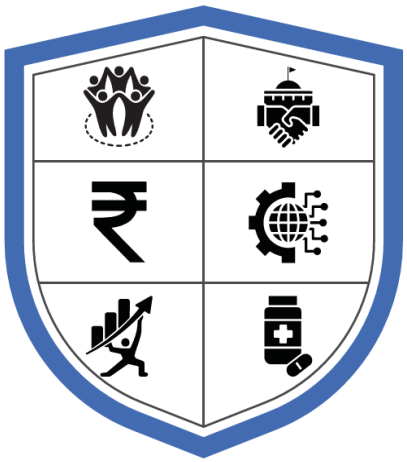
A GPS for UHC in India:
An Action Almanac



INDIAN SCHOOL OF PUBLIC POLICY

CENTRE FOR UNIVERSAL HEALTH ASSURANCE

A GPS for UHC in India: An Action Almanac



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INDIAN SCHOOL OF PUBLIC POLICY
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	The symbol represents **collective action and shared responsibility,** placing communities at the centre of health systems. Health is shaped through social **solidarity and community agency, highlighting participation, local knowledge, and accountability as essential to meaningful outcomes.**
	This symbol reflects **institutional authority and governance**, where societal values are translated into policy and law. It underscores the role of **evidence-informed decision-making** in advancing equity, a mechanism through which **justice is formalized and delivered**.
	The rupee signifies **resource allocation and financial protection** within health systems. It emphasizes that **equitable financing determines access and affordability**. Ultimately, it reflects the principle that **who pays vs who receives care**.
	This symbol represents **data, integration, and system connectivity** in modern health systems. Digital systems act as enablers of **efