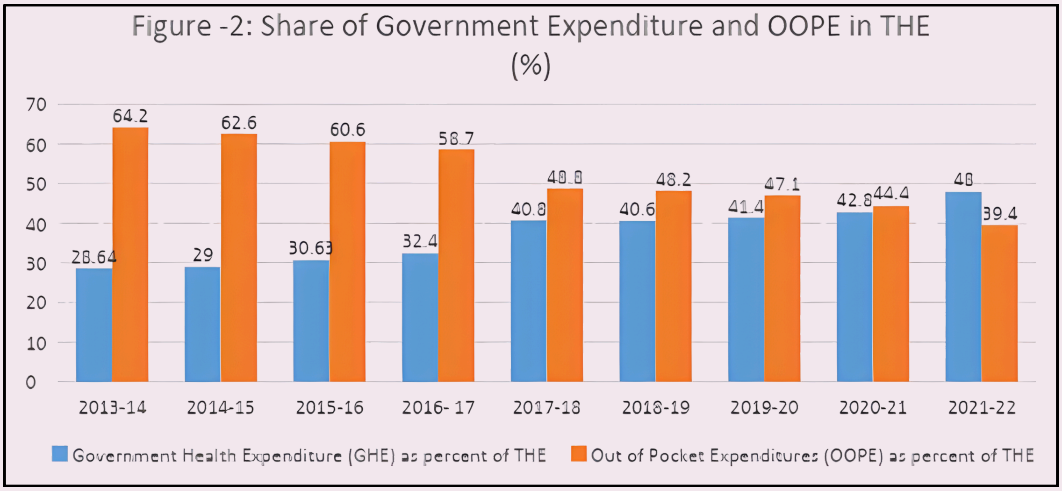
Trends in Out-of-Pocket Expenditures

OOPE as a method of financing is iniquitous and deters many from accessing healthcare. The share of OOPE in total health expenditure was 64% in 2013–14, close to two-thirds of total health expenditure. This declined to 39% in 2021–22. OOPE as a share of GDP was 2.58% in 2013–14 and gradually decreased to 1.51% in 2021–22. The main drivers of OOPE in India have been expenditure on medicine, diagnostic services and patient transport[ii]. Compared with other countries, the share of OOPE in current health expenditure in India is one of the highest at an average 54% between 2015–16 and 2022–23 compared with SEAR (South east Asian Region) average of 38% during the same period. The average (OOPE) in Thailand was 10%, Singapore 29%, and China, Indonesia and Malaysia we reach at approximately 35%, significantly lower than India (Table 2). Health systems in SEAR have been largely funded through OOPE, with more than half the countries spending more than one-third of their current health spending from household OOPE expenses. This was predominantly spent on medicines. While India has made progress in reducing OOPE in recent years, it is not adequate to provide financial protection to the population. Several studies have suggested that millions of people are pushed into poverty and many experience CHE because of higher OOPE at the point of care. At the 10% household consumption expenditure threshold, about 18% of households face CHE and 11% experience catastrophic spending due to medicines alone. This drives 38 million individuals to impoverishment. Another study estimated that 50 million people are pushed to poverty[iii]. Analysis from Brookings India based on NSSO surveys shows that over 24% of households incurred CHE in 2014 and 7% of India's population is pushed into poverty every year due to healthcare costs. The impoverishing impact is more or less similar in rural and urban areas.[iv]

Figure 1 : Share of GHE and OOPE in GDP (%)



Source: Ministry of Health and Family Welfare. (2023). National Health Accounts Estimates for India (2014–22). Government of India. https://nhsrcindia.org



Source: Ministry of Health and Family Welfare. (2023). National Health Accounts Estimates for India (2014–22). Government of India. https://nhsrcindia.org

Table 2: Share of OOPE in current Health Expenditure (CHE) in South East Asian Region (SEAR)

Countries	2015	2016	2017	2018	2019	2020	2021	2022	Average
Timor-Leste	7	8	8	10	10	7	6	5	8
Thailand	12	11	12	10	9	11	9	9	10
Maldives	19	19	21	20	17	17	15	18	18
Bhutan	20	20	13	13	18	15	21	35	19
Singapore	33	33	32	29	29	25	24	25	29
China	35	36	36	36	35	35	34	34	35
Indonesia	43	38	36	35	35	31	27	33	35
Malaysia	34	36	36	37	36	34	32	38	35
Sri Lanka	49	50	49	47	46	44	43	40	46
Philippines	51	50	50	50	49	45	41	45	48
India	65	63	55	53	52	50	45	46	54
Nepal	59	55	57	58	58	54	51	56	56
Myanmar	70	77	76	76	77	73	54	65	71
Bangladesh	73	71	70	71	72	74	73	73	72
SEAR	41	41	39	39	39	37	34	37	38

Data Source: Global Health Expenditure Database. World Health Organization. https://apps.who.int/nha/database

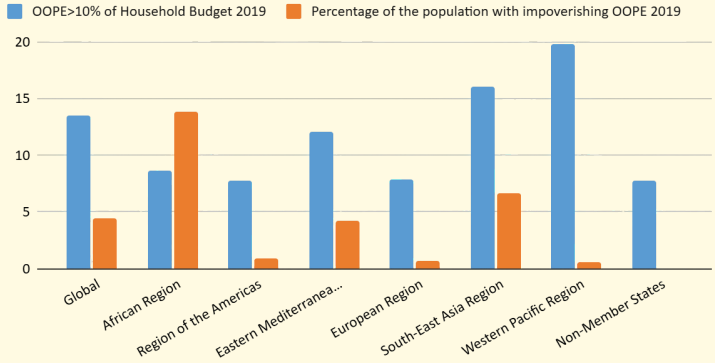
Catastrophic health expenditure across the Globe

Catastrophic health expenditure occurs when a household's OOPE on health exceeds a significant share of its income or consumption expenditure. The global threshold is expenditure exceeding 10% or 25% of total household income.

Globally, 13.5% of the population experienced CHE in 2019 at 10% threshold, which was 15.6% in 2015[v]. This translates to 1.04 billion people who faced catastrophic health expenditure in 2019, rising from 937 million 2015. Along with catastrophic health expenditure, a large proportion of the population faced impoverishment due to rising health expenditure. For instance, the proportion of the global population with impoverishing OOP health expenditure (at the 2017 PPP US$ 2.15 extreme poverty line) decreased from 22.2% in 2000 to 8.3% in
2015 and 4.4% in 2019. In 2019, 344 million people globally experienced impoverishment due to higher health expenditure. It is also observed the households with elderly members or those residing in rural areas tend to face higher rates of CHE and are more likely to experience impoverishment. The bottom two quintiles suffered the most financial hardship, showing increasing socio-demographic inequality in the incidence of catastrophic and impoverished health expenditure. Across the low- and low-middle income countries, the median population showing financial access barriers was 19% and this varied widely across countries.

The South East Asian region performed badly on catastrophic health expenditure: 16.1% of the total population faced catastrophic health expenditure at 10% threshold level in 2019 (Figure 3). Bangladesh had the highest proportion of households experiencing CHE (24.4%), followed closely by China (24.3%) and India (17.5%). In contrast, Thailand was a notable exception with only 2% of households facing such financial strain. Its success is largely attributed to its innovative health financing mechanisms which have significantly reduced OOPE. Furthermore, around 6.6% of the population of approximately 133.6 million people in the region faced impoverishment due to higher health expenditure in 2019.

Figure 3: Catastrophic Health Spending and Impoverishment in Various Regeon



Source : Tracking Universal Health Coverage: 2023 Global monitoring report; Table A 11.1

Table 3: Catastrophic health spending across South East Asia

Country	Latest year	At 10% of household total consumption or income	At 25% of household total consumption or income
Global*	2019	13.5	3.8
South East Asia*	2019	16.1	6.4
#Bangladesh	2016	24.4	8.4
Bhutan	2017	4	1.8
China	2018	24.3	6.9
India	2017	17.5	6.7
Indonesia	2021	2	0.4
Malaysia	2019	1.5	0.1
Maldives	2016	10.3	4.1
Myanmar	2017	12.7	3.5
Nepal	2016	10.7	2.1
Philippines	2015	6.3	1.4
Sri Lanka	2016	5.4	0.9
Singapore	2013	9	1.5
Thailand	2021	2.1	0.3
Timor-Leste	2014	2.6	0.5

*Percentage of the population with catastrophic OOP health spending due to: OOP health spending exceeding 25% of the household budget and OOP health spending exceeding 10% of the household budget.
Percentage of households with catastrophic OOP health spending due to: OOP health spending exceeding 25% of the household budget and OOPE health spending exceeding 10% of the household budget.
Source: Tracking Universal Health Coverage: 2023 Global monitoring report

Progress towards UHC: The case of Turkey (now Türkiye)

The Republic of Türkiye, with a population of 85.5 million and a GDP of $1.32 trillion in 2024, is the 17th largest economy in the world. Despite relatively modest health expenditure of 4% of GDP in 2022 and OOPE at 19%, Turkey has made significant strides towards achieving Universal Health Coverage. Its journey began in 2003 with the launch of the Health Transformation Program (HTP), a comprehensive reform agenda aimed to enhance the quality, accessibility and efficiency of the country's healthcare system. This programme outlined the broader health reform agendaincluding the universalization of health insurance and the marketization of healthcare provision in the country. The initiative attracted the attention and support of international partners, notably the World Bank. In 2006, it introduced a Social Security and Universal Health Insurance Law, implemented in 2008, which expanded health insurance by unifying public social insurance funds and creating a single-payer social security system (SGK). Fragmentation in financing was overcome by merging all the five insurance programmes functional before HTP and creating a social security institution (SSI). Initially, the law did not permit private sector involvement in health service provision or financing. However, subsequent amendments opened up private sector participation. In healthcare provision, persons covered by public insurance can now choose to receive treatment in one of the many private hospitals that have an agreement with the SGK. These private hospitals, however, can charge patients additional fees up to a legally defined percentage of the reimbursement price they receive from the SGK for each treatment. Moreover, insurance for the poor, known as green card programmes, have been integrated with SGK and these groups have benefitted largely through this programme.

In terms of financing, the ministry of finance is the main financier and the SSI is the purchaser of care. The ministry of finance provides a tax-based general budget to all three levels of health institutions—primary, secondary, and tertiary—mainly for physical infrastructure and human resources, including staff salaries. SSI purchases services from both public and contracted private hospitals (for secondary and tertiary care) through funds collected from both public and private employer contributions.

With these efforts, 95% of the population is covered. Private insurance currently accounts for only 2.6 % of total healthcare spending in the country. Furthermore, the country has achieved notable improvements in health, with life expectancy at birth rising to 78.5 years. The infant mortality rate was 9.1 deaths per 1,000 live births and maternal mortality rate was 15.0 deaths per 1,000 live births in 2023. The total fertility rate dropped from 2.37 children per woman in 2003 to about 1.48 in 2024, well below replacement level.

State-level progress in OOPE

India's progress towards UHC is contingent upon the performance of states. OOPE varied from as high as 64% in Uttar Pradesh to 25% in Karnataka and 28% in Assam in 2021–22. In 2014–15 almost all states except Gujarat, Himachal Pradesh, Karnataka and Chhattisgarh had OOPE more than 60%, and as much as 82% in Bihar (Figure 4). However, in 2021–22, the scenario changed and many states managed to reduce OOPE to a range of 30 to 40%, reflecting improved financial protection mechanisms. Chhattisgarh, Karnataka, Uttarakhand and Assam have made considerable progress in reducing OOPE to the range of 25 to 30%. Kerala being an advanced state in terms of human development indices continues to report a relatively high level of OOPE. This is attributed to the state's distinctive health-seeking behaviour, where people often prefer private healthcare providers despite the availability of public services. The state's high life expectancy contributes to increased health expenditures stemming from age-related morbidity.

An analysis of state-level public health expenditure shows a notable increase in spending as a share of Gross State Domestic Product (GSDP) between 2014–15 and 2021–22. In 2014–15, the majority of states allocated 1% or less of their GSDP to health. By 2021–22, this proportion had risen, with seven out of 21 states spending more than 2% of their GSDP on health, and six states allocating between 1.6% and 1.8 (Figure 5).

It is interesting to note that some of the high-income states—Gujarat, Maharashtra, Karnataka, Punjab and Tamil Nadu—reported health expenditure between 1–1.3% of GSDP. In spite of the relatively lower share of GSDP, these states have demonstrated improved financial protection to the people (except Punjab which has a higher share of OOPE in total health expenditure). This shows that where money is spent is more important than how much is spent. A comparison of health systems across India shows a consistent disparity between the southern and northern states in terms of health infrastructure and health outcomes, with southern states showing better performance. Among the southern states, Karnataka stands out in terms of strong performance in health protection to its people and has greater potential to achieve the objectives of UHC. Some states like Chhattisgarh, Karnataka, Odisha and Maharashtra have covered additional populations in the national PM-JAY programme through different financing mechanisms.

Overall, while significant progress has been made, the variation in OOPE across states highlights the need for targeted strategies in order to address state-specific challenges in the pursuit of UHC for all.

Figure 4 : Goverment Health Expenditure(GHE)(%) share of Gross State Domestic Product (GSDP): 2014-15, 2021-22

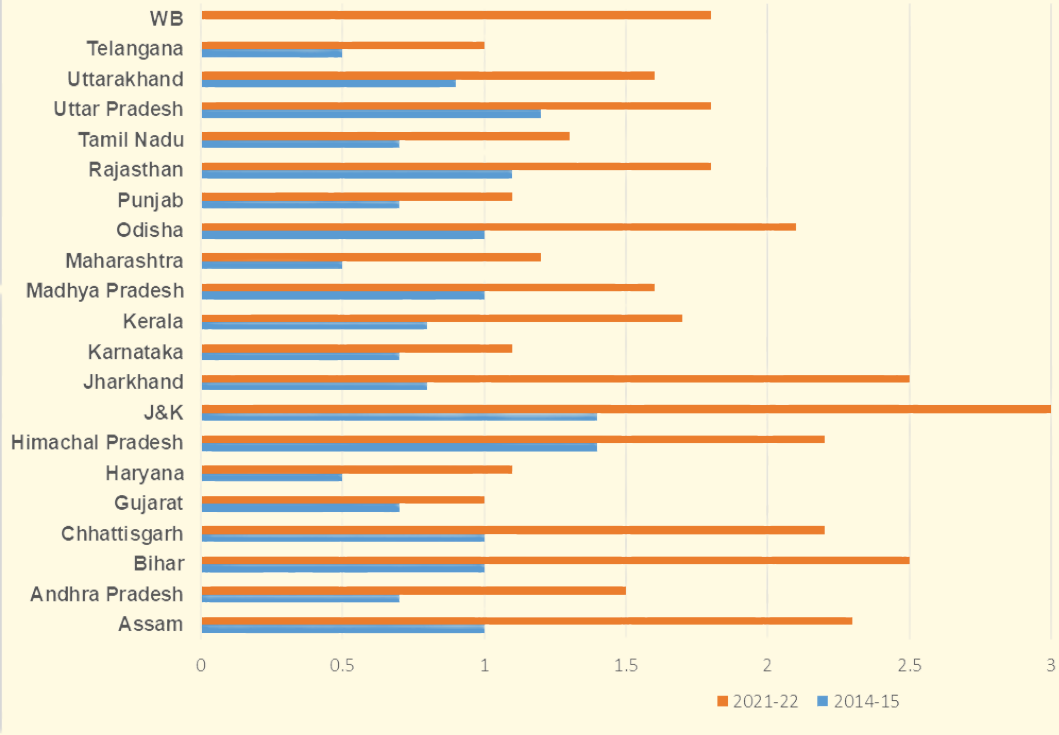
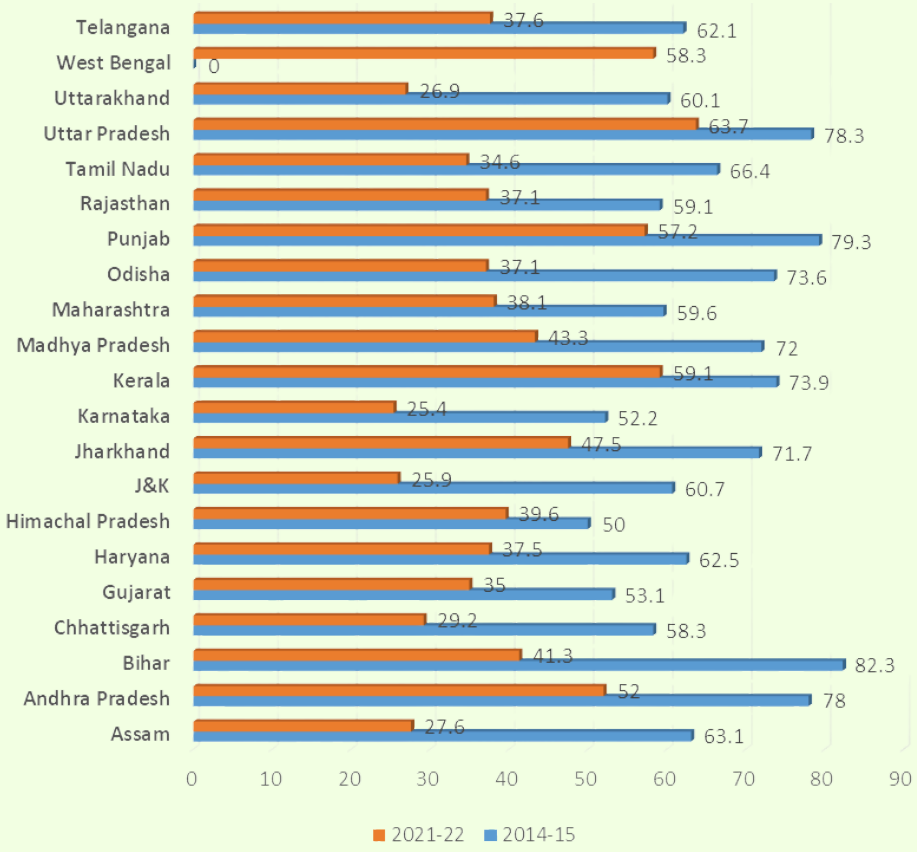


Figure 5 : Out of Pocket expenditure as % of Total Health Exp in major states of India: 2021-22 and 2014-15



Source: National Health Accounts 2014-15 and 2021-22

Steps towards achieving UHC: The Case of Karnataka

Karnataka has made significant strides toward achieving UHC. With per capita income ranked 3rd among the major Indian states, Karnataka is making remarkable progress in improving the health status of its population. With an IMR of 17, an MMR of 63 and total fertility rate (TFR) at 1.6, the state has surpassed national achievements. It is one of the few Indian states which introduced notable health financing schemes as far back as 2003. The Yeshasvini Cooperative Farmers Health Care Scheme was introduced by the Karnataka government in 2003, initially offering affordable surgical interventions for farmers and cooperative society members. It later introduced Arogya Karnataka (ArK), a publicly funded health insurance scheme by merging seven different state schemes to provide inpatient care up to an annual coverage of INR 20,0000 to poor households. In 2018, when the national government introduced Ayushman Bhart PM-JAY, Karnataka integrated it with the state scheme and formed AB-PMJAY-ArK to provide financial protection to all the residents of Karnataka (irrespective of income or other criteria). For people above the poverty line, it introduced a co-payment mechanism where 70% of the package cost has to be borne by households and 30% by the scheme. The scheme is implemented on an assurance mode by the State Health Agency, Suvarna Arogya Suraksha Trust (SAST). The state has included both public and private healthcare facilities in their empanelled list. In order to make the system more efficient, it has reserved 294 simple secondary care procedures for public hospitals and 40 other procedures to be performed by MBBS practitioners. As a cost-mitigation strategy, public health-care institutions follow a differential payment system under the Ayushman Bharat Arogya Karnataka (AB-ARK) Scheme. 5% of the procedure cost is covered.

This scheme has largely helped facilities to improve infrastructure and maintain facilities. Another advantage of the scheme is the use of digital technology, especially the online registration system, which has ensured efficient patient care. This has resulted in higher uptake in public hospitals in the state.

Apart from the introduction and implementation of the unique scheme for enhancing UHC, Karnataka has taken notable steps to increase public spending on healthcare. The share of health expenditure in total government expenditure has gone up from 5% in 2014–15 to 8.5% in 2021-22, a steep hike in a span of six years. This has led to reduction of the share of OOPE in total health expenditure to 25% in 2021–22 from 52% in 2014–15.

India's progress towards Universal Health Coverage: The role of PM-JAY

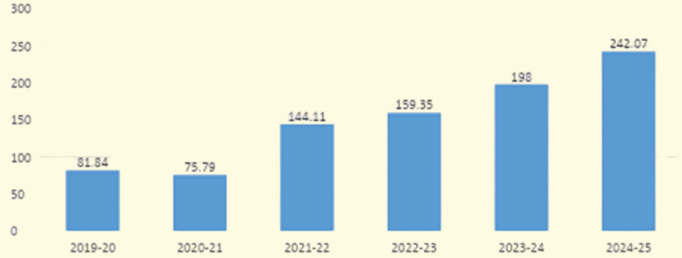
As mentioned earlier, over the past decade, India has undertaken a comprehensive set of reforms to advance UHC, the most comprehensive being the Ayushman Bharat -Pradhan Mantri Jan Arogya Yojana (PM-JAY) on 23 September 2018. The scheme aims to provide financial coverage of Rs 5 lakh per family per year for secondary and

tertiary care hospitalization to over 12 crore families (initially 10.74 crore families, later increased to 12 crore), covering nearly 55 crore individuals from the poor and vulnerable sections of the population as identified in the SECC 2011. The aim is to provide them affordable, accessible and quality care. The eligible beneficiaries will have cashless and paperless access to services at the empanelled hospitals [vi]. Efforts are underway to cover increasingly more families and, most recently, the government extended benefits to all citizens aged 70 years and above, irrespective of socio-economic status [vii]. This included nearly 6 crore individuals across 4.5 crore families. The government also included 37 lakh ASHAs, Anganwadi workers and their families as eligible beneficiaries.

PMJAY has expanded healthcare coverage across India, emerging as a transformative initiative. This marked a shift in the healthcare landscape of India. To date, all states, with the exception of West Bengal, have adopted the scheme. Prior to PM-JAY, RSBY emerged as a national scheme but its reach was limited with low financial coverage and design challenges. The other two social health insurance schemes—the Employees' State Insurance Corporation (ESIC) and the Central Government Health Scheme (CGHS)—which primarily cater to government employees and low-income workers in the private sector also play a critical role in providing financial protection. Currently, around 71% of the total population is covered by some insurance scheme, including publicly funded social health insurance, and voluntary private health insurance, with the remaining 30% not covered. This translates to approximately 404 million people who remain uncovered by any scheme. Known as the missing middle, they either access public healthcare or spend from their pocket.

As we write this report, 418.9 million health cards have been issued to the people. Hospital admissions are increasing over the years providing financial protection to the most vulnerable population. In the financial year 2024–25, the scheme has recorded a cumulative total of 9.01 crore hospital admissions since its inception. The year-wise utilization indicates an increasing trend. Figure 6 [O1] shows that total hospital admissions increased from 81.84 lakh in 2019–20 to 242.07 lakh in 2024–25 with a slight decline in 2020–21 during the COVID-19 pandemic. Utilization under the scheme has nearly tripled over the six-year period in tandem with increase in beneficiary enrolment and enhanced access to healthcare services.

Figure 6: Financial Year-wise Hospital Admissions (in Lakhs)



SOURCE: HTTPS://WWW.DATA.GOV.IN/RESOURCE/STATEUT-WISE-DETAILS-AUTHORIZED-HOSPITAL-ADMISSIONS-UNDER-AB-PMJAY-2018-19-2022-23

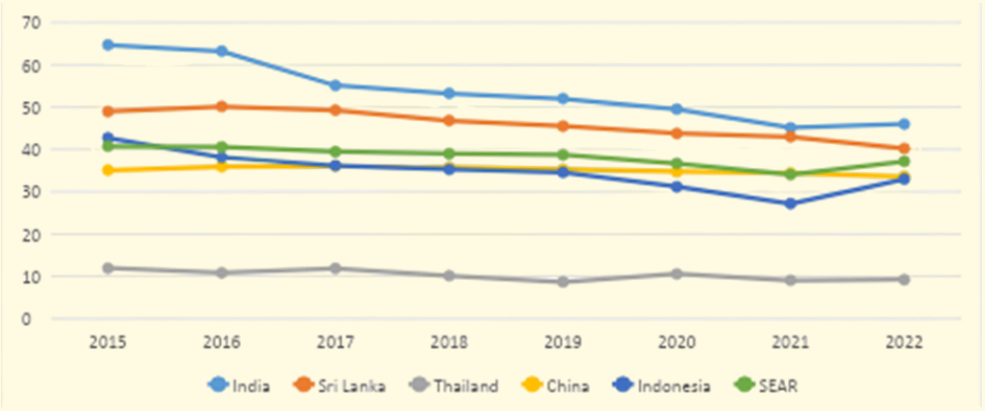
The number of hospitals empanelled under PM-JAY has increased over the years, and some low-income states like Madhya Pradesh, Chhattisgarh and Uttar Pradesh have shown a rise in hospital empanelment, indicating that the poorer states are taking benefit of the scheme. To date, 32,908 hospitals are empanelled under the scheme, of which 53% are public hospitals and the remaining are private hospitals. It is further observed that female participation in PM-JAY is increasing compared with their male counterparts, an indication that the scheme is fair in-service delivery.

There is paucity of evidence on the impact of the PM-JAY on reducing OOPE, but the limited evidence shows a mixed pattern. A notable study found that enrolment under PM-JAY did not significantly increase the utilization of inpatient services[viii] . Moreover, insured individuals who sought care in private hospitals continued to face high OOPE and a large proportion of insured patients incurred CHE. Similar findings were reported in a multi-state study covering Bihar, Chhattisgarh, Gujarat, Meghalaya, Tamil Nadu and Uttar Pradesh, showing increased healthcare utilization, but no conclusive reduction in OOPE or CHE[ix]. Two systematic reviews further reinforced this conclusion, indicating that while PM-JAY may have improved access to services, its impact on reducing the financial burden of healthcare remains uncertain and inconsistent across states[x] . Studies pertaining to timely treatment of cancer showthat enrolment under PM-JAY has increased timely treatment by 90% among those enrolled under PM-JAY, as against 33% for those not enrolled.[xi]

Though the scheme has shown progress in improving access to healthcare among poor and vulnerable households, its potential to provide UHC is fraught with several challenges. One of the major challenges is the magnitude of uncovered population. Around 30% of India's population access the overstretched public sector or the expensive private sector for healthcare.[xii] These populations need to be provided financial coverage with innovative financing mechanisms.

Another challenge is the substantial OOPE incurred by individuals for outpatient care, which remains largely excluded from existing insurance schemes. Medicines and diagnostic services are the primary cost drivers in outpatient care. Addressing this issue requires strengthening public healthcare delivery, particularly at the primary care level. The ongoing initiative to AAMs is a step in the right direction, as these facilities have the potential to offer a comprehensive range of essential health services and reduce the financial burden on households. It is also essential to improve primary care financing which is underfunded. A recent NHA report indicates that 50% of total health expenditure is on primary care against the 70% norm set by the National Health Policy of 2017.

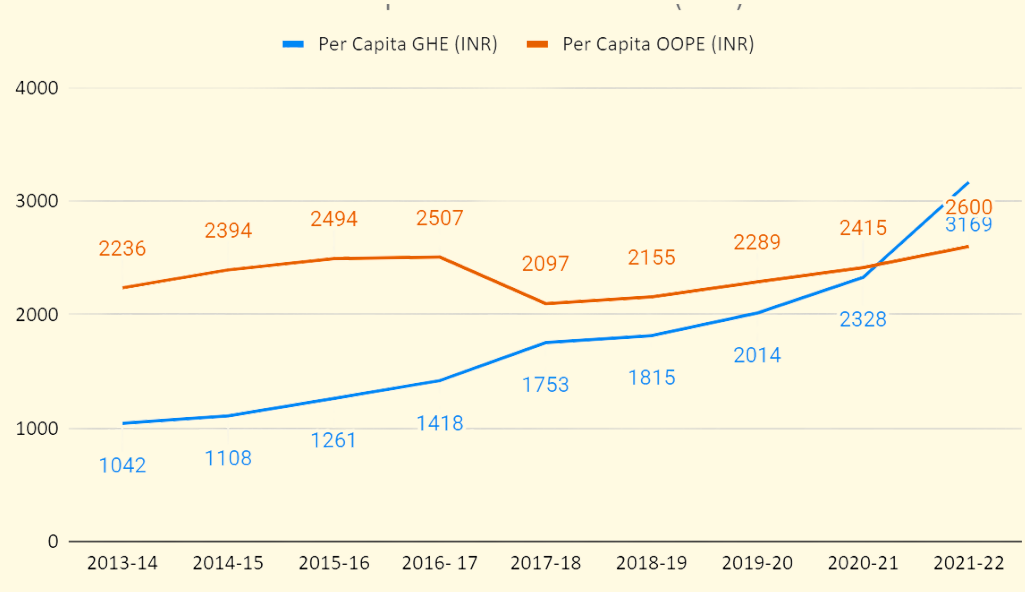
Figure 7: Share of OOPE in CHE in SEAR (%)



Data Source : Global Health Expenditure Database. World Health Organization. https://apps.who.int/nha/database

An examination of per capita government health expenditure and OOPE shows a significant gap between the two, with OOPE being much higher. Between 2013–14 and 2016–17, per capita OOPE was almost twice that of per capita government expenditure. However, this disparity began to reduce from 2017–18 onward. Notably, in 2021–22, per capita government health spending exceeded OOPE for the first time, indicating a positive trend towards greater public investment in healthcare. Total per capita government expenditure in 2021–22 was Rs. 3,169 compared with Rs. 2,600 for OOPE.

Figure 8: Per Capita GHE and OOPE (INR)



Recommendations

Improving Health Finance

Evidence suggests that a large segment of OOPE is on drugs and diagnostics services at outpatient facilities, not including the cost of transportation. OOPE per outpatient visit was Rs 910 in 2018 and OOPE incurred at public facilities was much higher than that at private facilities[xiii]. Disease-specific outpatient OOPE per visit varies significantly and the rising burden of NCDs, especially the increasing prevalence of diabetes and hypertension, increases the OOPE burden for outpatient care. Acute illnesses usually involve smaller, one-time costs, whereas chronic and long-term ailments involve higher OOPE due to ongoing consultations, diagnostics and medication costs. Goyanka et al. (2023) reported monthly outpatient OOPE for cancer at Rs.8,811, which was higher than the monthly inpatient OOPE (Rs.6,549). Another study reported that the median annual direct outpatient cost for mental health was approximately Rs.4,907, with medication accounting for the bulk of this expenditure. Research based on data from the 75th cycle of the NSS also shows that NCDs including diabetes and cardiovascular disorders have greater outpatient OOPE than communicable diseases.[xiv]

Although PM-JAY covers up to three days pre-hospitalization and 15 days post-hospitalization, and expenses such as diagnostics and medicines, it does not cover outpatient expenses beyond that period. Further, prioritizing costly hospital insurance over universal primary care will slow the progress of UHC, especially given India's weak primary health systems.

In order to arrest OOPE for outpatient care, it is recommended that outpatient care be included in the list of health benefit packages (HBPs) under PM-JAY (currently 27 specialties and 1,949 procedures are covered).These services could be delivered through empanelled public and private hospitals for beneficiaries already covered under PM-JAY. The cost of reimbursement per visit at public and private hospitals should be determined through costing studies and expert consultations. The variations in costs at the different levels of care should be accounted for to ensure uniformity in the system.

As mentioned earlier, advancing primary health care is a critical step towards achieving UHC in India. While HWCs have expanded access to basic health services, particularly in rural areas, this initiative is fraught with several challenges due to inadequate financing, infrastructure and human resources.

Adequate funding for primary care is the first step to achieve UHC. It is suggested that at least 8% of the state government budget should be allocated for health, of which 70% should be directed to primary care as per the 2017 National Health Policy target. Currently, according to the national health accounts, report, primary care spending constitutes 50% of total health expenditure, falling short of the national target.

Strategic involvement of private sector doctors in primary care

In many parts of the country, access to government-funded primary health care remains extremely limited. In such underserved areas, it is recommended that healthcare services be drawn from the private sector. For this approach to be effective, single-doctor clinics and solo practitioners operating in these regions should be empanelled to provide a comprehensive range of primary care services.The cost of consultation and dispensing of medicines should be packaged and fixed at a standardized rate. Private pharmacies should be linked to this system to dispense drugs based on prescriptions. Learnings from the national TB programme where private doctors and pharmacies are involved under the patient provider support agency (PPSA) can be useful to define and expand this model for providing comprehensive primary care in India.

Co-payment through insurance system for the missing middle with an opt-in and opt-out options

Currently, the existing national, state and voluntary insurance programmes cover around 70% of the total population and the remaining 30% remains uncovered. This translates to approximately 404 million people, the missing middle, who remain uncovered by any scheme. They either access public healthcare whenever available or spend from their pocket for their healthcare needs. In order to provide coverage to this group, it is recommended that they be included within the existing national health insurance scheme, which can be redefined as PM-JAY+ with an income graded co-payment arrangement where the premium varies by incomes. This option is not mandatory and anyone can opt out of the scheme. The National Health Authority and the state health assurance societies can be entrusted with pooling and managing such funds for this additional population. Some states (Karnataka, Mizoram) have included additional populations beyond PM-JAY with the co-payment options and this model can be refined at the national level.

Strengthening PM-JAY for increasing utilization and reducing administrative bottlenecks to increase uptake

Increase hospital empanelment to reach the unserved in the low-income states: There is a significant urban–rural divide in hospital availability and healthcare utilization, with services being concentrated largely in urban areas. Moreover, a majority of empanelled hospitals are clustered in just four to five states, leaving other regions underserved. The aspirational districts still grapple with inequities with low claim values and skewed distribution of empanelled hospitals. Therefore, prioritizing hospital empanelment in underserved and aspirational districts will address geographic inequities in access.

Increase coverage of vulnerable populations, female-headed households and those of low socio-economic status. PM-JAY's technological interoperability with several national and state databases has helped verify eligibility criteria, prevent duplication, and minimize inclusion and exclusion errors. However, as SECC 2011 is outdated, it fails to capture current socio-economic and demographic realities, leading to exclusion and mis-targeting. Integrating dynamic datasets like the National Food Security Act (NFSA) can improve accuracy and better target vulnerable populations to promote equity in access and financial coverage.

Ensure clinical quality to improve uptake: There are systematic gaps in human resources, availability of medicines, diagnostics and infrastructure that impact the quality of care, particularly in public-sector facilities located in low-resource settings. Although STGs are used in claim processing and serve as a reference for physicians, there are inherent weaknesses in their implementation, leading to several quality-related challenges. It is therefore important to clarify the role of STGs in clinical decision-making and to establish an independent body responsible for interpreting these guidelines, monitoring deviations in clinical quality and overseeing claim processing. Strengthening the supply chain is also crucial to ensure consistent availability of medicines and diagnostic services in public health facilities, thereby restoring public trust and increasing reliance on the government health system.

Another area of concern is higher readmission rates for certain procedures and this raises questions related to the quality of care in hospitals. There is a need to target interventions in states with elevated readmission rates and consider linking quality metrics to payment incentives.

Streamline claims processing mechanism and minimize delays in payments: Private hospitals have frequently reported delays in claim processing, claim rejections and payment settlements. Such issues have often led to dissatisfaction among private providers, with some even expressing concerns or threatening to withdraw from service delivery under the scheme. Government healthcare facilities must be strengthened to increase their capacity for truncated care delivery.

It is further observed that PM-JAY relies heavily on private hospitals, as reflected in higher hospitalization rates and utilization of specialized, high-claim packages in private hospitals. This leads to increased cost of care, often several times higher than that incurred at public health facilities.

Addressing OOPE at the point of care: Higher costs and continued OOPE for PM-JAY beneficiaries can be attributed to the prevalence of double billing and deviation from the established rates of HBPs. With poor monitoring of choice of treatment, fund wastage resulting from unnecessary high-cost services, and lack of an invoice for therapy received through PM-JAY, patients are unable to verify what they have been charged by hospitals. Stricter regulations, prompt grievance resolution, use of STGs, and action against double billing and inflated prices are required to reduce OOPE in private hospitals. Regulating private providers through standards, audits and accreditation will advance UHC and its financial protection goals.

Strengthening primary healthcare and public hospitals, along with ensuring seamless coordination between PM-JAY and AAMs through the use of unique IDs, common registration systems, and two-way care coordination protocols is essential to enhance the utilization and effectiveness of PM-JAY. There should be structured communication among all the participants involved in a patient's care, including the patient, their family, primary care providers and specialists. Leveraging digital technologies to enable and streamline this is vital for advancing in this direction.

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Primary Care

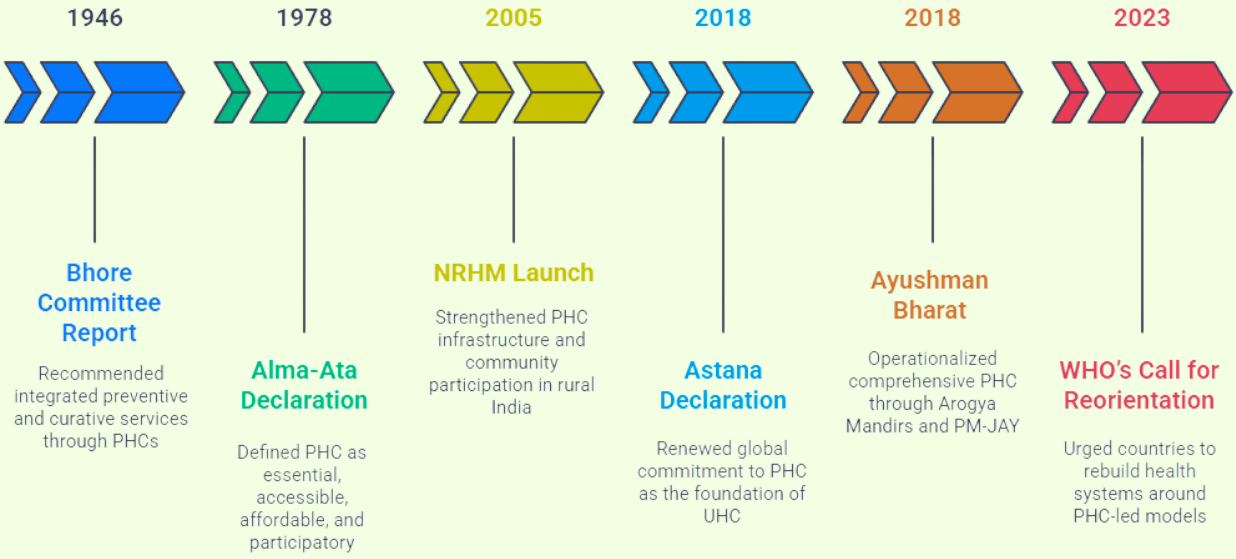
- Strengthening Rural Primary Care

- Urban Health: The Make-Or-Break Game

Strengthening Rural Primary Care

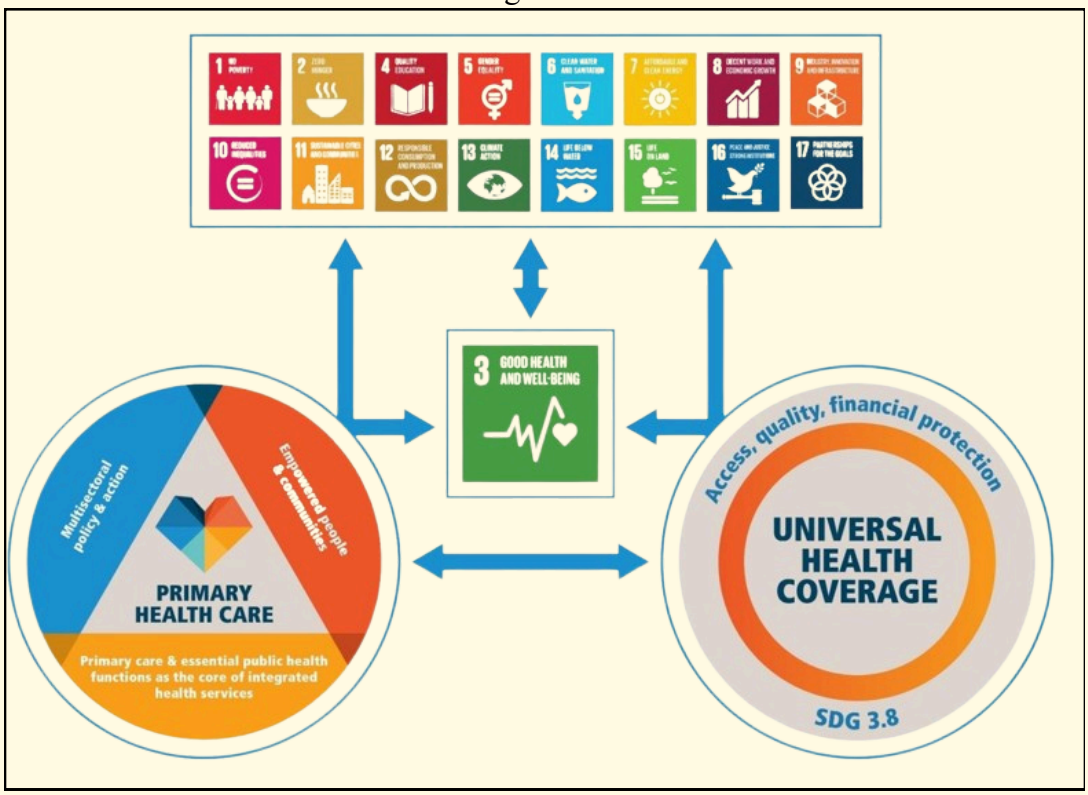
Primary Health Care is the bedrock of equitable and sustainable health systems, representing not merely a level of care but a philosophy that connects people, communities and health systems. Primary health care serves as the backbone of both UHC and UHA.

Figure 1: Key Milestones in the Evolution of Primary Health Care



The concept was first articulated in the Alma-Ata Declaration of 1978, where global health leaders endorsed it as the key to achieving 'Health for All' through universal, community-based and preventive services that address the broader determinants of health, not just disease treatment [i]. Forty years later, the Astana Declaration (2018) reaffirmed these principles, calling for a 'renewed commitment to strengthening PHC as the foundation of universal health coverage (UHC) and the Sustainable Development Goals (SDGs)'[ii]. Together, these declarations define primary health care as an inclusive, multi-sectoral approach to health that integrates primary care services, public health functions and community engagement to promote wellbeing across the life course.

Figure 2



The Role of Primary Health Care in Achieving Universal Health Coverage and Universal Health Assurance

The goal of universal health coverage is that all individuals and communities receive the health services they need without financial hardship. However, in recent years, there has been an important conceptual evolution towards UHA; a more inclusive idea emphasizing not only coverage and access but also quality, trust and accountability in health care delivery. UHA also creates conditions conducive to a healthy society through multi-sectoral actions which promote and protect health ('Health in all Policies').

Evidence from select countries shows that those with strong primary health care systems consistently achieve better population health outcomes, lower health inequalities and reduced financial burden. For instance, Thailand's Universal Coverage Scheme, anchored in community-based primary care and district-level planning, has achieved over 98% coverage and sharply reduced CHE[iii]. Similarly, Brazil's Family Health Strategy, with its multidisciplinary teams embedded in local communities, has led to measurable improvements in maternal and child health, reductions in hospitalizations and better chronic disease management[iv]. Costa Rica's EBAIS model integrates primary care teams with strong community participation. In this sense, primary health care is not a gatekeeper but a bridge linking households to hospitals, curative to preventive services and health systems to social systems[v]. It is an approach where 'care is delivered not to the people, but with the people', fostering ownership, participation and trust in public health institutions.[vi]

Despite decades of health planning, health systems in the Indian context have historically been hospital-centric and programme-driven, prioritizing vertical disease control over integrated primary care. Public expenditure has been skewed towards tertiary facilities, leading to underinvestment in rural primary health infrastructure and human resources. As a result, communities continue to bypass primary health centres (PHCs), seeking care directly from higher facilities or unregulated private providers, a pattern that drives high OOPE spending and health inequities.[vii]

The WHO's 2023 call for 'reorienting health systems toward primary health care' is particularly relevant for India. It emphasizes that investment in primary health care yields triple returns: improved health outcomes, enhanced equity and greater system resilience against shocks such as pandemics or climate disasters[viii]. The COVID-19 pandemic reaffirmed the necessity for robust primary health care: areas with strong primary care networks like Kerala's family health centres and Chhattisgarh's Mitanin-led community system were able to detect, contain and manage the crisis more effectively than others.[ix]

Thus, reorienting India's health system towards primary care is not merely a technical choice but a moral and economic imperative. A primary health care-led system ensures universal access, quality assurance and continuity of care, while aligning with the nation's vision of 'Health for All by 2047' under the Viksit Bharat framework. As the country moves towards UHA, strengthening rural primary care with a special focus on HWCs will be the most crucial step in building a people-centred, equitable and resilient health system.

> "Primary health care must be the front door of health assurance, not a waiting room for hospitals."
>
> **Dr. T. Sundararaman**, Former Executive Director, NHSRC India

Selective vs. Comprehensive Primary Health Care: Conceptual Debates and Evolving Perspectives

The distinction between Selective and Comprehensive Primary Health Care has been one of the defining debates in global health policy since the Alma-Ata Declaration of 1978. Comprehensive primary health care, as envisioned at Alma-Ata, promoted a broad, community-based approach encompassing promotive, preventive, curative and rehabilitative care anchored in intersectoral collaboration, community participation and social justice. It viewed health as a product of social determinants and aimed for universal accessibility through strengthened local systems. However,

constrained settings led to the emergence of the selective model in the early 1980s, which prioritized a narrow set of cost-effective interventions such as immunization, oral rehydration and malaria control to achieve quick health gains.

Proponents of the selective model argued that targeted interventions were a practical and economically efficient approach for developing countries with limited fiscal and administrative capacities. In contrast, advocates of the comprehensiveapproach contended that selective strategies risked fragmenting health systems and overlooking long-term determinants of health equity, continuity of care and community empowerment. Over time, the dichotomy between the two models has softened, with scholars and policymakers recognizing that both approaches can coexist within a broader health system strengthening framework. Some global health experts have advocated a 'diagonal approach' (Julio Frenk, Jaime Sepulveda). Selective primary health care may serve as an entry point or 'building block' towards comprehensive care, especially where infrastructure and workforce capacity are still evolving.

In recent years, policy frameworks such as AAMs have sought to bridge this divide by combining targeted service packages (maternal and child health, NCD screening) with systemic strengthening measures (digital records, community engagement and expanded human resources). This hybrid model reflects an evolving consensus that effective primary health care must be both comprehensive in vision and selective in operational focus, balancing population-level equity with pragmatic delivery strategies tailored to local contexts, particularly in rural India.

Urban–Rural Disparity

Despite major investments in health over the past two decades, India continues to exhibit deep and persistent urban–rural inequalities across almost every major health indicator. Urban areas benefit from higher density of health infrastructure, greater availability of specialists and better access to diagnostics and emergency services, while rural populations, which constitute nearly 65% of India's residents, remain dependent on a relatively thinly spread and often under-resourced primary care network. The disparities reflected in NFHS-5 data starkly illustrate this divide. Rural India carries a consistently higher burden of mortality and morbidity: the under-five mortality rate (46 per 1,000) is significantly higher that of urban areas and the infant mortality rate remains 12 points higher. Fertility is substantially elevated in rural areas (2.14 vs. 1.63), reflecting gaps in reproductive health access and social determinants. Maternal health advantages are seen in urban spaces with higher institutional deliveries, better ANC and greater use of menstrual hygiene products, all of which are markedly weaker in rural districts. Nutrition indicators show similar inequities, with rural children experiencing far higher levels of stunting and wasting. Rural households also face greater deficits in literacy, access to sanitation and financial protection, amplifying their vulnerability to ill-health. These multi-sectoral disparities reinforce why rural primary health care must be central to India's universal health assurance vision and why AAMs need greater financial, workforce and governance support to bridge the country's most enduring health divide.

Table 1

Indicators	India	Urban	Rural
Crude Birth Rate	19.5	15.9	20.9
Crude Death Rate	7.5	6.6	7.9
U5MR	42	32	46
IMR	35.2	26.6	38.4
TFR	2	1.63	2.14
At least four ANC visits during pregnancy	59%	69%	55%
Institutional births	89%	91%	85%
Stunting	35.5	30.1	37.3
Wasting	19.3	17	20
Tobacco use (males)	38.00%	28.80%	42.70%
Access to toilet facility	83%	96%	76%
Female literacy rate	71.50%	83%	66%
Menstrual protection	77.60%	89.60%	72.60%
Health insurance coverage	41	42.4	40.3

Restructuring Ayushman Arogya Mandirs as the Backbone of Assurance

Ayushman Arogya Mandirs, created by upgrading sub-health centres and primary health centres (PHCs) under the Ayushman Bharat Health and Wellness Centres programme, represent India's most ambitious attempt to reorient its health system towards comprehensive primary health care. They embody the shift from facility-based, episodic care to continuity-centred, team-based primary care that integrates prevention, early detection, risk management and community engagement. AAMs expand the scope of services beyond traditional maternal and child health services to cover 12 service packages, including NCDs, palliative care, mental health, ophthalmic and ENT problems and basic emergency services. Positioned closest to rural households, AAMs are intended to be the trusted first point of contact, a place where people not only seek treatment

but also receive counselling, screening, lifestyle guidance, medication and coordinated referrals. The presence of a community health officer (CHO), supported by ANMs, ASHAs and MPWs, creates a new frontline team capable of managing up to 70–80% of rural health needs locally. In many ways, AAMs are the institutional mechanism through which India operationalizes the Astana commitment to 'primary health care as the centrepiece of UHC'.

The Status of AAMs in India

As of 2024, India has over 178,000+ AAMs, making it one of the largest primary health care networks in the world. Nearly 95% of sub-health centres and PHCs targeted for transformation have already been notified as AAMs and digital reporting through the HWC portal has increased measurability and transparency. Monthly footfalls exceed 170 million and over half of these visits relate to chronic disease management, reflecting a rapid reorientation towards NCD-focused primary care. The deployment of CHOs marks a major workforce innovation, enabling task sharing and expanding the capacity of rural teams. Evidence from states like Tamil Nadu, Meghalaya and Chhattisgarh shows noticeable improvements in hypertension/diabetes control, cancer screening and palliative outreach after upgrading HWCs.

Despite this scale-up, challenges remain. Footfall varies widely, from 8-12 patients/day in poorer-performing states to 60–80/day in high-performing states, suggesting uneven utilization and inconsistent service readiness. Many AAMs lack a full complement of staff, essential diagnostics, uninterrupted drug supplies, functional internet connectivity and supportive supervision, limiting their potential to deliver comprehensive primary health care.

The transition from universal health coverage to universal health assurance necessitates that health systems not only reach people, but reliably deliver quality care when and where they need it. Rural primary health care is central to that transformation; serving as first contact, providing continuous care, preventing disease progression and coordinating referrals.[x]

> "Ayushman Arogya Mandir represents the paradigm shift from selective care to comprehensive primary healthcare."
> Maj Gen (Prof) Atul Kotwal, Former Executive Director NHSRC

In India's rural context; home to approximately 65% of the population, well-functioning AAMs are critical for accessibility, equity and financial protection. These centres reduce the need for hospitalizations, limit catastrophic expenditure and build community trust (Starfield

Best Practices

Global Models

Thailand: Rural primary health care is strengthened by staffing rural hospitals and health centres with bonded health professionals (doctors, nurses, dentists), mandatory rural service and centrally-funded capitation mode of payments to providers. Thailand's sub-district health centres anchor outreach and prevention that expands immunization, ANC and chronic disease control in rural areas using strong community health volunteer networks.

Ghana: Community-based Health Planning and Services (CHPS) places community nurses in rural settings to work directly with local populations. It focuses on household outreach, preventive care and treatment of common illnesses. CHPS brings basic health services into remote villages and facilitates community engagement in health governance.

Indonesia: The Puskesmas (community health centres) are the cornerstone of rural health service delivery, providing primary care, immunization and maternal-child services. It is often supplemented by mobile outreach for remote villages.

Indian Innovations & State-level Successes

Kerala

Family Health Centres (Aardram): Extended hours, high nurse staffing and robust outreach have led to high coverage and trust.[xi]

Tamil Nadu

The Makkalai Thedi Marutthuvamscheme (door-step NCD management) integrates primary health care outreach with continuity of care.[xii]

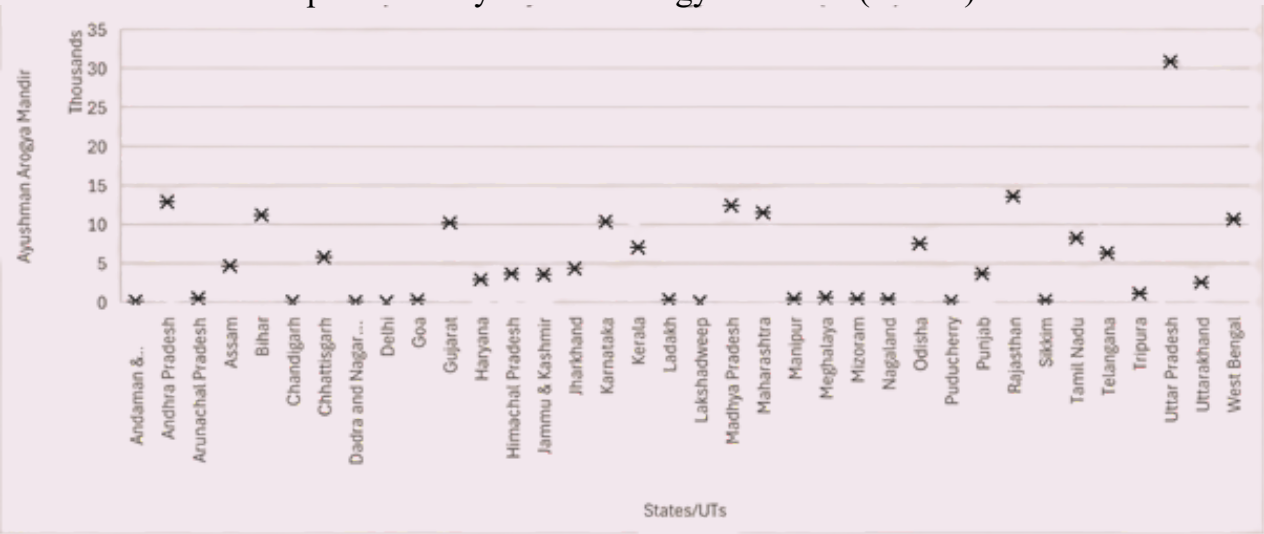
Rajasthan

State has operationalized nurse-led primary care units in inaccessible tribal and desert areas by developing Nurse Practitioners in Midwifery (NPMs) and strengthening nurse-led continuity-of-care models, with outcomes comparable to doctor-led models.[xiii]

et al. 2005). However, to fulfil their potential they must go beyond episodic curative care and become platforms of wellness, prevention and dependable continuity.

"HWC even in its design is focused only on illness care. The 12 packages for clinical care are sufficiently comprehensive, but similar attention to details regarding wellness is not visible." - Dr. Yogesh Jain, Founder, Jan Swasthya Sahyog

Operational Ayushman Aarogya Mandirs (AAMs)



The chart illustrates the state-wise operationalization of AAMs, reflecting India's progress in expanding Comprehensive Primary Health Care (CPHC).

High performers: Uttar Pradesh, West Bengal, Andhra Pradesh, Madhya Pradesh and Maharashtra show the highest number of operational AAMs, indicating strong rural outreach and administrative capacity.

Moderate performers: States such as Tamil Nadu, Karnataka, Gujarat and Odisha have mid-range numbers, reflecting steady but regionally varied progress.

Low performers: North-eastern and smaller hill states, along with Union Territories, lag behind due to geographic isolation, smaller populations and human resource constraints.

Core Bottlenecks

- Uneven service readiness and incomplete operationalization of the 12-service package: Many AAMs remain curative outpatient counters rather than comprehensive PHC nodes. Essential diagnostics, point-of-care tests, telemedicine equipment and uninterrupted drug availability are inconsistent across states.

- Workforce gaps and overburdened frontline teams: CHO vacancies exceed 25% nationally. ASHAs and ANMs are often overburdened with administrative tasks, parallel reporting systems and vertical programme duties, which reduces time for community outreach.

- Weak community empanelment and continuity-of-care loops: Many rural populations are not empanelled to a specific AAM, leading to low trust, bypassing of PHCs and limited follow-up of cases of chronic diseases. Counter-referrals back to AAMs after hospital care remain minimal.

- Digital overload and infrastructure constraints: Poor connectivity in rural districts increases the administrative burden on CHOs/ANMs; multiple digital platforms (ABDM, HWC portal, HMIS, NCD app) remain poorly integrated.

- Limited integration with PM-JAY and district hospitals: AAMs often function in isolation from secondary care. PM-JAY claims that data, hospital discharge summaries and e-Sanjeevani teleconsultations are not systematically linked to AAM registries.

- Inadequate financing for primary care: Most AAMs lack predictable funds for minor repairs, diesel for generators, sanitation and community events. Capitation-based financing is still absent.[xiv]

- Weak governance, supervision and quality assurance: IPHS compliance remains partial, national quality assurance standards (NQAS) rollout is slow and district-level supervisory structures struggle with staff shortages and large catchment areas.[xv]

Recommendations

1. Make AAMs the nucleus of a 'continuity ecosystem' for rural households.
   - Mandatory empanelment of families with their nearest AAM.
   - Automatic linkage of hospital discharges (public and PM-JAY private) back to AAMs for follow-up.[xvi]

2. Fully operationalize the 12-service package with uniform service readiness.
   - Ensure essential diagnostics (HbA1c, RBS, lipids, malaria, dengue) at all AAMs.
   - State-level pooled procurement of drugs with quarterly stock audits.[xvii]

3. Strengthen the rural PHC workforce through skill diversification and team-based care
   - Fill CHO vacancies with contractual or bridge-trained nurses.
   - Offer mentorship to ANMs, ASHAs and MPWs (weekly case reviews, tele-mentoring).
   - Provide task-sharing protocols for NCDs, palliative care and mental health.[xviii]

4. Reduce digital burden through an 'Offline-First Rural PHC Stack'.
   - Integrate ABDM, HMIS and HWC portals into a single dashboard, pushed offline automatically when connectivity drops.
   - Use biometric or QR-based patient follow-up lists for NCDs and ANC.

5. Institutionalize AAM district hospital–PM-JAY integration.
   - AAMs should issue digital referrals and receive mandatory counter-referrals.
   - PM-JAY should reimburse outpatient medicines and diagnostics at AAMs.

6. Establish predictable financing for operation and maintenance through hybrid capitation.
   - A per-capita PHC allocation for each AAM, linked to size of catchment population, screening coverage, follow-up rates and service quality.

7. Strengthen governance and local accountability.
   - Quarterly AAM scorecards at the district level covering service readiness, footfall, stock-outs and screening rates.
   - Jan Arogya Samitis (JASs) should serve as grievance redressal forums with SLA-based responses.

8. Use community-led strategies to enhance trust and utilisation.
   - Introduce evening OPD sessions during agricultural seasons.
   - Use CHOs, ASHAs, panchayat members and women's groups to promote screenings, NCD follow-up, TB adherence and mental health awareness.

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Urban Health in India

India is witnessing an unprecedented scale of urbanization as cities are becoming hubs of growth, innovation and creativity. They are the destination for the socio-economic aspirations of citizens; 350 million people are likely to move to cities by 2030 and this is expected to double by 2050. This implies that every minute during the next 20 years, 30 people will leave rural areas for urban areas. About 70% of the urban population is concentrated in larger cities, specifically in the 534 million-plus cities and 1,374 towns identified by the NUHM. It is estimated that urban India will contribute to 70% of the GDP by 2030, indicating a rapid increase in new opportunities in urban areas. Fulfilling basic needs, i.e., regular income, shelter, reliable and safe public transport, affordable electricity, clean drinking water, education, including access to healthcare, is the responsibility of government, especially city administrations.

The Urban Health Landscape

Cities are also growth engines for the country, and it is the informal sector which absorbs 90 per cent of a city's poor and vulnerable (an estimated 146 million reside in slums or makeshift conditions). Cities notably serve their residential population along with the floating population and migrants from rural and urban areas who are dependent on cities for livelihood, education, quality healthcare services, etc. Improvements in road systems allow a large number of people to travel into and out of the city, adding to the burden on health systems and social determinants of health. To support this rapid urbanization and leverage the anticipated economic growth in cities, it is essential to ensure the health and wellbeing of its citizens and provide a better quality of life for all.

Stress and Challenges of Health Systems

Primary health care services cater to 80–90% of an individual's healthcare needs during their lifetime [i]. The existing healthcare system in Indian cities is stressed. There is one urban primary health care centre for roughly 78,000 people, surpassing the recommended standard of one centre per 50,000–60,000 people. Likewise, the current allopathic doctor–population ratio stands at 1:1,100 [ii]. Externalities that are particularly predominant in cities like stressful lifestyles, compromised living conditions, inadequate sanitation facilities, poor environment (air, soil and water pollution), etc., can cause diseases like vector-borne, chronic respiratory disorder, mental stress, heart conditions, etc., further deteriorating the health and wellbeing of urban dwellers.

To ensure healthy lives and promote the wellbeing of all at all ages, the targets of SDG 3 encompass various aspects of healthy living and healthy lifestyles. Progress towards 13 targets of SDG 3 is measured using 28 indicators. As per SDG indicators (2019–20), in urban India, 12% of

births are still not institutional, 39% of children in the age group 0–5 years are yet not fully immunized, under-5 mortality rate per 1,000 live births is 26 against the target of 25, and neonatal mortality rate per 1,000 live births is 14 against the target of 12.

COVID-19 and Urban Vulnerability

The COVID-19 pandemic exposed deep vulnerabilities in urban health systems. Densely populated settlements, poor housing, and limited access to healthcare exacerbated infection rates and mortality, especially among the urban poor, women, children and elderly. The crisis revealed significant deficits in health infrastructure, human resources and preparedness. It underscored the urgent need to strengthen medical, paramedical and pharmaceutical capacities, and to build resilient and adaptive healthcare systems in cities.

City administrations have a critical role in catering to the healthcare needs of the increasing urban population. These needs are often met through conventional healthcare systems which include primary, secondary and tertiary services. Furthermore, private facilities in cities makes the urban healthcare environment more complex, adding to the multiplicity of service providers.

Considering these aspirational, environmental and institutional complexities of Indian cities and the gaps in health infrastructure, the key is to understand the relationship between the changing urban environment and human health to develop a resilient healthcare system.

National Urban Health Mission

Over the years, the central and state governments have taken measures to improve access to primary health care for the vulnerable. In this context, the National Urban Health Mission as launched as a sub-mission under the NHM with the specific aim of reducing maternal mortality rate (MMR) and infant mortality rate (IMR), along with providing universal access to reproductive healthcare and ensuring convergence of all health-related interventions in urban areas. The aim is to set up a unified system where one community organization, guided by the urban local body, manages all important areas like water, sanitation, nutrition, healthcare, education, skills training and housing. It emphasizes primary health and reducing OOPE using different interventions.

Even after the inception of NUHM, it is evident from recent statistics that there is a substantial shortfall in terms of infrastructure and human resources in the urban health sector. To address these gaps, the 15th Finance Commission (2021–26) has recommended a grant of Rs. 24,028 crore (34% of the total health grant) for urban HWCs and Rs. 2,095 crore for UPHCs. Healthcare services in cities are a mix of public and private sector facilities. State and city administrations are responsible for providing all levels of care—primary, secondary, tertiary and specialized services.

The growth and expansion of cities in terms of population and area is not proportionate to the expansion of public sector healthcare services. Private and philanthropic sectors are critically filling this gap.

Private-sector services are profit-driven and market-oriented, which results in limited attention to the reach, accessibility and coverage of these facilities. While the public sector must remain more accessible and self-sufficient for vulnerable populations, it is equally important to ensure smooth integration of the private sector within the broader health and wellbeing ecosystem. A major challenge lies in sustaining implementation efforts within the health department itself. Effective multi-sector engagement will require additional effort, as the health department has limited say over other departments.

With the experience of COVID-19 and the introduction of PM-ABHIM and the 15th Finance Commission, it is evident that the role of the urban local bodies (ULBs) is set to evolve. With some support, they have to take the lead in urban health ecosystem convergence and system-level changes.

Current State of Urban Public Health

Of the 1,374 urban areas covered by NUHM, 81% cities have completed mapping urban health facilities, 80% have completed mapping urban slums, and 64% have completed vulnerability mapping. The reason for such slow performance is poor focus on urban health and lack of dedicated management structures.

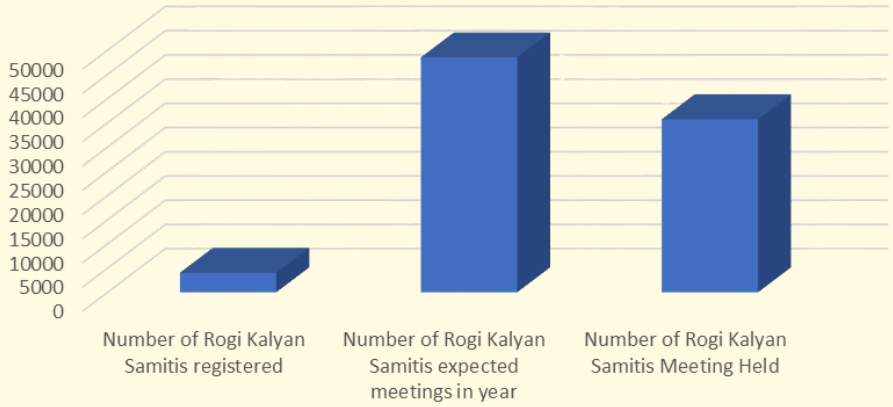
Outreach work is poor in slums due to the number of ASHAs: currently there are approximately 90,000 ASHAs for a vulnerable population of 146 million residing in slums and slum-like conditions. 82% have received induction training and 75% have been trained in modules 6 and 7 which focus specifically on home-based newborn care (HBNC) drug kits. 87% have non-HBNC drug kits[iii]. The attrition rate of ASHAs is nearly 8–15% for a variety of reasons: They are expected to support the most vulnerable populations, yet they must do so with inadequate systems that fail to address the needs of socio-economically diverse communities. Compensation—especially for transportation—is limited, delayed and often insufficient. In addition, their safety is not ensured, and many report that they could earn better in private-sector jobs.[iv]

Current State of Urban Public Health

- Inadequate infrastructure and human resources in urban health facilities.
- Weak governance and interdepartmental coordination.
- Overreliance on unregulated private healthcare providers.
- Poor surveillance and fragmented data systems.
- Limited outreach in informal and marginalized communities

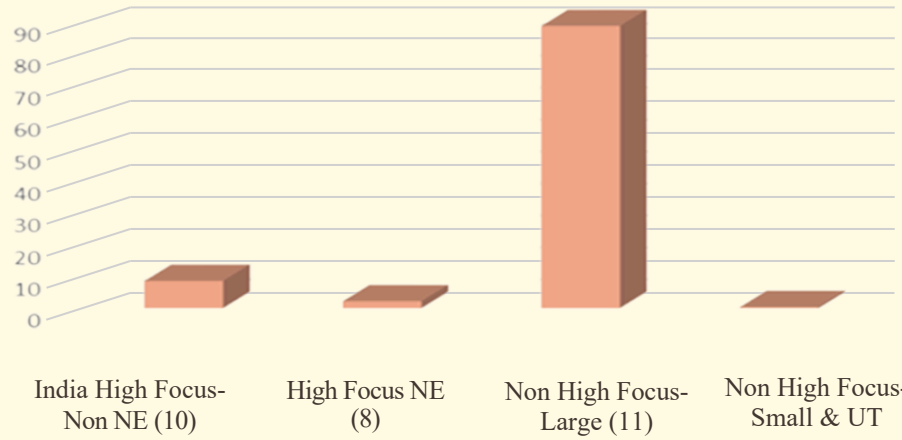
The governance structures are the 'Achillies heel' in the entire system of service delivery. Community-based institutional structures like Mahila Arogya Samitis (MAS) are dysfunctional in many urban areas. Odisha is one of the few states with functional MAS. Both the JAS and the Rogi Kalyan Samiti (RKS) are still at a nascent stage. Each of the 98,274 MAS formed across the country should be conducting 1,179,822 meetings annually (at one meeting per month). However, only 813,227 meetings were actually conducted, and neither the quality nor the outcomes have been assessed.

Figure 1: UPHC



The total number of members of ULBs trained under NUHM is 42,709, of which 41,205 have been trained in non-EAG large states which are already making efficient use of NUHM funds.

Figure 2: No. of SNs undergone Orientation/Training



Service delivery in urban health systems depends on the **'3 Ds' — Doctors, Drugs, and Diagnostics** — each requiring strong infrastructure and decentralized resource planning. However, the current distribution and condition of UPHCs highlight major gaps.

According to available statistics, 3,661 UPHCs supported by the NUHM are operating from government buildings, most of which are located in non-EAG large states. In contrast, 1,641 UPHCs currently function out of rented buildings, and 983 of these are in EAG large states. The rigidity of requirements around physical infrastructure continues to pose challenges, particularly in securing appropriate land and buildings. As cities expand and slums become denser due to escalating land costs, even finding rented spaces is becoming increasingly difficult. This situation underscores the need to explore alternative models of service delivery.

Human resource availability in these facilities is also a major constraint. For example, the proportion of trained doctors, nursing staff, lab technicians and pharmacists is significantly higher in non-EAG large states, resulting in comparatively better service delivery (one 'D') in these regions. The extent of OOPE in urban areas for primary care further highlights gaps in other service-delivery dimensions. Current data indicates that the decline in OOP does not originate from the urban population.

On average, outpatient medical expenses related to hospitalization amount to Rs. 15,937 in rural areas and Rs. 22,031 in urban areas. In public hospitals, individuals spend about Rs. 4,072 in rural areas and Rs. 4,408 in urban areas, compared with Rs. 26,157 in rural and Rs. 32,047 in urban areas in private hospitals. Additionally, about 5% of children in rural India and 14% in urban India receive vaccinations from non-government providers (doctors, clinics, charitable organizations, NGO-run hospitals). Health-insurance coverage remains limited, with only 13% of the rural population and 9% of the urban population enrolled government-sponsored schemes.[v]

Social Determinants of Health

There is wide disparity in urban living conditions. For instance, Dharavi, India's largest slum, has an exceptionally high population density of over 480,000 people per square kilometre, while smaller cities such as Ujjain record much lower densities of around 500 people per square kilometre. Socio-economic vulnerability is acute and women are the most affected by spousal abusive and violence. Between 44% and 65% of women aged 15–19 years[vi] believe that a husband is justified in beating his wife for at least one specific reason. Similarly, 23% to 44% of women aged 20–24 years share this belief. A significant proportion of these women live in urban slums, where socio-economic vulnerability is most acute. Among ever-married women aged 18–49 years in urban areas, 24.2% have experienced spousal violence, while 2.5% have faced physical violence during pregnancy. Additionally, 1.1% of young women aged 18–29 years[vii] report experiencing sexual violence before the age of 18.

Malnutrition among children remains a persistent concern: 30.1% of children under five are stunted (low height-for-age), 18.5% are wasted (low weight-for-height) and 7.6% are severely wasted. The difference between urban and rural malnutrition levels remains marginal, highlighting the shared depth of deprivation.

Recommendations

To develop a resilient healthcare system within the complexities of Indian cities, focus must be placed on governance and financing, access, data and social determinants.

1. Governance and Financing

i. Rather than attempting to overhaul existing governance structures- a lengthy constitutional process- efforts should focus on regulation, reform and role clarity. The first step is to resolve overlaps among ULBs, state governments and health departments, as mandated by the 74th Constitutional Amendment.

ii. Decentralized, self-financing models are key to effective municipal expenditure, as demonstrated by cities like Mumbai and Chennai. Strengthening ULB capacity, enhancing fiscal autonomy and improving municipal tax collection efficiency are critical.

iii. Innovative financing mechanisms such as blended finance, municipal bonds and health mutual funds can be introduced by municipal corporations or councils to generate revenue and cross-subsidize health and its social determinants.

iv. Environmental health measures should be prioritized:

- Enforce emission standards, restrict industrial effluents and promote cleaner transport. (e.g., Delhi's odd–even scheme).
- Strengthen waste management through integrated solid waste disposal, vector control and water sanitation.
- Develop green infrastructure by expanding initiatives like Nagar Van Yojana to mitigate heat islands and improve mental wellbeing.
- Ensure occupational safety by strengthening systems for informal, construction and industrial workers.

v. Given climate change and extreme weather events such as heat waves, floods and cold spells, investment in resilient housing for slum and informal settlements is essential to reduce morbidity and mortality.

vi. Roadside heat shelters should be provided, constructed using locally available resources. Bus stop shelters can be converted into glass panelled enclosures with cost-efficient photo voltaic (solar) panels which can generate power. These will also serve as rain shelters in extreme weather conditions.

vii. Stakeholder collaboration is equally vital. Partnerships with NGOs, community groups and charitable trusts can help reach marginalized populations. Establishing a dedicated Urban Health Directorate at both state and municipal levels is imperative. The Directorate should integrate cross-departmental data and leverage technology—similar to City Coordination Rooms initially developed for waste management and later repurposed as COVID-19 war rooms.

viii. To foster transparency, community-based monitoring and planning (CBMP) frameworks should be implemented nationwide for urban health facilities.

ix. Capacity building of municipal staff in health governance, fund utilization, and the linkage between health and social determinants is crucial. Training curricula should emphasize social security as a determinant of health. Modules developed by organizations such as Janaagraha and PATH can serve as models.
x. The roles of existing community institutions like MAS and JAS should be reimagined. Their mandate can be expanded to facilitate outreach for social security schemes, preventive care and grievance redressal.
xi. City programme management units (CPMUs) must be operationalized for efficient fund utilization, planning and financial disbursement. Monitoring should be integral to these units, and the terms of reference for human resources should clearly reflect these priorities.

2. Access and Availability to Services

i. To ensure equitable access, UPHCs should be established in line with population norms (one UPHC per 50,000 residents). Services must extend beyond slums to include the missing middle, ensuring quality care for all socio-economic groups.
ii. Innovative use of existing infrastructure can expand coverage. For example, Hyderabad opens its community centres for UPHCs, fostering community ownership. Delhi's Mohalla Clinics employ prefabricated units. Jaipur operates from shipping containers, and NGOs have deployed mobile clinics. Unused buses or railway coaches can also be refurbished as micro-health centres.
iii. Flexible service delivery—such as extended hours for working populations or mobile units with fixed schedules at large construction sites—can enhance accessibility. Integrated mobile teams could rotate as urban health action units.
iv. Successful models such as Gujarat's urban health systems (Ahmedabad, Surat), Delhi's Mohalla Clinics and Punjab's Urban Health Kiosks (UHKs) should be scaled up.
v. Medical colleges, nursing institutions and allied health worker training programmes should incorporate urban primary care training into their curricula.
vi. The private sector, an integral yet heterogeneous component of service delivery, should be systematically mapped and registered under the ABDM. They can be engaged through strategic purchasing mechanisms and existing schemes like PM-JAY.
vii. Flexible quality assurance parameters analogous to NQAS should be developed for private OPD empanelment. Clearly defined service packages, standard treatment guidelines (STGs) and robust audit mechanisms should be instituted, supported by technology-based payment systems managed by autonomous municipal bodies.
viii. Preventive care must take precedence. Efforts should include campaigns on healthy diets, physical activity, vaccination drives, NCD screening, epidemic preparedness in vulnerable areas, food safety, water quality testing and pest control.

ix. Environmental and lifestyle interventions—preventing NCDs is crucial in decreasing and averting chronic morbidity, especially given our changing population demographics. A comprehensive approach involves creating health-enabling environments and promoting active lifestyles. Key urban infrastructure and community interventions like promoting safe, accessible physical activity spaces by setting up well-lit, unhindered pedestrian pathways and dedicated cycling lanes, more and better equipped open-air gyms, community recreational areas and green spaces suitable for small children.

x. Nutritional and product regulation—strong nutritional monitoring is essential across various sectors, from early childhood to manufacturing. Critical interventions include:

- Nutritional surveillance: Implement robust nutritional monitoring systems in schools, Anganwadis and hostels.
- Product regulation and supply chain management: This is a vital intervention that requires strict regulations at the level of production, supply, and packaging. Specific focus areas include:
- Ensuring high-quality ingredients in packaged foods and controlling salt and sugar content in manufactured products.

xi.Addressing addiction, mental health and social issues.

- The interconnected challenges of drug addiction, alcoholism, gender-based violence (GBV) and mental health form a vicious circle. It must be broken through strong intersectoral implementation of coordinated policies in urban areas.
- Substance abuse prevention: Increase awareness and implement preventive measures targeting parents, teachers, employees in workspaces, outreach workers and healthcare facilities (both formal and informal). Social media must be used responsibly and judiciously to support these efforts.

3. Data-driven and Evidence-based Policy

i. Vulnerability mapping should be conducted every five years to guide service and resource allocation. The UNICEF-supported GIS mapping model in Mumbai's slums is a replicable framework for identifying unaddressed populations. Postal departments can also support similar efforts.

ii. Urban health surveillance remains weak. Establishing real-time, interoperable systems—drawing from the Madurai model for uniform ward distribution and data harmonization—can enable early detection of both communicable and NCD outbreaks at the city level.

iii. Urban health research must be strengthened by mobilizing 'grey data' from medical, nursing and social science institutions. Designating select universities as research aggregators can facilitate analysis, foster collaboration, and guide students towards priority research topics.

iv.Technology-enabled task-shifting models—with nurse-led telehealth units, QR-coded prescriptions, drug-dispensing ATMs and point-of-care diagnostics—can deliver quality care in space-constrained settings.

Endnote

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Integrated Care and Provider Networks

Integrated Care and Provider Networks

The growing complexity of health needs, ageing populations and the surging burden of non-communicable diseases (NCDs) have placed unprecedented strain on health systems globally. Fragmented, episodic and disease-centric service delivery models have proven inadequate in addressing contemporary health challenges, particularly those that require continuity of care, multidisciplinary coordination, and integration across preventive, curative, rehabilitative and palliative domains.[1]

Integrated care is now a commonly accepted concept across the world, but there remains a persistent and enduring 'confusion of languages' when it comes to understanding it.[ii]

> Integrated care refers to the systematic coordination of health services across different levels and settings of care, organised around the holistic needs of individuals and communities rather than specific diseases or institutions

It seeks to ensure that people receive comprehensive, continuous and coordinated care throughout their life course, ranging from health promotion, disease prevention, treatment, rehabilitation and end-of-life services. Integrated care models coordinate services across all levels of healthcare (community, primary, secondary, tertiary) and all sectors which influence the determinants of health to provide continuous, people-centred care. For UHC, primary care led-integration is critical to ensure that services are accessible, comprehensive and equitable.

Provider models, by divergence, describe how healthcare delivery is supervised, governed and financed. These models encompass the assembly of healthcare providers, such as primary care networks, multidisciplinary teams or hospital alliances, and the apparatus through which they are incentivized and held liable for pursuance and quality outcomes. The integration of care delivery and optimization of provider models are fundamental to achieving UHC and, more broadly, UHA. UHC aspires to ensure that all individuals receive necessary health services of adequate quality without financial hardship. This also includes avoidance of delay when referrals are needed from one level of care to another. However, fragmented service delivery remains a major barrier to this goal, leading to inefficiencies, duplication of efforts, inequitable access and poor health outcomes. Integrated and coordinated provider models bridge these gaps by aligning resources and incentives across care levels, improving both health outcomes and system performance.

Moreover, integrated models reinforce the people-centred approach central to UHC and UHA, prioritizing community engagement, health promotion and preventive care. When designed effectively, these models strengthen primary health care as the first point of contact, ensuring timely referrals, seamless transitions and reduced catastrophic expenditures.

Empirical evidence supports the positive outcomes of integrated and coordinated provider models.

For example, in Switzerland, enrollment in integrated care schemes was associated with significantly lower average healthcare expenditure compared to traditional insurance plans, while maintaining comparable or superior health outcomes. In low- and middle-income countries, integrated chronic disease management programmes have improved adherence, reduced hospitalisation rates and enhanced continuity of care.

> The World Health Organization (WHO) emphasises that such models are essential to realizing resilient, efficient, and equitable health systems capable of delivering the "right care, at the right time, by the right team, in the right place."

Typologies and Design Approaches

Integrated care is characterised by complexity. However, a number of different conceptual frameworks and taxonomies have been developed to help manage our understanding. Typically, these have examined:[iii] [iv]

- the type of integration (i.e., organizational, professional, cultural, technological);
- the level at which integration occurs (i.e., macro-, meso- and micro-);
- the process of integration (i.e., how integrated care delivery is organized and managed);
- the breadth of integration (i.e., to a whole population group or specific beneficiary group); and
- the degree or intensity of integration (i.e., across a continuum from informal linkages to more structured care coordination and fully integrated teams or organizations).

Moreover, integrated care takes a number of key forms, including:

1. Horizontal integration. Integrated care between health services, social services and other care providers that is usually based on the development of multidisciplinary teams and/or care networks that support a specific beneficiary group (e.g., for older people with complex needs).
2. Vertical integration. Integrated care across primary, community, hospital and tertiary care services manifest in protocol-driven (best practice) care pathways for people with specific diseases (such as COPD and diabetes), and/or care transitions between hospitals to intermediate and community-based care providers.
3. Sectoral integration. Integrated care within one sector, for example combining horizontal and vertical programmes of integrated care within mental health services through multi-professional teams and networks of primary, community and secondary care providers.

2. People-centred integration: Integrated care between providers and patients and other service users to engage and enable people through health education, shared decision-making, supported self-management and community engagement.
3. Whole-system integration: Integrated care that embraces public health to support both a population-based and person-centred approach to care. This is integrated care at its most ambitious since it focuses on the multiple needs of whole populations, not just care groups or diseases.

Horizontal Integration

Horizontal integration involves organizations acquiring or integrating with others offering the **same or similar services.**

Table 1

Characteristic	Key Features
Integrated Providers	Providers who offer similar services.
Examples of Structures	Single speciality group practices: Physicians with a common speciality integrate, often to achieve economies of scale and gain market share. Multi-hospital systems: Integration of facilities that provide similar acute care services in multiple locations, aiming for economies of scale and expanded delivery networks. Multi-speciality group practices (MSGPs): Diverse physicians (primary and speciality care) sharing governance, infrastructure and finances, allowing them to provide most of the care needed within the group and achieve greater care coordination. Independent practice associations (IPAs): Loosely, contractually integrated networks of independent physicians organized mainly for risk-based contracting.
Goals	Typically formed to achieve economies of scale and gain market share, or to seek professional management or infrastructure investments.
Historical Context	The shift in the predominant type of integration in the US healthcare delivery system moved from horizontal integration to vertical integration between the 1980s and mid-1990s.

Vertical Integration

Vertical integration involves organizations acquiring or integrating with others offering different levels of care, services or functions along the care continuum.

Table 2

Characteristic	Details
Key Features	Providers fulfil different functions along the care continuum, such as hospital ownership of physician practices. These providers are linked to offer a complete, coordinated continuum of care.
Examples of Structures	**Integrated delivery systems (IDSs)**: These systems include providers such as hospitals, medical groups, post-acute care providers, behavioural health providers, community-based organizations, and sometimes health plans, providing a comprehensive, full continuum of care. **Physician-hospital organizations (PHOs)**: A formal partnership between hospitals and affiliated physicians for contracting with health plans and facilitating alignment, while often allowing physicians to maintain autonomy. **Foundation models**: Corporate entities, usually non-profit, that employ physicians and exist within non-profit hospital systems to facilitate close physician-hospital integration. **Clinically integrated networks (CINs)**: Networks of physicians and hospitals (and potentially other providers) who may otherwise be competitors, coming together in a joint venture that focuses on clinical integration criteria requiring activities like quality improvement programmes and shared functionalities.
Goals	Vertically integrated structures aim to encourage coordination and integration across providers to ultimately improve quality and cost outcomes. They are often designed to improve health outcomes and patient-centredness across the care continuum. The current emphasis in US healthcare is on patient-centred models that require better integration and coordination of health services to manage chronic disease and population health, driving the need for engagement of diverse providers along the care continuum.
Policy Influence	Major policy shifts, such as the Patient Protection and Affordable Care Act (ACA) of 2010, have driven the trend towards vertical integration and consolidation of providers into health systems.

A Comparison of Integrated Care Model Archetypes

Table 3

Model Name	Core Principle	Key Processes	Integration Type	Governance	Financing	Digital Enablers	Country Examples
Patient-Centred Medical Home (PCMH)	Whole-person care led by primary care teams	Comprehensive primary care, care coordination, patient engagement	Horizontal + vertical	Practice-level leadership with payer incentives	Capitation, bundled payments, performance-based incentives	Electronic medical records (EMRs), patient portals, referral tracking	USA (Medicaid PCMHs), Australia (Health care Homes), UK (GP practices)
Collaborative Care Model (CoCM)	Embedding behavioural health into primary care	Care managers, psychiatric consultation, stepped care protocols	Horizontal	Clinical protocols and shared care plans	Fee-for-service + bundled behavioural health payments	Shared mental health records, telepsychiatry	USA (Medicare CoCM), Netherlands (GP mental health), Chile (depression care)
Chronic Care Model (CCM)	Structured management of long-term conditions	Self-management support, clinical info systems, decision support, team-based care	Horizontal	Disease-specific protocols and registries	Disease management incentives, bundled payments	Registries, dashboards, remote monitoring	Canada (Ontario Diabetes Strategy), Australia, Sweden

Accountable Care Organizations / Integrated Delivery Systems	Shared accountability for outcomes and costs	Risk-sharing contracts, population health management, data integration	Vertical	Network-level governance boards	Global budgets, shared savings, value-based payments	Health information exchanges, predictive analytics	USA (ACOs, Kaiser Permanente), UK (ICS), Germany (Gesundes Kinzigtal)
Hub-and-Spoke Model	Centralized specialty hubs linked to peripheral units	Referral pathways, mobile outreach, centralized diagnostics	Vertical	District/state-level health authorities	Public funding, PPPs, mobile unit contracts	Telemedicine, GIS mapping, referral tracking	India (MMU–PHC–District Hospital), Rwanda, Nepal
Community-based Integrated Care	Localized, culturally adapted care networks	CHWs, local governance, outreach, home-based care	Horizontal	Municipal or district health boards	Government budgets, donor support	Mobile apps for CHWs, SMS reminders	Brazil (Family Health Strategy), Ethiopia, Thailand
Virtual Integrated Care Networks	Digital-first integration across providers	Teleconsultations, shared EMRs, remote monitoring	Horizontal + vertical	Platform-based governance, PPPs	Subscription models, insurance reimbursements	AI triage, cloud EMRs, mobile apps	India (e-Sanjeevani), UK (Babylon Health), USA (Teladoc)
Integrated Care Pathways (ICPs)	Standardized protocols across providers for conditions	Clinical pathways, multidisciplinary teams, shared documentation	Horizontal	Clinical governance committees	Bundled payments per pathway	Pathway dashboards, EMR templates	UK (NHS ICPs), Italy (stroke pathways), Singapore (diabetes ICPs)

Integrated Primary Health Care in India

India's public health system is formally structured as a three-tier network: sub-centres/health and HWCs at the community level, primary and community health centres (PHCs/CHCs) at the district level, and district/secondary and tertiary hospitals. In principle this tiered system provides a clear referral hierarchy, but in practice it is highly fragmented. Patients often bypass primary care for higher-level hospitals, resulting in congestion and delays, while lower-level facilities remain underutilized. For example, a recent urban study in India reported significant non-adherence to referral mechanisms among patients, which contributed to overcrowding at tertiary centres[v]. To address this, the National Health Mission and Ayushman

Bharat programmes emphasize functional integration, using coordinated systems and processes, rather than simply reorganizing facilities (structural integration). Functional integration involves linking information, financing and management systems around patient care so that every level works in concert.

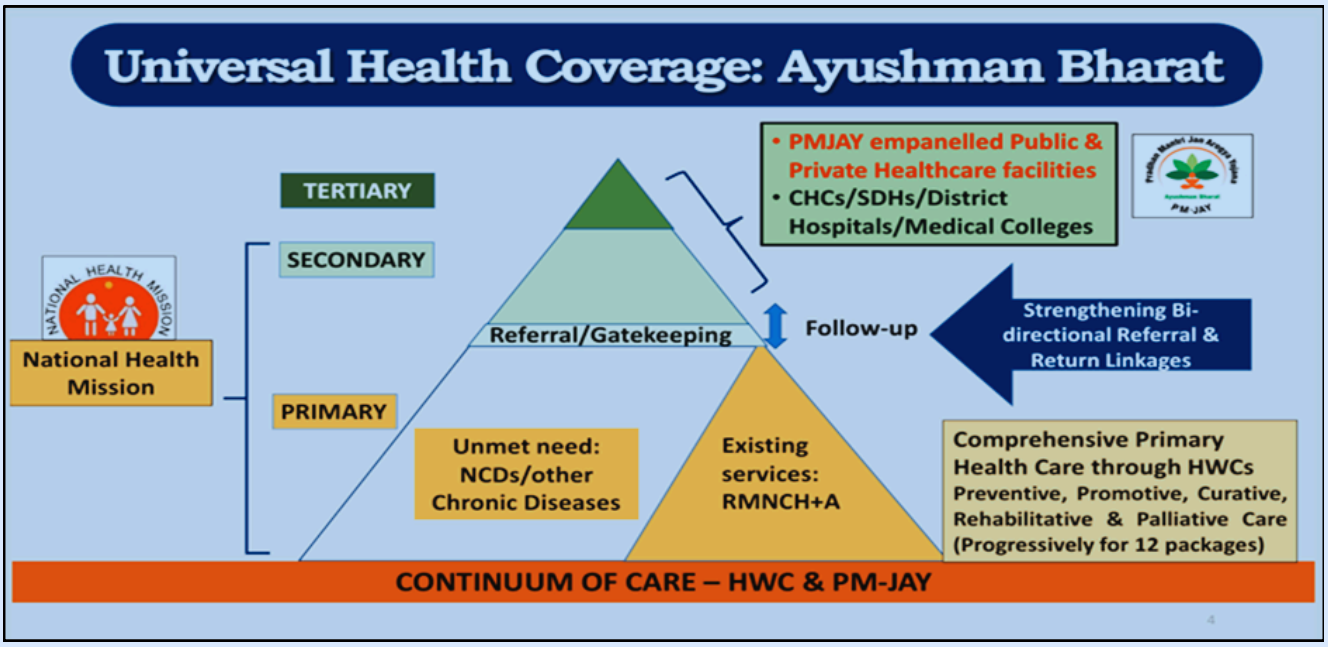

Figure 1

Functional vs. Structural Integration

In health systems, functional integration means coordinating the 'back office' and support functions (financing, HR, IT, logistics) so that they enable seamless patient care, without necessarily merging institutions. For example, shared electronic health records and standardized referral protocols connect a PHC and a district hospital even if they remain separate entities. By contrast, structural integration would entail physically merging or corporatizing organizations (e.g., the NHS model). India's strategy is to pursue functional integration: for instance, the Ayushman Bharat Digital Mission (ABDM) assigns every patient an ABHA (health ID) and registers all facilities and providers, so patient records and referrals can flow digitally across primary, secondary and tertiary levels These shared information and financial systems help link each level and keep patients "on track" through the care continuum.

Vertical Integration of Care Levels

Vertical integration refers to coordinating care between levels, from community clinics up to tertiary hospitals and back. In India, establishing two-way referral pathways is a key focus. National guidelines for HWCs explicitly mandate a 'two-way referral system and follow-up support' to ensure that continuity primary care providers at PHCs and HWCs have to manage most common conditions and refer only when needed, while tertiary centres return patients to local care for follow-up. For chronic diseases, periodic specialist referral from a PHC to a district hospital is planned, with the PHC team remaining involved in ongoing management. Likewise, surgical emergencies may trigger direct referral to a district or tertiary hospital if primary care lacks first-class capabilities (e.g., an operating room), but local follow-up continues post-discharge. These protocols are reinforced by digital tools: telemedicine links HWCs to specialists (for example, via e-Sanjeevani) to improve referral advice and reduce unnecessary travel.

A bi-directional referral model integrating HWCs and PM-JAY machinery to strengthen the continuum of care.

- Upward referrals: Individuals identified at primary-level facilities (HWCs or PHCs) who require hospitalization are referred to CHCs, sub-district hospitals (SDHs), district hospitals (DHs) or PM-JAY - empanelled hospitals, including private providers. Eligible beneficiaries are entitled to cashless secondary and tertiary treatment of up to INR 5 lakh annually.
- Downward referrals: Patients discharged from higher-level facilities are connected back to primary care providers for rehabilitation, chronic disease management and follow-up care. This return pathway secures continuity, unifies patient journeys, and maintains a patient-centred system of mutual accountability between care levels.

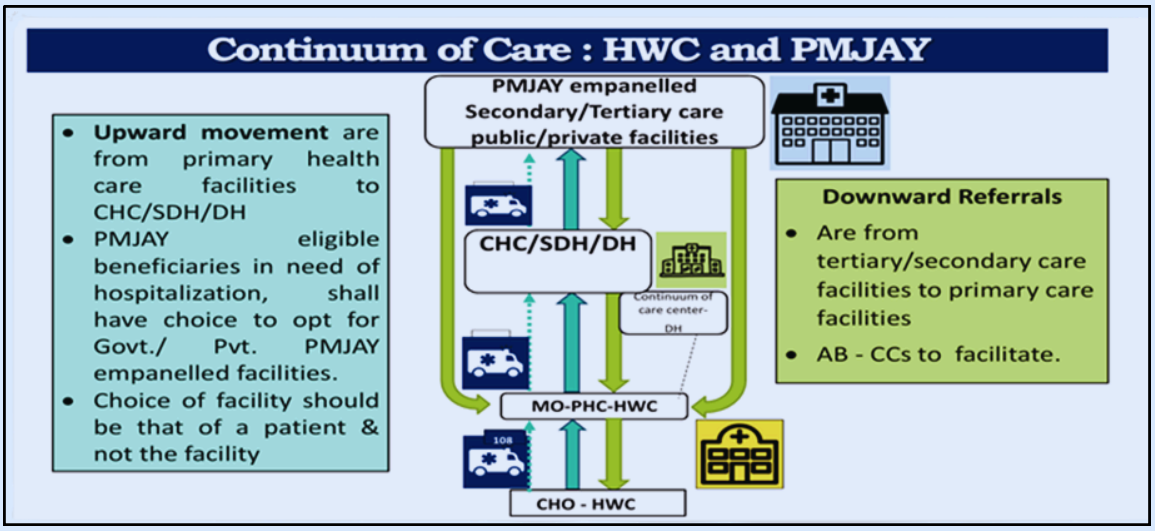

Figure 2

Overall, stronger vertical integration ensures that lower levels act as gatekeepers and care continuers, reducing 'bypass' and decongesting higher levels. Indeed, official policy highlights that a robust network of HWCs and PHCs at the sub-district (block) level will reduce overcrowding in secondary and tertiary hospitals by resolving more cases locally and controlling referral flow. In practice, states are upgrading every PHC and some sub-centres to HWCs, staffed by mid-level providers, to expand primary care scope (NCD screening, mental health, etc.) so that specialist referrals become exceptions, not the norm.

Collectively, these linkages transform the delivery structure into one that integrates preventive, promotive and curative care within a single, patient-tracked pathway.

Institutional Mechanisms:Ayushman Bharat Counselling Centres

To operationalize this convergence, the framework introduces Ayushman Bharat Counselling Centres (AB-CCs) at the district level to serve as nodal coordination units. Their principal functions include:

- Maintaining an updated database of PM-JAY-empanelled hospitals.
- Guiding and counselling patients (both beneficiaries and non-beneficiaries) on their available care options.
- Coordinating referrals across districts and states for advanced medical consultations.
- Managing downward referrals following hospital discharge to support follow-up and continuity.
- Logging and resolving grievances related to service denial or entitlement issues.
- Providing real-time assistance to beneficiaries to ensure timely care transitions.

By centralising information and patient navigation functions, AB-CCs enhance system transparency, ensure mobility of care and strengthen responsiveness to patient needs.

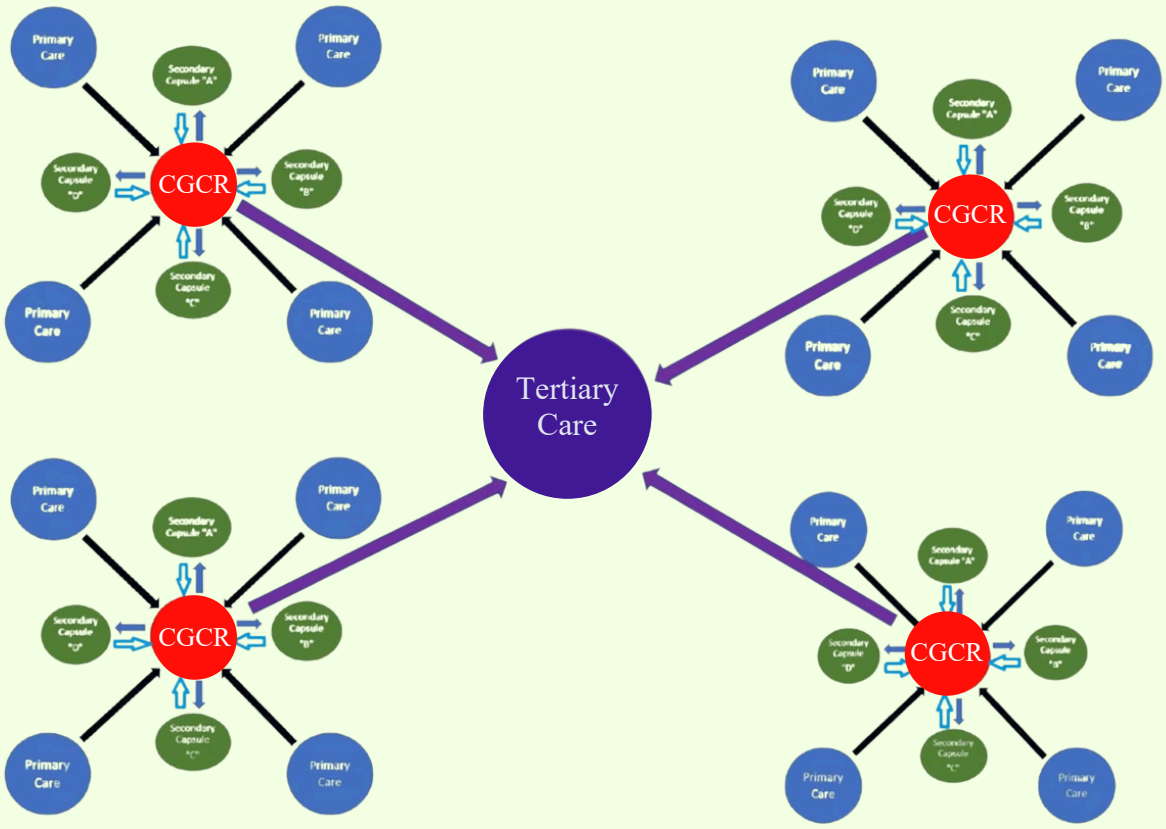

Figure 3: Conceptual referral network (CGCR = Central Gateway Control Room) linking primary care centres and secondary 'capsules' to tertiary care (Indian Model of Integrated Healthcare)

Horizontal and Cross-sector Integration

Horizontal integration involves coordinating among providers at the same level or across sectors. For primary care, horizontal integration means linking different community services (public health outreach, social services, AYUSH/traditional providers) and bridging public and private clinics. A recognized framework envisions 'horizontal integration between public health and primary care', for example, routine immunization and sanitation programmes working closely with PHC staff, and within each level integrating public and private providers and payers. In practice, this could take the form of joint planning between public PHCs and nearby private clinics, shared community health workers, or referral agreements linking an NGO-run health post with government CHCs. District health societies can formalize such linkages (for instance, by empanelling private providers to fill service gaps).

Interdisciplinary 'team-based' care is another horizontal element: HWCs are advised to adopt a team approach combining clinical care, health promotion and rehabilitation under one roof. This means doctors, nurses, pharmacists, social workers and volunteers coordinate around patient panels. Schools, nutrition programmes and sanitation committees are also linked to primary care (e.g., village health sanitation nutrition committees working with ASHAs at the PHC level). Such horizontal linkages aim to address social determinants together with curative care access.

Public–Private Collaboration at the District Level

India's mixed health system requires optimization of well-regulated public–private integration at the local level. Both sectors have complementary strengths: the private sector provides ~58% of hospitals and 81% of doctors (mainly urban and specialists), while the public sector has wide rural reach via sub-centres and PHCs. Harnessing both would mean, for example, locating a private diagnostic lab or teleconsulting hub at a government PHC (a PPP) or sending rural PHC patients to empanelled private specialists when needed. District hospitals can enter into formal contracts with local private clinics for radiology, cardiology or palliative services lacking in the public hospital. Even though this may be expedient and appear efficient, such arrangements should not lead to dwindling of public sector capacity or slackening of investments to strengthen public sector capacity.

Policy already supports such partnerships. Ayushman Bharat guidelines explicitly encourage partnering with NGOs and private agencies 'for gap filling in a range of primary health care functions'. During COVID-19, India witnessed unprecedented public–private collaboration (e.g., the Co-Win vaccination platform and many state-level PPP testing labs). Those lessons underscore that by working together, public and private sectors can take quality healthcare forward much faster and affordably (e.g., telemedicine networks bring private specialist expertise to government clinics). Indeed, initiatives like e-Sanjeevani illustrate digital PPP: government IT infrastructure enabling private doctors to consult with rural PHC patients. Conflicts of interest must be guarded against in such models.

Practically, district health authorities (DHS) can serve as the coordination platform. The DHS (under the National Health Mission) include local officers and can convene public and private stakeholders. For example, a district could organize joint training, pooled purchasing of medications and unified transport services. If one sector faces a gap (e.g., no MRI at the district hospital), a private clinic can be tapped. In emergencies, mobile medical units may also link with private hospitals for referrals. Thus, at the district level, public and private facilities should back each other with shared referrals, shared staffing (e.g., private doctors on rotation at CHCs), and shared accountability for population health.

Digital Health and Telemedicine

Modern technology is a linchpin of functional integration. India's federal initiatives have built digital foundations: the ABDM assigns unique IDs to individuals and providers, interconnects registries and enforces interoperable systems. When a patient visits a PHC, they generate an ABHA number; if referred, that number links all records at the higher centre. The goal is real-time referral tracking and unified health records across levels.

Telemedicine and e-health platforms are explicitly integrated into primary care. Operational guidelines mandate teleconsultation 'at all levels' to improve referrals, get specialist advice, and even provide virtual training to PHC staff. For example, a midwife at a sub-centre can video-conference a doctor for an emergency before transfer, or a CHC doctor can mentor an HWC nurse on chronic disease management via e-consult. The government's national telemedicine service

(e-Sanjeevani) already links 139,000 centres nationwide, allowing GPs to connect patients with specialists in district hospitals.

Digital tools also include mobile health records and SMS reminders to improve follow-up (echoing US-style patient portals). Home-based records and mobile health apps are encouraged so that families carry their health data from the PHC to any referral hospital. A strong IT base makes functional integration more than a theoretical proposition: it literally connects the levels. For instance, with ABDM and e-Sanjeevani, a PHC physician could 'see' the specialist's notes on a patient's file via digital platforms, ensuring even informal referrals do not skip care coordination.

Care Coordination and Navigation

Beyond systems and technology, integrated care often relies on dedicated personnel to guide patients through the system. In the US and other countries, care coordinators or case managers (often nurses) are employed in primary care to oversee patients with complex needs. These coordinators arrange appointments, follow up after hospital discharge, reconcile medications, and fill preventive care gaps. For example, a Texas clinic hired nurse coordinators who, before each visit, ensured lab tests and vaccines were ordered, and checked in with discharged patients to schedule follow-ups. This approach drastically reduced no-shows and readmissions.

India has nascent versions of this concept. ASHAs act as community-level care navigators, but their focus is preventive (maternal/child health). To bring true care coordination into primary facilities, India could formally fund health workers (perhaps at PHCs or HWCs) whose role would be to track high-risk patients: diabetes, TB, elderly, etc. These workers would liaise between levels, reminding a hypertensive patient at the CHC to return for medication pick-up or checking if a referred surgical patient reached the district hospital and attended follow-up at the PHC. Such 'patient navigators' would ensure that 'hand-offs' are closed on both sides of a referral. Introducing a care coordinator into Indian primary-care teams, similar to the patient-centred US Patient-Centred Medical Home (PCMH), can strengthen continuity of care and reduce drop-outs across referral levels.

State-specific Models and Local Adaptation

While national policy provides a framework, integration must be tailored to India's diversity. The central government's guidelines themselves note that states have the flexibility to adapt based on local needs and capacities. For example, mountainous Himachal Pradesh may emphasize telemedicine and mobile units, whereas a state with a more urban population (Karnataka) might integrate large private hospitals into district health networks. Similarly, disease patterns vary: north-eastern states might integrate traditional medicine providers and TB programmes differently than malarial districts.

State health missions can develop region-specific referral maps (e.g., linking certain CHCs to designated secondary hospitals) and customized IT dashboards. Districts should define their own referral 'catchment' areas and public–private resource shares. The design of integrated care should thus be decentralized: central guidelines set principles and interoperability standards, but each state/district crafts the actual pathways, resource pools and governance models that suit its geography, epidemiology and health economy.

Recommendations

1. **Strengthen the reliability of referral pathways**: A major obstacle to integrated care in India is the inconsistent and largely informal referral culture across facilities. Patients continue to bypass primary care centres because referral protocols are weak, inconsistently followed and rarely enforced. Strengthening integration requires a dependable referral chain where PHCs initiate clear, documented referrals and higher-level facilities acknowledge and respond to them in a structured manner. Digitized referrals, standardized clinical summaries and routine feedback loops will allow patients to move upward in the system when necessary and return to primary care for follow-up. Establishing this discipline builds both continuity of care and trust while reducing unnecessary tertiary hospital load.
2. **Improve functional capacity at primary care facilities**: For primary care to genuinely anchor the system, HWCs and PHCs must be capable of delivering the expanded service packages they are mandated to provide. Insufficient diagnostics, erratic medicine availability, and limited preventive and chronic disease management capacity often drive patients to seek care elsewhere. Strengthening these facilities with reliable laboratory services, adequate staffing and continuous training while empowering mid-level providers to lead routine chronic care ensures that patients can be effectively managed closer to home. Once primary care becomes dependable, integration across levels becomes far more achievable.
3. **Embed digital tools within care pathways, not parallel to them**: While India has made progress in health digitization through ABDM, digital tools often remain underused or disconnected from actual clinical workflows. For integration to take root, digital systems must be embedded directly into the processes of care: referrals should automatically transmit clinical data; specialists should receive real-time patient histories; and primary facilities should instantly receive discharge summaries and follow-up instructions. Telemedicine platforms such as e-Sanjeevani should support routine decision-making and reduce avoidable referrals by providing timely specialist inputs to primary-level providers. A digital health framework that mirrors real clinical logic is essential for seamless integration.
4. **Create district-level mechanisms for public–private collaboration**: India's mixed healthcare system cannot achieve integration without bridging the divide between public and private providers. Yet, collaboration remains largely ad hoc and transactional. District-level mechanisms are needed to map private capacity, identify system gaps and establish targeted micro-partnerships, whether for diagnostics, specialist consultations, telehealth support or emergency referrals. Private hospitals empanelled under PM-JAY should be obligated to issue structured discharge notes and counter-referrals back to primary care. These district-based arrangements allow integration to be responsive to local needs instead of relying on generic state- or national-level PPP models.
5. **Establish care coordination roles to support patient navigation**: Given the complexity of India's service landscape, patients, especially those with chronic or multi-morbidity conditions, often struggle to navigate transitions between levels of care. Introducing care

coordinators at PHCs or district hospitals can significantly improve continuity. Drawing from the US care-coordinator model, these personnel can track referred patients, schedule follow-up appointments, facilitate communication between specialists and primary providers, and support elderly or vulnerable patients through complex care pathways. These roles serve as the human connector between facilities, ensuring that transitions are not left to chance.

6. **Design state- and district-specific models of integrated care**: Uniform care pathways do not reflect India's epidemiological or geographic variation. High NCD-burden states need integration models centred on long-term chronic disease management, whereas aspirational districts require referral systems orientated towards maternal, neonatal and infectious disease challenges. Hill regions need stronger telehealth and mobile outreach frameworks, while urban districts require coordination across a dense and diverse provider ecosystem. Allowing states and, ideally, districts, to design and periodically revise their own integrated care models ensures that integration is realistic, context-appropriate, and aligned with local health system constraints and capacities.
7. **Build horizontal networks within each level of care**: Integration is not only vertical. Facilities at the same level must function as coordinated networks rather than isolated units. HWCs should share diagnostics, outreach plans and clinical responsibilities where appropriate. CHCs can rotate specialists across multiple blocks, and district hospitals can coordinate teleconsultation schedules supporting peripheral facilities. Collaboration between AYUSH and allopathic providers, when clinically appropriate, can improve community reach and expand the scope of primary care. Horizontal integration ensures that the system uses its existing resources more efficiently while expanding access to essential services.
8. **Institutionalize accountability for integration at the state and district levels**: Integration is not possible without explicit accountability. States and districts should routinely track indicators such as referral adherence rates, counter-referral completion, teleconsultation utilization and follow-up compliance for chronic diseases. District health societies and Rogi Kalyan Samitis can expand their oversight roles to monitor integration efforts, review public–private partnerships, and identify operational bottlenecks. Transparent monitoring, combined with local problem solving, anchors integration as a core governance function rather than an abstract policy goal.

Endnote

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PM-JAY Reflections

PMJAY has completed seven years of implementation and has undergone a series of strategic reforms to increase its efficiency, reach and impact. A growing body of evidence, documented in both published and grey literature, has emerged on the programme during this period. This offers an opportunity to review which strategies have worked well, identify gaps, and consolidate actionable insights for programme strengthening.

This chapter is a synthesis of the available evidence on the key programme attributes. The following sections outline the methods adopted for this review and present findings across major thematic areas.

Methods

Published and grey literature on PMJAY in English for the period January 2018 to August 2025 was systematically gathered. Peer reviewed research articles, editorials, commentaries and expert perspectives were obtained through a structured search of the PubMed and Economic and Political Weekly (EPW) repositories. Subsequently, progress reports, policy briefs, working papers and operational guidelines on PMJAY published by the NHA and policy briefs by the WHO India office were compiled. A five-member research team screened and shortlisted the documents for full-text review and data extraction. Relevant information was extracted in a structured Excel format and mapped against three core domains: (1) strengths of PMJAY; (2) gaps and challenges; and (3) recommendations for improvement.

Findings

A total of 127 documents comprising 103 peer reviewed research articles, two national evaluation reports, 16 policy briefs and six working papers were reviewed. The year-wise distribution of evidence indicates a surge in publications over 2023 and 2024 (Figure 1).

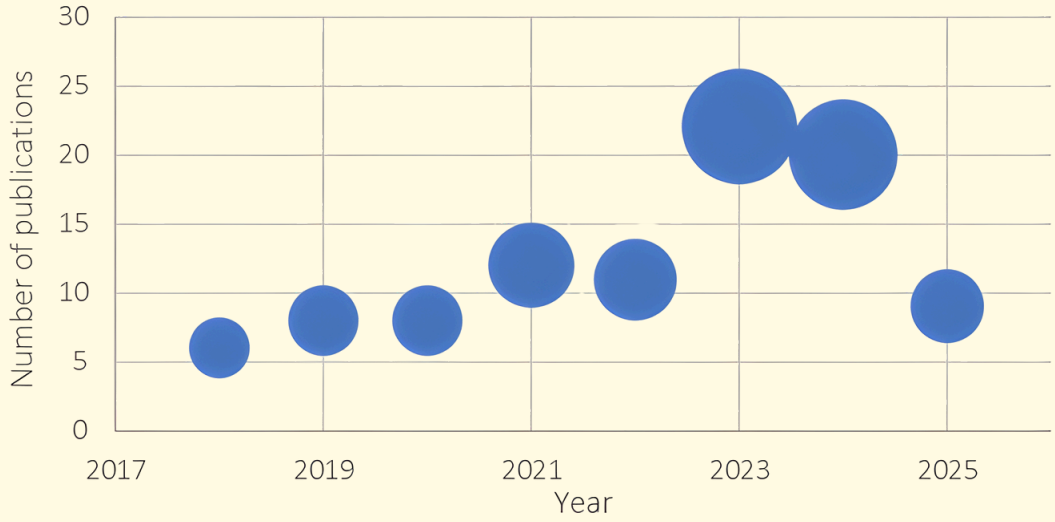

Figure 1: Year Wise publications on PMJAY

Figure 2 shows the key PMJAY themes identified in our literature review. The evidence can be grouped into four broad areas: (1) programme design and governance; (2) demand-side strategies; (3) supply-side interventions to ensure insurance coverage; and (4) contributions to UHC, including ethical considerations, financial protection and lessons for advancing UHC goals. Within each theme, we discuss specific PMJAY initiatives, highlighting their strengths, challenges and recommendations in the literature.

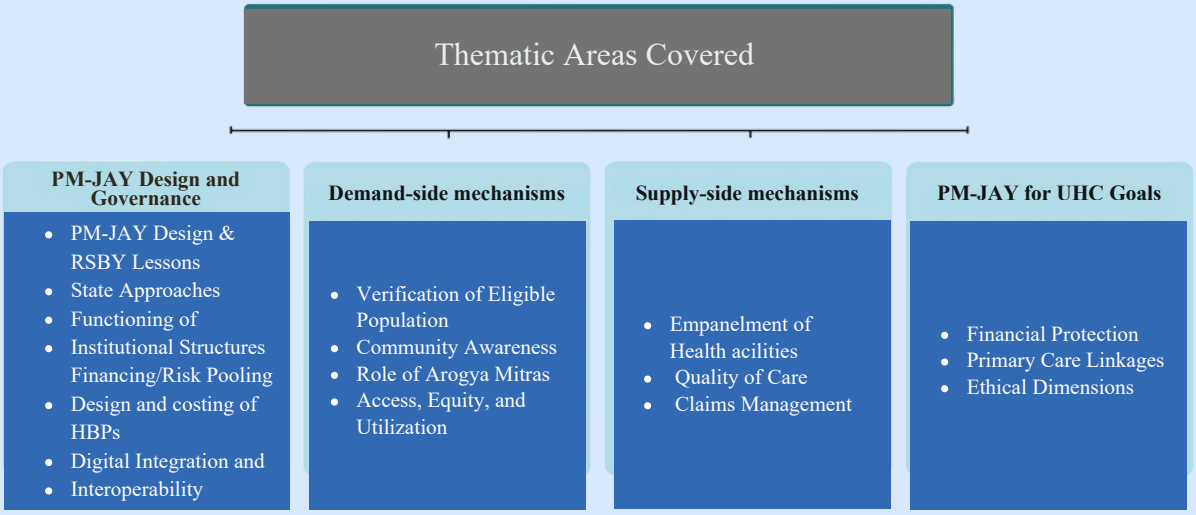

Figure 2: Themes identified for PMJAY

1. PMJAY: Design and Governance

1.1. PMJAY Design Lessons from Rashtriya Swasthya Bima Yojana (RSBY)

Launched in 2018 to advance UHC, PMJAY's design was built on lessons from RSBY through extensive policy deliberations driven by central and state governments, and expert consultations on UHC and strategic purchasing. The available literature shows that its design process involved balanced negotiations and opened space for a cohesive reform that facilitated its national adoption[i]. PMJAY was designed to be more inclusive than its precursor schemes, increased coverage from INR 30,000 in RSBY to INR 500,000 per family annually, removed age and family size limits, eliminated user fees, expanded enrolment, benefit packages, introduced administrative efficiency, and allowed state governments greater implementation flexibility.[ii]

1.2. Perspectives on the Functioning of PMJAY Institutional Structures

PMJAY operates through a multi-tiered governance structure: the National Health Authority (NHA) at the apex for overall policy direction, stewardship, and oversight; the state health agencies (SHAs) for state-level implementation; and district implementation units (DIUs) for field-level operations. This structure has enabled the translation of national policy intent into implementation aligned with state contexts.

NHA ensures policy coherence, standardizes benefit packages, and provides regulatory oversight. SHAs are responsible for empanelment of hospitals, claims management and state-level innovations[iii] DIUs enable stakeholder coordination, monitor empanelled facilities and conduct awareness campaigns for on-the-ground implementation. However, overlapping mandates and unclear authority lines within these structures cause operational bottlenecks[iv]. Many SHAs face difficulties in uniform application of guidelines, especially in package rates, pre-authorization norms and claims management. Quality assurance mechanisms are inconsistently applied, and gaps in real-time monitoring affect both accountability and efficiency[v]. DIUs struggle with acute manpower shortages, delayed recruitment and training, and inadequate technical capacity—particularly in newly created districts or under-resourced states. The absence of standardized data templates and weak digital infrastructure further limit their ability to collect and report performance data systematically.[vi]

Recommendations: Clear role delineations and reporting relationships are required among NHA, SHAs and DIUs. Implementation of regular, competency-based training for SHAs and DIU staff on empanelment, claims, fraud control, grievance redressal, monitoring and IEC activities will strengthen implementation.

1.3. State Approaches for PMJAY Implementation

States can choose between direct (trust), insurance, or hybrid models (combination of insurance and trust) for PMJAY rollout, depending on institutional capacity, historical experience with earlier publicly financed health insurance (PFHI) schemes and their state-specific context. For some states, this has meant integrating PMJAY with existing PFHI models to leverage established capacities, while others have had to set up entirely new institutional systems. The choice of model influences risk pooling, purchasing arrangements and claims processing.

In both models, SHAs retain final authority over provider contracting. However, while SHAs handle claims management under the trust model, insurance companies lead claims processing under the insurance model. States using the insurance model usually show higher beneficiary enrolment, utilization, faster claims and higher-quality empanelled hospitals, while the trust model offers lower administrative costs and tighter empanelment[vii]. Some states take a collaborative approach; for example, in Chhattisgarh (insurance model), only high-value claims are processed by the SHA, while others (below INR 50,000, about 90% of the total) are not. Uttar Pradesh and Jharkhand, both using the trust model, have shown greater oversight by support agencies but also longer processing times and higher claim rejection rates. Support agencies often lack the necessary clinical expertise required for claims approval.

Recommendations: In the insurance model, SHAs must maintain responsive communication channels with the hospitals for easy resolution of the queries. SHAs must also conduct comprehensive audits of claims rejected by insurance companies. For states implementing the trust model, SHAs must leverage the Implementation Support Agency resources to expand beneficiary base and claim processing efficiencies.

1.4. Financing/Risk Pooling

PMJAY is funded through general taxation, shared 60:40 between centre and states (90:10 for hill/north-eastern states). Unlike earlier health programmes focused on supply-side financing through health infrastructure, human resources and service delivery investments, PMJAY marks a strategic shift towards demand-side financing. By linking financial flows directly to service

delivery investments, PMJAY marks a strategic shift towards demand-side financing. By linking financial flows directly to service utilization, it promotes competition, quality and efficiency within the healthcare system while providing an additional revenue stream for public hospitals to strengthen the public health sector.[viii]

However, researchers noted that despite an outlay of Rs 2,000 crore in 2018–19, early funding remained far below the required Rs 12,000–50,000 crore[ix]. Financial allocations have grown substantially over the years, with current outlay being INR 9406 crore. PMJAY already constitutes 14% of the overall health ministry budget[x]. Literature has highlighted the risk of 'resource displacement', where funds may be diverted from primary and public health services to secondary and tertiary care under PMJAY, potentially exacerbating service inequities . Growing reliance on the private sector could further exacerbate the inequities.[xi]

Recommendations: Universal adoption of gatekeeping mechanisms are needed to limit usage of costly private care to situations only where public options are unavailable, to reduce burden on PMJAY budgetary allocations. Further, building SHA's capacity will enable informed decision-making in selecting appropriate financing, approving the right selection of health facilities and risk pooling strategies.[xii]

1.5. **Design and Costing of Health Benefit Packages**

HBPs form the backbone of any health insurance scheme. The procedures under PMJAY are provided in the form of packages consisting of various services, including diagnostics, curative interventions (surgical, medical, radiotherapy, etc.), hospitalization, day care and follow-up care (drugs up to 15 days) required for treating a particular disease or a medical condition. Since 2018, the NHA has made several changes in the constituents and pricing of HBPs based on feedback from stakeholders, implementation challenges, evidence of utilization and costing procedures, including health technology assessments (HTA).[xiii]

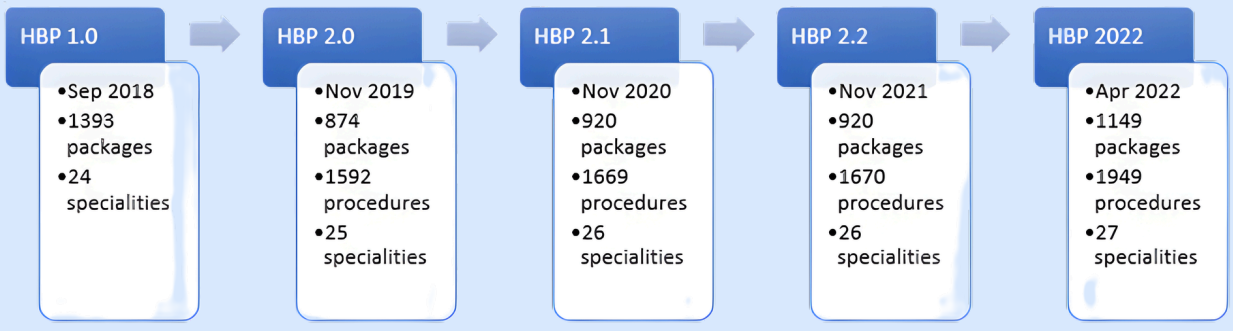

Figure 3: Component transitions from HBP 1.0 to HBP 2022

The pricing of HBPs balances incentivizing private providers to get empanelled with maintaining cost-effectiveness to ensure financial sustainability[xiv] . To address concerns over low reimbursement rates under HBP 1.0, the NHA launched the Costing of Health Services in India (CHSI) study which informed price revisions in HBP 2.0 and HBP 2022. Revisions increased package rates and introduced differential pricing based on supply-side factors such as geographic location, provider type and level of care provided[xv]. Other updates included additional packages

and introducing multi-procedure, cross-specialty and follow-up packages. The revisions improved utilization and reduced under-pricing [xvi], but challenges remain.

First, HBP pricing relies on CHSI estimates, reflecting the existing practices rather than standard treatment guidelines (STG). Second, most estimates use a top-down approach and lack bottom-up costing review due to limited analytical capacity of staff at the NHA[xvii]. Private hospitals dominate surgical and tertiary care packages, but their compliance with agreed prices remains weak [xviii] , while district hospitals contribute less to secondary care claims. Finally, HBPs miss out on preventive, promotive and rehabilitative services, notably for mental health and TB, and exclude transport, medicines and outpatient care, major drivers of OOPE [xix]. HTAs or cost-effectiveness exists only for oncology-related packages.

Recommendations: The NHA can expand HBPs to include omitted procedures such as non-pharmacological interventions (cognitive behavioural therapy for mental health disorders, management of pulmonary TB, other missed forms of TB and co-morbid conditions, maintenance medicines like anti-platelet drugs under cardiac care, etc.) [xx]. Reimbursements for indirect costs like travel, food, accommodation of patient and attendant, child care and wage loss could particularly improve utilization by women [xxi]. Regular reviews of unspecified packages (not explicitly listed in the HBP), stronger gatekeeping, and disinvestment from procedures covered under national programmes will be helpful [xxii] . Assessing the impact of differential pricing on coverage, quality and provider incentives is necessary, along with involving HTA experts and health economists to strengthen cost analyses and improve evidence for HBP pricing.[xxiii]

1.6. **Digital Integration and Interoperability**

Digital integration under PMJAY seamlessly links beneficiary identification, hospital empanelment, portability and claims management using Aadhaar and state-adapted. States using integrated information and communication technology (ICT) show enhanced administrative efficiency, fewer instances of fraud and improved claims turnaround.

Concerns remain about rural connectivity, digital literacy, elderly inclusion, data privacy, and proper integration with outpatient and preventive services. Interoperability with other schemes (CGHS, ESIS, state health insurance) is partial in some major states (ibid.).

Recommendations: There is a need to plan scalable investments in ICT infrastructure, ongoing digital training, and cross-scheme data sharing to maximize benefits for both administrators and beneficiaries, and to advance UHC.

2. **Demand-side Mechanisms: Enrolee Behaviour, Access and Uptake**

Demand-side strategies within PMJAY include focus on beneficiary verification, awareness, enrolment in the scheme and equitable access. This gives us an idea to what extent PMJAY strategies for community engagement, integrating citizen voice and grievance redressal have been successful in promoting equity, and to what extent they have enabled programme uptake by overcoming socio-economic, geographic and gender inequalities.

2.1. **Verification of the Eligible Population**

PMJAY has designed a robust eligibility and beneficiary verification system drawing on Socio Economic and Caste Census (SECC) 2011 data . Identification [xxiv] through official IDs with biometrics and photographs, coupled with a structured registration process, has further enhanced reliability. PMJAY ICT interoperability with several national and state databases has helped verify

eligibility, prevent duplication, and minimize inclusion and exclusion errors. However, as SECC 2011 is outdated, it fails to capture the current socio-economic and demographic realities, leading to exclusion and mis-targeting.

Recommendations: Integrating dynamic datasets like that of the National Food Security Act (NFSA) can improve accuracy and better target vulnerable populations[xxv].

2.2. **Community Awareness and Participation in Inclusive Scheme Implementation**

While PMJAY's communication strategy of consistent branding and well-aligned messaging through its name and structure provided public visibility[xxvi], awareness amongst the poor, women and marginalized groups remains limited.[xxvii]

Early evaluations suggest that peer networks and frontline workers could expand rural coverage, but gaps in understanding portability benefits, coverage, services and eligibility persist due to lack of sustained engagement. Targeted efforts to overcome gender-related barriers are required because women face mobility, financial and decision-making constraints[xxviii] . One study indicated that because of a lack of community trust—shaped by poor identification of eligible households and the negative legacy of RSBY—some people viewed PMJAY with suspicion, especially when only partial benefits were offered [xxix].

However, a promising model from Gujarat offers lessons on communicating transparent and accurate information to the community and building trust. The community-managed SEWA Shakti Kendras, operated by sevikas (trained local women), serve as trusted one-stop hubs for information sharing. They are an effective bridge between communities and government and address key barriers to PMJAY through awareness generation, documentation, local networking and health system navigation support [xxx]

Arogya Mitras as facilitators and insurance navigators guide beneficiaries through entitlement verification, enrolment, hospitalization and follow-up care. However, occasional non-cooperation, high turnover and inconsistent availability (lack of 24/7 presence) at hospitals, collectively constrain timely registration and service uptake [xxxi].

Recommendations: Context-specific tailored IEC campaigns, informed by community needs assessments, can improve awareness of services and grievance redressal mechanisms. Utilizing social media platforms like Facebook, X (Twitter) and Instagram, along with traditional media like local television, radio and newspapers can provide targeted, interactive communication and broader outreach. Engaging beneficiaries as community champions and leveraging platforms like ASHAs, VHSNCs and women's groups can strengthen trust and uptake, especially among rural, female and less educated populations. Institutionalizing accountability through social audits, feedback forums and Ayushman Bharat Counselling Centres, and leveraging models like the SEWA Shakti Kendras will enhance community engagement [xxxii] . Regular capacity-building for Arogya Mitras is essential to enhance supervision, support claims processing, and promote accountability at health facilities.[xxxiii]

2.3. **Access, Equity and Utilization**

Evidence shows that coverage and utilization of PMJAY have expanded across states, but persistent inequities still limit its reach and impact. Societal hierarchies of caste, gender, wealth and religion exclude vulnerable groups like marginalized women, newlywed women, immigrants and people in unofficial unions, reflecting design gaps similar to RSBY[xxxiv] . Mistrust based on

RBSY's negative legacy, coupled with exclusion of transport, medicines and outpatient care under PMJAY, adversely affects health expenditures, further hindering access. These inequities are accentuated through gatekeeping by local power brokers like ration shop owners, panchayat leaders and political workers. Even after acquiring eligibility letters or cards, women often remain unaware of the benefits due to ambiguity surrounding the one-card-per-household rule and gender-insensitive definitions of 'legal spouse' and 'dependents'[xxxv].
Weak public health systems hinder access in rural and tribal areas, where there are fewer empanelled hospitals[xxxvi] . Poor internet connectivity and lack of digital skills limit online registration and grievance redressal.

Recommendations: It is necessary to focus on vulnerable, lower socio-economic groups, female-headed households, and households composed entirely of female members to promote equity in access and financial coverage. There is a need to improve portability services, and increase the number of empanelled hospitals in remote, rural and tribal areas. Facility- and district-level assessments should be conducted to identify gaps in access and utilization[xxxvii]. Offline and alternative systems for claim and registration in areas with low connectivity are required.

3. **Supply-side Mechanisms: Provider Behaviour and Service Delivery**

Supply-side interventions in PMJAY are targeted towards empanelled health facilities, their resources, administrative processes followed and quality of care—all of which have significant bearing on accessibility, responsiveness and impact of the programme.

3.1. **Empanelment of Health Facilities**

PMJAY beneficiaries can access cashless treatment from any of the empanelled facilities which have increased over the years. Robust guidelines on eligibility criteria, accreditation and monitoring support SHAs in programme implementation and maintaining quality standards, while allowing flexibility for contextual adaptations in eligibility criteria that lead to variations in types of private hospitals empanelled. Some states limit the number of empanelled facilities while some reserve certain packages for public facilities only[xxxviii] . The nation-wide portability feature allows beneficiaries, particularly migrants, to avail of care from any of the facilities across states and districts[xxxix] .
There are gaps despite strict empanelment guidelines. All public health facilities with inpatient care are automatically empanelled, without assessing their resource adequacy. Distribution of empanelled health facilities is skewed towards urban areas and high-income states. This again leaves rural and marginal communities heavily reliant on public health facilities. Small private providers are reluctant to join the scheme due to slow and cumbersome empanelment processes, stringent eligibility criteria, insufficient economic viability resulting from low package rates, and a lack of administrative and technological capacity (Srivastava et al. 2023; Jyani et al. 2025; WHO 2025). Private providers display preferential treatment towards patients covered under other schemes which offer easy claims processing and reimbursement rates.

Recommendations: It is important to review the service readiness of PMJAY empanelled facilities inherited from RSBY. Prioritizing hospital empanelment in underserved and aspirational districts will address geographic inequities in access. Conducting regular monitoring and audits to de-empanel providers engaging in unfair practices, while incentivizing ethical private providers

with flexible rates to encourage their participation in underserved areas is imperative [xl] .

3.2. **Quality of care**

The NHA has introduced various mechanisms to ensure that qualityservices are delivered through empanelled healthcare providers, such as a monthly quality audit checklist, PMJAY quality certifications in collaboration with Quality Council of India (QCI), grievance redressal mechanisms, and a defined set of STGs.

3.2.1. **Structural quality and accreditation**

Systemic gaps in terms of human resources, medicines, diagnostics and infrastructure persist, affecting the quality of care, particularly at public sector facilities in low-resource settings. Accreditation remains low (only 3.2% of facilities), and especially so in aspirational districts (1.2%). Empanelment of public hospitals without detailed review of readiness has also been reported. Weak district health systems also result in increased OOPE due to travel costs. Private hospitals tend to have better infrastructure and accreditation rates but face limited reach in underserved areas.

3.2.2. **Standard Treatment Guidelines**

STGs from PMJAY were launched nationally in 2020, with the release of the first batch of 10 STGs, followed by more. As of 2022, a total of 647 STGs covering 1,508 procedures were published by the NHA. According to PMJAY guidelines, the objective of STGs is to aid the panel doctors of third-party administrators (TPAs), insurance companies and SHAs in processing pre-authorization or claims, while serving as a tool to guide the doctors.

A study found that STGs reduced claim rejections and improved documentation and transparency. However, literature shows that providers remain confused about their role, as STGs were treated as mandatory despite being intended only as reference tools. There is also no systematic approach to train providers or engage users, and no platform to collect and incorporate feedback[xli].

3.3.3. **Effects on Quality of Care**

Multiple studies have examined the effects of PMJAY on different quality parameters such as readmission rates, average length of stay and respectful maternity care. Studies report variable re-admission rates across states and specialties. Rates are similar between private and public hospitals (5.2% vs 5.0%), but there is lower in-hospital mortality in private hospitals (0.50% vs 0.70%). Mechanisms for reporting patient issues are limited, and perceived quality of care is not strongly linked to PMJAY enrolment. Tracking quality indicators does take place but remains under-documented and under-researched.

Recommendations: Strengthening the existing healthcare infrastructure will help in delivering quality care. There is a need to target interventions on high readmission procedures in states with elevated readmission rates, and consider linking the quality metrics to payment incentives. Regarding STGs, clarifying the role of STGs in clinical decision-making, establishing an independent body to clarify STG interpretation, and monitoring variance in clinical quality and claim processing is required.

3.3.4. **Claims Management**

Evidence on claims management is limited but the increase in utilization and procedure-wise

claims reflects growing beneficiary reach. The median claim amount was higher for BPL households, suggesting financial protection for vulnerable populations[xlii] . Evidence also highlights that structured contractual terms between SHAs and insurers helped limit profit-driven claim rejections, while shared claim processing among insurers, SHAs and TPAs improved efficiency. There is a positive correlation between state governance capacity (measured through the Public Affairs Index, the NITI Aayog State Health Index and data on budget execution in the health sector) and PMJAY uptake (claims and claim outlays).

The aspirational districts still grapple with inequities with low claim values and skewed distribution of empanelled hospitals. These inequities are compounded by reimbursement delays that frustrate providers, along with documentation and administrative gaps that contribute to claim rejections. Further concerns arise from mismatches between the competency of hospital doctors and junior clinicians approving claims, coupled with inadequate staffing, training and limited round-the-clock service at the hospitals.

Recommendations: The development and enforcement of STGs can enhance transparency and minimize disputes of claims management. Greater efficiency in claim processing—through improved coordination, simplified procedures and timely reimbursements—will help address provider dissatisfaction[xliii] . Technology-driven monitoring, including the use of Artificial Intelligence and Machine Learning tools, can strengthen fraud detection, curb overclaiming and improve transparency, drawing on global lessons . Finally, leveraging the National Health Claim Exchange (NHCX) can foster stronger coordination and transparency between public and private insurers.

4. **PMJAY's Contribution to UHC: Financial Protection, Primary Care Linkages and Ethical Dimensions**

Over the years, numerous studies have evaluated and highlighted the mixed impact of PMJAY on OOPE, varying by socio-economic conditions, geography, type of provider and treatment received. Some studies report significant decrease in OOPE and CHE catastrophic health expenditure (CHE). PMJAY relies heavily on private hospitals, as reflected in higher hospitalization rates and utilization of specialized, high-claim packages in private hospitals, leading to increased care expenses, often found to be several times higher than that incurred at public health facilities. Higher costs and limited impact on OOPE can be attributed to the prevalence of 'double billing' and deviation from the established HBP rates. Poor monitoring of choice of treatment regimens and fund wastage resulting from unnecessarily high-cost services and lack of an invoice for therapy received through PMJAY often results in patients being unable to verify the expense.

Mixed evidence on financial protection reinforces concerns about PMJAY's limited role in advancing the broader goals of UHC. Our review highlights that the scheme risks diverting resources away from primary care and public health, echoing concerns raised at its inception that prioritizing PMJAY over AAMs—the primary healthcare arm of Ayushman Bharat—could undermine progress towards comprehensive health coverage. Experts caution that prioritizing costly hospital insurance over universal primary care is not ethical, especially given India's weak primary health systems, and will slow progress on UHC.Other ethical concerns with PMJAY are: limited need-based focus, burden on health workers, disadvantages to patients, insurers' profits, and an unregulated private sector that undermines its justice-driven orientation [xliv].

Recommendations Inclusion of outpatient care, direct costs such as drugs and diagnostics, and indirect costs like wage loss in PMJAY benefit packages will ensure comprehensive financial protection[xlv]. Stricter regulations, prompt grievance resolution, use of STGs, and action against double billing and inflated prices are required to reduce OOPE expenses in private hospitals. Strengthening primary health care and public hospitals, and ensuring seamless AAM–PMJAY coordination through unique IDs, common registration and two-way care protocols—combined with transparent, accountable priority-setting—can[xlvi] ensure PMJAY benefits reach people effectively[xlvii] . Regulating private providers through standards, audits and accreditation will advance UHC and its financial protection goals.

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Strengthening Community Engagement for UHC

Achieving UHC necessitates a fundamental shift from viewing communities as passive beneficiaries of health care to recognizing them as co-creators of health. Community engagement (CE) is the process through which health stakeholders and community members build mutual trust and work together to promote health and well-being. Linked to civic governance, it is a practical manifestation of democratic principles within health system [i]. CE ensures that health system is accountable and responsive to people's needs [ii]. CE was first articulated in the Alma-Ata Declaration (1978), powerfully reiterated in the Astana Declaration (2018), as a key pillar of primary healthcare (PHC). These global frameworks posit that people have both the right and duty to participate in the planning and implementation of their health care [iii].

Realizing the full potential of CE for advancing UHC requires examining how it is embedded within policy, governance, and implementation processes. With such an understanding of how CE approaches have been conceptualized, institutionalized, and implemented, we may glean insights on where to place emphasis for strengthening nature and impact of CE.

Approach to Synthesizing Insights on Community Engagement

This section presents reflections compiled from a collaborative expert elicitation and a targeted review of select published and gray literature on CE. For the collaborative elicitation, experts with policy, research, or implementation experience in CE were identified by ISSP. Experts used a dialogic-discursive process [iv] to synthesize their tacit understanding and co-produce perspectives on key challenges and pathways to strengthen CE for UHC in India. This consultative approach supported iterative reasoning and elicited authors' implicit knowledge on CE. Two authors reviewed consultation notes, conducted targeted literature searches based on emerging themes, and identified documents on policies, governance and implementation of CE models. Additional practitioners were consulted for reports and toolkits. All information was thematically organized into different components and was collaboratively refined by the authors.

We first trace the evolution of CE policies in India, examine governance structures and on-ground practices related to priorities and targets groups for CE, reflect on primary care providers involved, functioning of community platforms and initiatives and finally offer recommendations to strengthen CE.

1.Policy Evolution of Community Engagement for UHC in India

India has a strong legacy of community engagement. The Bhore Committee Report of 1946 and subsequent health policy frameworks identified CE as a foundational pillar of primary health care [v]. The 73rd and 74th Constitutional Amendment of 1992 and 1995 Panchayati Raj Bill further provided it a legal foundation [vi].

The launch of the National Rural Health Mission (NRHM) in 2005 marked a major structural shift, operationalizing community engagement through its core strategy of 'Communitisation' [vii]. The NRHM, and later the National Health Mission (NHM) institutionalized CE through Accredited

Social Health Activists (ASHAs), Village Health Sanitation and Nutrition Committees (VHSNCs), Mahila Arogya Samities (MAS) in urban settings, Rogi Kalyan Samitis (RKS) or Patient Welfare Committees, the Community Action for Health initiative, involvement of Panchayati Raj Institutions (PRIs), urban local bodies and NGOs all promoting community-led action[viii].

The 2011 High Level Expert Group Report on UHC re-emphasized that effective citizen participation deepens democracy, empowers people and improves health while maintaining state accountability[ix]. It recommended two ASHAs per 1,000 population, transformation of health committees into participatory councils to strengthen oversight and planning, health assemblies, stronger PRIs, and civil society engagement, and an effective grievance redressal system to support UHC.

The 2014 MoHFW Task Force on Comprehensive Primary Health Care charted an evolutionary path for CE, emphasizing stronger PRIs, especially Gram Sabha for community-led planning and accountability. It recommended integrating CE into Gram Panchayat plans, using panchayat funds for community priorities, linking VHSNC funding to performance, training primary care teams on equity, forming patient support groups, and enhancing women's participation[x]. The National Health Policy 2017 rearticulated some of these recommendations but emphasized a stronger need of CE to address emerging challenges of mental health, elderly and palliative care and climate related emergencies[xi].

2. **Positive Impact of CE Initiatives**

Evidence suggests CE initiatives in India have improved health awareness, service utilization, and, in some contexts, accountability[xii]. ASHAs, globally recognized as feminist beacons of health empowerment, have been the most transformative force, scaling equity driven CE[xiii]. Launched in Chhattisgarh in 2005 - 06, the Swasthya Panchayat Yojana exemplifies community-led health governance, where Mitanins and Gram Panchayats strengthened VHSNCs and integrated health into local governance. Using participatory tools, audits, and regular Jan Samwads, communities identified health gaps, planned collective action, and promoted accountability; transforming VHSNCs into platforms for decentralized, inclusive, and data-driven health governance[xiv]. Similarly, Community Action for Health (CAH) pilots under NHM showed how empowered communities and local bodies advance accountability, inclusion, and health outcomes[xv].

While ASHAs remain the most significant success, most other initiatives lost their transformative nature at scale or remained as only checklist-driven exercises[xvi]. In the next few sections, we critically examine the reasons for this.

3. Addressing Policy Gaps: Positioning Community Engagement as a Right

Despite clear policy commitments for CE, few states have been able to implement the recommendations outlined in the policy frameworks with complete fidelity. A foundational dimension of effective CE is its grounding as a legal right for the citizens. Despite a legal mandate of decentralized governance provided through the Panchayat Raj Bill, the challenge remains in positioning CE as an indispensable input for health services design, implementation, and oversight and recognizing it unequivocally as a citizen's right and making local implementers accountable for ensuring the same[xvii]. Inability to transform engagement to a non-negotiable activity of democratic health governance has led engagement through community platforms to remain

tokenistic [xviii].

The Nagaland's Communitization of Public Institutions and Services Act, 2002 (amended 2004) is possibly the only attempt to establish communitization as a legal framework across sectors including health. The law mandates community management through village and facility committees, granting them financial powers such as managing joint accounts and sanctioning funds and authority to oversee staff attendance, enforce "no work, no pay," and disburse salaries accordingly. While not bereft of training and implementation challenges, evaluations reported better access to healthcare, improved staff attendance and greater community participation in facilities where such health committees were present [xix]. Globally, several exemplars further demonstrate how legal frameworks can institutionalize CE based on a rights-based framework.

In the **UK National Health Service (NHS)**, the Health and Care Act 2022 established a statutory "duty to involve", mandating Integrated Care Systems and Health and Wellbeing Boards to embed citizen voices in planning and joint strategizing, with clear accountability for incorporating and demonstrating the influence of public feedback on decisions [xx].

In **Thailand**, the National Health Act 2007 created the National Health Commission and mandated annual National Health Assemblies - formal participatory platforms uniting government, civil society, and citizens to shape health policy; further strengthened by decentralized/issue-based assemblies and creation of Participatory Health Regions [xxi].

In **Brazil**, the 1988 Constitution and Law 8.142/90 made citizen participation a constitutional right through multi-level Participatory Health Councils. Composed of at least 50% citizen or civil society members, the councils hold significant power over health planning and participatory budgeting, institutionalizing CE as a mechanism of shared governance and accountability [xxii].

4. CE Governance and Support Systems

The transition from policy to meaningful CE is also mediated by the governance and support mechanisms created. Within India's federal structure, health is a state subject. But states often rely on the centre for agenda setting, institutional design and funding for community processes, limiting state-led innovation and ownership.

4.1 **Institutional Capacities for CE**

At the national level, the National Health Systems Resource Centre (NHSRC) serves as the apex body for technical support on CE to the Centre and states for-the ASHA, VHSNC, Mahila Arogya Samities (MAS), Rogi Kalyan Samities (RKS) or the newly formed Jan Arogya Samities (JAS) under Ayushman Bharat. An Advisory Group on Community Action (AGCA) was created by MoHFW in 2005 to provide guidance for the Community Action for Health (CAH) with the Population Foundation of India serving as its secretariat from 2005 to 2023. NHM enabled states to deploy a dedicated cadre of program managers, coordinators and facilitators from state to sub-block levels to support CE initiatives [xxiii]. However, evidence from empirical studies reveals that CE support mechanisms remain fragmented and unevenly institutionalized [xxiv]. While most high focus states have dedicated program personnel for CE, other states rely on a mix of dedicated and existing staff of NHM, to support community processes, leading to variable implementation [xxv].

We see that CE could thrive where state institutions retained civil society like autonomy with strong government linkages, as was seen in Chhattisgarh's State Health Resource Centre. However, such boundary institutions are still evolving in most states [xxvi].

4.2 Need for Adaptive Implementation

Reports suggest that while ASHA program management capacities could mature across states, institutional support for broader initiatives like VHSNCs and CAH remains weak. The tools and standard training guidelines are provided by the government, but most states lack well-established systems for implementation-based learning, monitoring, and feedback to contextualize these guidelines. One reason could be that financing for CE is not enough for structured facilitation, peer learning, and local experimentation that constrains innovation and local adaptability[xxvii]. Unlike other programs, there are also limited structured review mechanisms for CE at state or district levels, and low capacities of program staff make adaptations or corrective actions difficult.

Experts also reflected that health programs are predominantly managed by clinicians, who tend to prioritize service delivery over participatory governance, inadvertently sidelining community processes. Extensive focus on service delivery, with scant attention to the quality of community participation is a common pitfall noted in community health initiatives globally[xxviii]. The absence of a dedicated district official to lead community processes weakens oversight of community platforms, as present NHM coordinators anchoring these initiatives lack the authority to drive systemic change.

4.3 The Problem of Governmentalization and the Diminishing Role of NGOs

Other studies examining India's 'communitization' process have indicated that 'beginning 2012, there was a shift from communitisation towards governmentalization of community processes' [xxix]. This is because as Civil Society Organizations (CSOs) became more integrated into government systems, community initiatives were absorbed into official processes, which changed local power dynamics. After 2012–2013, the focus of NHM initiatives like ASHA and VHSNCs also shifted from strengthening community accountability to emphasizing service delivery. With reduced funding for civil society or community-based organizations, there was increased reliance on government structures particularly for initiatives like Community Action for Health (CAH). This shift increased emphasis on supply-side priorities while reducing attention and flexibility for addressing demand-side needs through meaningful community relationships.

Under NHM, NGO engagement in community processes was to be state led with national facilitation, but limited investment in long-term NGO partnerships has limited sustained mentoring and capacity building of community structures, despite proven models which rely on civil society facilitators [xxx]. This shift weakened the trust-based relationships with NGOs needed for effective community engagement. While CSO participation continues in the form of consultations, workshops, and policy dialogues, sustaining it through stronger institutional support and stable financing, needs to be enhanced for health sector governance and accountability for UHC [xxxi].

5. Operational Mechanisms of Community Engagement

5.1 Key Approaches, Priorities and Target Groups

The WHO's framework for community engagement for UHC outlines four key approaches that guide how health initiatives can involve communities in various ways (3). Figure 1 depicts how India's wide ranging CE initiatives align with these approaches. [O1] [IA2]

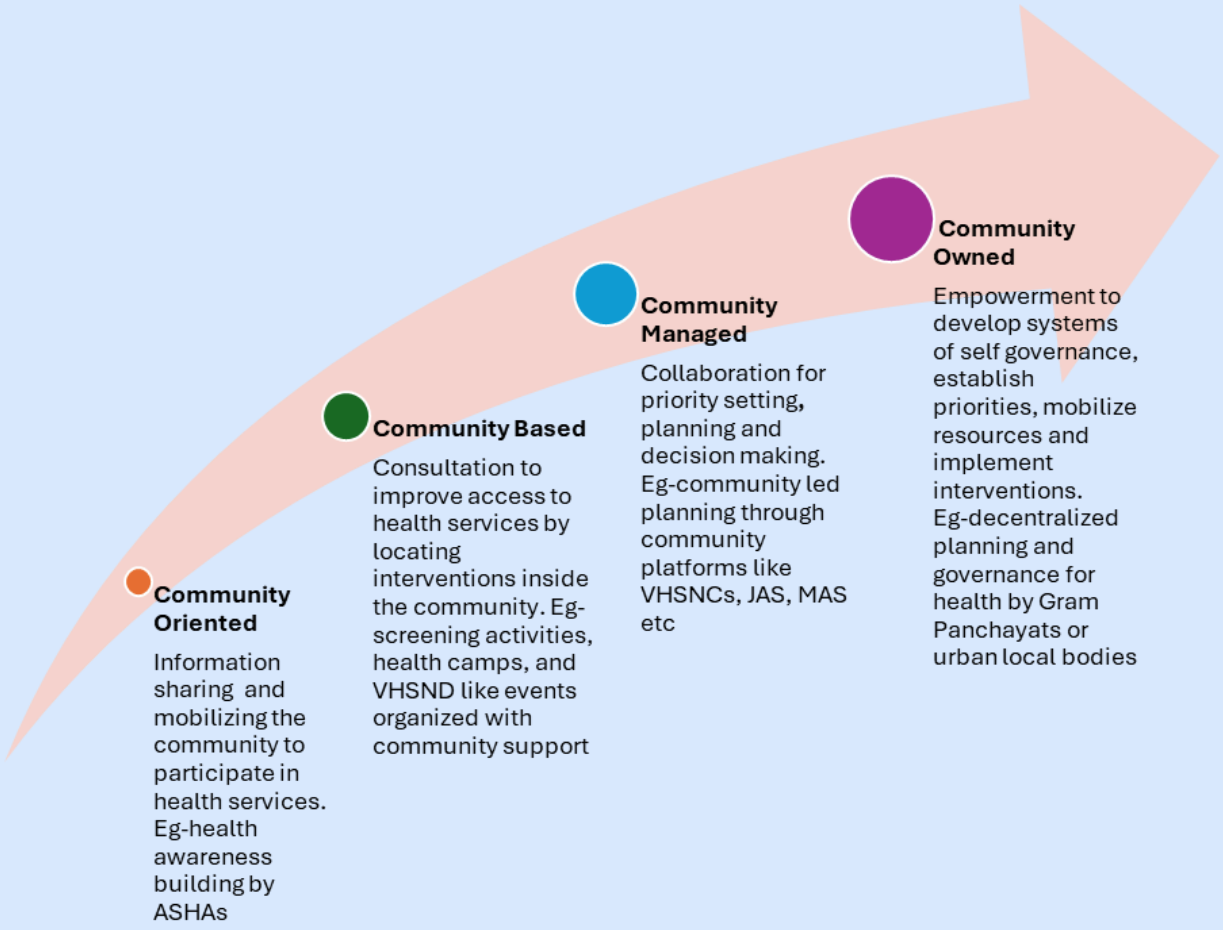

Figure 1: Community Engagement Approaches for Universal Health Coverage (WHO)

Although the NHM framework aimed to link health services with social determinants through VHSNCs and PRIs, in most locations, CE has largely remained top-down, driven by vertical programs and limited behavior change efforts for select groups. Primary care providers' service charters are not informed by community input, leading to sidelining of community priorities like sanitation, food or income security, and domestic violence, which are important for the community, making engagement non-holistic, a compliance tool, rather than a responsive process. A shift towards balancing top-down directives with 'bottom-up advice' centered on the 'holistic needs of the community' is essential[xxxii]. Ekjut's Participatory Learning and Action (PLA) initiative exemplifies this integration, using trained community facilitators or ASHAs who use participatory methods and mobilize the community for identifying priorities, solving problems, and planning local health strategies. ASHA's, along with the team at the district and block levels are also involved in the process of training, implementation, and evaluation of dashboard content for strengthened community based monitoring[xxxiii].

CE priorities also need to align with India's shifting disease burden - from communicable, maternal, and child health to growing prevalence of non-communicable diseases and injuries [xxxiv]. Areas such as non-communicable diseases have begun to attract greater financial attention in recent years alongside reproductive, maternal, and child health services which continue to receive the largest share of funding [xxxv] . States need to leverage this support, prioritize otherwise overlooked population groups with distinct health needs and risks [xxxvi].

Experts emphasized focus on overlooked populations and contexts:
Adolescents face challenges such as malnutrition, mental health issues, substance use, and early marriage; stronger engagement with this group through existing NHM initiatives like peer educators, school health initiatives or adolescent health days is vital for shaping a healthier future generation[xxxvii].
Ageing populations need sustained care and social inclusion, yet current strategies rarely incorporate their voices; strengthening geriatric support groups, caregiver engagement, and long-term care into local health action plans is a growing need[xxxviii].
Urban vulnerable groups remain underrepresented due to weak institutional support for urban CE platforms like MAS, limited public awareness, and socio-economic disparities. This requires tailored, well-supported urban strategies distinct from rural models; and a greater engagement of urban local bodies in urban health related considerations [xxxix].
Patients and caregivers must also be recognized as active partners; their involvement enhances preventive and recovery care, coordination, and overall health outcomes while balancing the burden on health systems and caregivers [xl].

5.2 Role of Primary Care Providers in Community Engagement

Among the primary care providers - ASHAs, multi-purpose workers/ANMs, and community health officers (CHOs), ASHAs play the most prominent role in driving CE efforts and have advanced health outcomes through home-based care, referrals, community mobilization and anchoring health promotion efforts via platforms like VHSNCs and MAS[xli]. As services expand under Ayushman Bharat, growing demands from mobilization drives, data reporting, and surveys, along with the need for new skills and tasks, have strained ASHAs and their existing capacities[xlii]. Their increasing service delivery focus, administrative load, and legitimate demands for fair pay have led them to be perceived closer to the system than the community. Balancing their fair employment while maintaining their community affiliation will be crucial for effective CE [xliii]. An emerging need for a second ASHA per 1,000 population, along with their career progression pathways as recommended by the HLEG report, warrants consideration now, especially in contexts with changing demographic composition [xliv].
Similarly, ANMs, though central to maternal and child health delivery, spend much of their time on record-keeping and supporting clinical tasks, rather than community engagement [xlv]. CHOs are expected to lead CE efforts with ASHAs, ANMs, and Gram Panchayats to promote community health, and have strengthened facility-based service use, but their engagement with community platforms remains limited, making it hard for them to navigate complex community relationships[xlvi]. Though CE appears in all cadres' roles, their training mostly centers on service delivery, with limited focus on competencies for people-centeredness and collaboration essential for UHC [xlvii]. Strengthening community orientation, reducing administrative load, improving training, and working conditions for the three cadres will be crucial for CE [xlviii].

5.3 Platforms of Community Engagement

To integrate community voices in health decision-making, VHSNCs are formed at the village level, MAS are created for every 2000-2500 population within each urban primary health centres, RKS at health facilities, and more recently Jan Arogya Samitis (JAS) have been added in AAMs. These committees comprise of health providers, PRI representatives, frontline staff of other allied departments and community members. Field reviews indicate better participation of communities

in these platforms when discussions focus on their priorities and social determinants of health, rather than just health messaging alone [xlixi] VHSNCs could flourish better in states with a context of participatory governance [l] . Kerala, Chhattisgarh, Jharkhand and Maharashtra demonstrated good performance of these committees, which improved health-seeking behaviour and strengthened women's ability to negotiate intra-community inequalities [li] .

In most other settings the CE platforms could not meet their objectives of community led planning and accountability for health services [lii]. The weakening of community platforms reflects the broader tendency to prioritize service delivery over participatory engagement [liii]. We see that reasons for low functioning are similar for all and include weak community participation, unclear roles, poor ownership, limited training and supervision, weak coordination with local governments, and funding delays [liv]. Most often these barriers have been attributed to 'operating at scale', including the difficulty of training large numbers of members, and the complexity of monitoring these platforms without strong district or block level ownership [lv]. Community facilitators who are crucial for coordinating collective action, are either not engaged or lack the capacity to lead these efforts [lvi]. Reluctance of government administrative frameworks to expand the reach of such health committees, entrenched power hierarchies, gender and caste norms; further complicate their functioning [lvii]. Even in areas where they were functional, lacking any binding directives that require the government to act on their feedback, leaves them demotivated [lviii].

5.4 Implementation of Community Action for Health: Key Lessons

NHM's CAH program involves activities for assessing community-level health services, preparing village and health facility reports, conducting Jan Samwads (public dialogues) to advocate for improvements, and undertaking corrective action and planning to address identified gaps and issues. In 2007-09 pilots covered 1,620 villages across 9 states and demonstrated that structured community action could reinvigorate the vision of 'communitization' of health. CAH empowered marginalized groups, strengthened service delivery, enabled local planning, and enhanced provider accountability. An independent evaluation affirmed these outcomes and recommended establishing State-level institutional support mechanisms with continued technical and financial backing from the MoHFW for scaling up [lix] . In practice, CAH momentum waned in many states after the pilot, with no efforts made to extend the approach to urban platforms.

However, there are lessons to be drawn from CAH's implementation. Intensive CE efforts require dedicated institutional structures at all levels, systemic accountability, sustained financial and technical support and locally adaptive models. Experience from Tamil Nadu's CAH implementation underscores that differing ways of problematizing the issue, whether viewed as gaps in service delivery or as power imbalances between communities and an expert-driven system can themselves become sources of implementation challenge. Creating institutional spaces that allow for dialogues on diverse views and balance power hierarchies are essential to sustain and integrate community accountability processes [lx] . CAH lessons show that integrating community-led accountability for UHC requires strong institutional support and institutional spaces to allow for inclusive dialogue between communities and the health system [lxi].

6. Role of Local Self Governments

Gram Panchayats (GP) are accountable for advancing community health outcomes in rural areas.

Most recently, their leadership during the COVID-19 pandemic, GP anchored health screenings of NREGA workers, or efforts for TB elimination through community surveillance, support to vulnerable households, and coordination with frontline workers demonstrated how decentralized governance can promote local resilience and improve health outcomes[lxii]. The Kerala experience stands out, where empowered Panchayats have anchored action on the social determinants of health, driving primary healthcare reforms or serving as custodians of the marginalized community [lxiii]. GPs' engagement in health varies with state context.In most states, this is constrained due to their skewed focus on visible infrastructure over preventive health, limited training and fiscal flexibility, inadequate local revenues or untied grants to fund community priorities [lxiv]. Absence of genuine political agency, their increasing accountability to the state and weak citizen linkage in certain contexts have prevented GPs from functioning as spaces of participatory governance, undermining the broader goals of decentralization in rural health [lxv].

In 2015-16 the Ministry of Rural Development and Panchayat Raj introduced Gram Panchayat Development Plans, that involve a multi-staged participatory planning process allowing community to prioritize and utilize local resources available with their Gram Panchayats for the overall human development including health [lxvi]. If effectively implemented, this can enable communities to set priorities and mobilize resources for health and development. However, the process of integrating VHSNC or JAS plans into GPDPs remains unclear, and there remain challenges like tendency of reusing previous year plans, weak coordination, and low representation of women and marginalized groups [lxvii] .

There are even fewer examples that exemplify the role of municipal bodies leading CE for urban populations. Despite NUHM's mandate and support, role of municipal bodies in primary healthcare and community action remains weak due to poor multisectoral collaboration among health, municipal bodies, and allied departments. We also observe that for both rural and urban areas, health continues to operate as a departmental service rather than a devolved function of local bodies, limiting opportunities for genuine community-led governance and local accountability.

Sustained capacity building is essential to shift local self-governments' accountability toward citizens. Strengthening State Institutes of Rural/Urban Development to function like Kerala Institute of Local Administration can enhance the ability of local bodies to drive participatory governance. It conducts training programs, research and anchors operationalization of several CE initiatives through local governments [lxviii].

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7. Recommendations to Strengthen Community Engagement for UHC

- Position CE within a rights-based framework: through state-specific legislation that establishes it as a non-negotiable right of citizens in the planning, implementation and oversight of health programmes. District- and state-level systems should ensure that community feedback from engagement platforms is compiled and presented to decision-makers at appropriate levels, with a designated district official made accountable for community processes and integrating feedback into decisions.
- Strengthen state-level institutional capacities by nurturing SHSRCs, state institutes of rural/urban development, modelled on KILA, to anchor community processes. These institutions can train local governments, drive participatory engagement, multi-sectoral collaboration and decentralized health planning. As autonomous yet government-linked bodies, they can bridge policy and implementation, promote learning from practice, and

develop sustainable, context-specific models of community engagement and governance for UHC.

- **Institutionalize adaptive implementation at the district level and below:** by enabling a dedicated district official to lead and drive community engagement efforts in health, monitor community platforms and ensure accountability. Establishing regular review mechanisms at district and state levels is crucial for timely course correction and adapting strategies to local contexts.
- **Revitalize strategic partnerships with NGOs and community-based organizations:** for training, mentoring and support functions, while ensuring government leadership and ownership remain central. The NHM framework allows 5% of overall funding for contracting specific functions to experienced and credible NGOs to leverage their technical expertise, especially at the district and sub-district levels, without diluting state accountability or programme stewardship. This can be utilized to build relational, long-term partnerships with NGOs through a process of empanelment by the state government.
- **Strengthen financing and support mechanisms for community engagement:** by creating dynamic funding budgets for CE, based on evolving local cross-sectoral priorities, responsive to community needs, and flexible to allow for contextual adaptations at the state and district levels. CE financing mechanisms should protect long-term financing for NGO facilitation and SHSRCs to support community accountability mechanisms.
- **Prioritize holistic and inclusive community engagement:** by allowing engagement activities to move from a vertical, programme-driven focus towards a more holistic approach, centred on the social determinants of health and community priorities. The inclusion of adolescents, elderly, urban vulnerable groups, patients and caregivers should be actively supported by developing avenues for their participation in priority setting and community health planning.
- **Support PHC workforce:** by easing data and reporting burdens on frontline workers, particularly ASHAs and ANMs, and improving their overall working conditions. Simultaneous investments should be made to build their capacity and skills on social negotiations and participatory governance with the support of NGOs with expertise in this area.
- **Revitalize platforms for community engagement** by shifting from a one-time training model to continuous mentoring and support by trained NGO mentors or community facilitators, who can promote community rapport building, ensure participatory engagement and iterative programme improvements. They can also ensure active involvement of local leaders, and coordination with local committees to ensure integration and sharing of action plans from these committees with local bodies for feedback and issue resolution.

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Way Forward

The Centre for Universal Health Assurance (CUHA) envisions India's achievement in UHC and UHA on a progressive path that will be marked by many milestones:

1. **Achievement of an effectively delivered UHC by 2030**

This will include:

- Primary care led integrated health services. This approach aims to provide **seamless, person-centred care**, thereby improving health outcomes and patient experience while optimizing resource use. It focuses on holistic care, addressing both medical and psychosocial needs, often through multidisciplinary teams.
- Public sector led mixed health system. The public sector retains a critical **stewardship and regulatory role.** It is responsible for policymaking, setting quality standards, and financial rules that govern both public and private providers to ensure services are equitable, affordable and of high quality. Funding involves a combination of **public sources** (taxes/social contributions) and **private sources** (private insurance premiums, direct user payments). Healthcare services are delivered by both **government owned facilities** (public hospitals, community health centres) and a variety of **private providers** (for-profit, non-profit or independent practitioners).
- Pluralistic combination of allopathic and Indian systems of medicine. This refers to the simultaneous and often integrated use of modern Western medicine **(Allopathy)** alongside India's traditional systems such as **AYUSH**. This approach recognizes the value and strengths of both systems. It offers a more comprehensive range of healthcare options and in a more locally accepted cultural milieu.
- Affordable drugs, diagnostics, equipment and vaccines, enabled by quality assured domestic production, and cost-saving pooled procurement practices adopted by both public sector health agencies and private sector hospital consortia.
- Support for indigenous production and unconstrained distribution of generic drugs and biosimilars, with public sector capacity added to a strong Indian-owned private pharma sector.
- Price controls on all essential drugs and diagnostics.
- Creation of a health workforce model where care delivery is stratified (multi-layered) and diverse (multi-skilled), with technology-enabled, non-physician healthcare providers (NHPs) and family physicians working collaboratively as frontline leaders in community-based primary care settings, regardless of whether they are rural or urban. The key is using NHPs and tech to extend and enhance the reach and efficiency of physician-led care.
- Upgradation of district hospitals to training institutions for doctors, nurses and allied health professionals. Team-based training for primary health teams is a structured educational approach designed to enhance collaboration, communication and shared understanding among healthcare providers from different categories (e.g., family physicians, nurses, non-physician providers, community health workers) who jointly work to deliver comprehensive primary care.
- A strong, innovative, contextually configured, adaptively evolving digital architecture which will enhance connectivity between people, patients and various elements of the health system, while improving representativeness, accuracy and timeliness of national and disaggregated regional health information systems.

- The primary goals of this training model are to ensure that the team can function as a cohesive unit and deliver high-quality, integrated care:
    1. **Role Clarity:** Ensuring that every team member understands their own responsibilities and the specific skills and roles of their colleagues (Interprofessional Role Clarification).
    2. **Enhanced Communication:** Improving effective and structured communication methods, such as SBAR (Situation, Background, Assessment, Recommendation), to reduce errors and improve patient transitions.
    3. **Shared Mental Models:** Developing a common understanding of team goals, patient care protocols and decision-making processes, leading to more predictable and coordinated actions.
- Active engagement of an informed community, enabled by community-based CSOs, in the design, delivery, monitoring and evaluation of health, nutrition and sanitation programmes.

2. Alignment of multi-sectoral policies towards healthy life expectancy for all to create a 'Swasth Bharat' which is' Sudhrud, Sashakt and Sampann' as befits the vision of Viksit Bharat 2047

This will call for:

1. Food and agriculture policies which will enable the production and equitable distribution of nutritious foods, based on the principle of dietary variations drawn from crop diversity provided by climate smart and climate resilient food systems.
2. Urban design and transport policies which reduce harmful emissions, promote physical activity, protect against heat and extreme weather events, while monitoring migration patterns that may spread pathogens.
3. One health system of integrated surveillance and pandemic prevention strategies through connectivity between forestry and wildlife, veterinary medicine, agriculture, health and environment related agencies and institutions.
4. Water, sanitation and hygiene policies which reduce the risk of infectious diseases.
5. Promotion of renewable energy production and use.
6. Education and communication policies should actively integrate and promote health and nutrition literacy among the general population, embedding this vital knowledge through both formal curricula (in schools and institutions) and non-formal, community-based educational outreach programmes.
7. Gender equity and gender safety policies must be implemented to actively protect women from discrimination and violence, while simultaneously empowering them to take on a greater and more impactful role in the design, delivery and utilization of health services. This will ensure that services are sensitive to women's needs and that women's professional contributions are maximized.
8. Active and meaningful engagement of tribal communities, persons with disabilities, and other historically marginalized and vulnerable groups must be institutionalized throughout the entire cycle of health policy and programme development to ensure relevance, accessibility and cultural appropriateness of all health interventions.

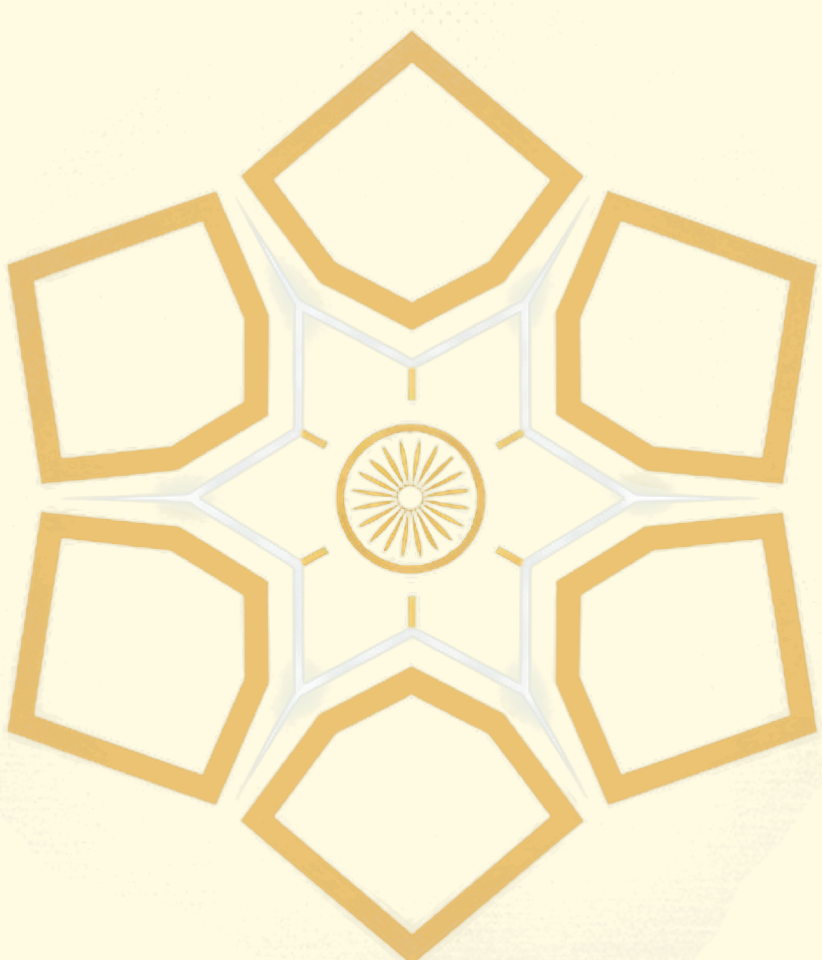
Efforts to align policies and programmes in these sectors with the public health objective of creating a healthy society will have to start now to progressively deliver 'Health in All Policies' by 2047.

CUHA's Role in Paving this Road

CUHA serves as a vital catalyst and facilitator for building an evidence-based ecosystem by creating and disseminating knowledge products essential for achieving UHC in India.

CUHA will assist in laying this ground by:

- **Convening multi-stakeholder consultations:** Systematically bringing together diverse groups (e.g., policymakers, academics, health system leaders) to foster shared learning and co-create policy solutions grounded in real-world experiences.
- **Catalysing multi-institutional and multi-agency partnerships:** Strategically forging alliances between research centres, governmental bodies and service providers to pool data, resources and expertise to accelerate the development of robust, scalable UHC models.
- **Supporting informed public policy development through periodic publications:** Producing high-quality analytic reviews and policy briefs to act as key knowledge products. These publications provide evidence-informed, context-relevant, and resource-optimising recommendations designed to be system-enabling, culturally compatible and equity-promoting for immediate use in policy and practice.



Annexure

Annexure-I

Domains and Indicators used in Universal Health Coverage Index

- Domain 1: RMNCH+A
  1. Demand satisfied with modern method of contraception (married women, 15–49 years [%])
  2. Four or more (ANC) care visits (%)
  3. DTP3 immunization coverage among 1-year-old children (%)
  4. Care-seeking for suspected pneumonia in children (%)
- Domain 2: Infectious Diseases
  1. TB treatment coverage (%)
  2. People living with HIV receiving ART (%)
  3. Population at risk sleeping under insecticide-treated nets (ITNs) (%)
  4. Households with access to at least basic sanitation (%)
- Domain 3: NCDs
  1. Proportion of adults (30–79 years) with hypertension receiving treatment (%)
  2. Proportion of population with normal random blood glucose levels (%)
  3. Adults (≥15 years) not smoking in the last 30 days (%)
- Domain 4: Service Delivery & Access
  1. Hospital beds per capita (against threshold)
  2. Health professionals per capita (per 10,000): allopathic doctors, nurses and midwives
  3. Expanded health professionals per capita (per 10,000): including AYUSH practitioners
- Domain 5: Financial Risk Protection
  1. % population covered by health insurance
  2. % households not experiencing CHE.

Annexure-II

Summary Table of Data Sources used for UHC Index

Domain	Indicators	Source
RMNCH+A	Modern contraception (%)	NFHS-5
	4 ANC visits (%)	NFHS-5
	DTP3 immunization (%)	NFHS-5
	Pneumonia care-seeking (%)	
Infectious Diseases	TB treatment coverage (%)	NTEP Report 2024
	ART coverage (%)	Sankalakh 2024
	Bed-net coverage (%)	NFHS-5
	Basic sanitation (%)	NFHS-5
NCDs	Hypertension treatment (%)	NFHS-5
	Normoglycemic population (%)	NFHS-5
	Non-smoking adults (%)	GATS 2016-17
Service Delivery and Access	Hospital beds/capita	National Health Profile 2022
	Health professionals/capita	Health Dynamics of India 2022-23
	Expanded HRH/capita	Health Dynamics of India 2022-23
Financial Risk Protection	Health insurance coverage (%)	NFHS-5
	Non-catastrophic expenditure (%)	75th NSS

Annexure-III

Table: Emerging State Specific Approaches of CE to Advance the Goals of Ayushman Bharat

State/s	Program/ Area of Focus	Key interventions and strategies	Lessons for CE Process Improvements
Jharkhand	Implementation of Jan Arogya Samiti in collaboration with the Gram Panchayats for *Community led accountability and Quality Assurance for AAM Services*	● Initiated through structured virtual training and on-ground support and handholding from community facilitators (two for five JAS supported by NGO) ● Facilitators guided village health planning, meetings, and AAM provider training through a hands-on approach. ● Leadership and participation of sarpanch is ensured ● Linkage with GPs promoted through monthly feedback on AAM services and action plans to Sarpanch in GP secretariat meetings ● CHOs were provided standardized agendas and checklists to conduct the meetings ● Benefits: stronger community linkages, higher utilization of AAM services, and reduced social exclusion.	● One time training needs to be coupled with hands-on mentoring and support for driving community structures ● Mentoring by NGO community facilitators promotes fidelity to program objectives ● Active Sarpanch and coordination with GP committees enables integration of JAS action plans, feedback on AAM services, and issue resolution.
Jharkhand	Ekjut's Peer-led Participatory Learning and Action for Adolescents *Community led planning and problem solving for adolescents health promotion*	● Aims improving school attendance, dietary diversity, and mental well-being among adolescents ● Scoping conversations with adolescents on the issues faced ● Meticulous selection of youth facilitators (Yuva Saathis) and their effective and well-executed training by the Ekjut Team ● Four-phase PLA cycle—community identifying problems, planning strategies, implementation, and evaluating progress on outcomes.	● Integrating community feedback is crucial for iterative program improvement ● Careful facilitator selection and training are essential ● PLA process ensures structured, engaging community meetings ● PLA processes can be adapted to services beyond MCH ● Non-health entry points sustain adolescent engagement ● Youth facilitator reviews should enable peer learning and motivational feedback

States	Program/ Area of Focus	Key interventions and strategies	Lessons for CE Process Improvement
Kerala	Home-based palliative care provision by nurses and community volunteers *Community led approach to expand service delivery*	• Public-private partnerships through collaboration among NGOs, CBOs, hospitals, and local governments to deliver palliative care. • Home-based care-Free services are provided through health professionals and trained community volunteers. • Addresses patients' physical, psychosocial, spiritual, and emotional needs. • Local networks aid decision-making and family resource mobilisation. • NGOs and panchayats jointly train nurses and volunteers for home-based elderly care.	• GPs can mobilize local finances and human resources for home-based care for elderly • Community volunteers trained for elderly care help integrate local customs and socio-economic norms to enhance acceptance and implementation
Gujarat	SEWA Shakti Kendras (SSKs): community resource centres to improve access to health insurance *Women led Community forums to promote information and access to entitlements and government services*	• Community resource centres- Improve women's access to pensions, health insurance, and other entitlements. • Trained Sevikas: Paid community workers provide basic treatment and screenings. • Community outreach by Sevikas and leaders • Documentation support to citizens	• Trust-based delivery with Sevikas from the same communities. • Context-specific design: Each SSK adapts to rural–urban and regional differences. • Women's empowerment • 'User-centred design adaptation: Addresses barriers like mobility and low literacy. • Strong community–government linkages improve service delivery.
Indore and Delhi	Samagra Project Women entrepreneurship model to create resilient urban health ecosystem *Community women champions promoting information and access to entitlements*	• Haqdarshikas (trained local women entrepreneurs) deliver health entitlements. • Multi-lingual app provides details of 200+ welfare schemes for community use. • Haqdarshikas trained to access scheme and document information via the app. • Provide doorstep delivery of entitlements information and documents. • Partner with government health systems for integrated service delivery.	• Local women can be trained and empowered to improve scheme enrolment and their socio-economic status. • Community-based Haqdarshikas foster trust among members. • Self-help groups can be used to build local ties with the community and provide organisational support

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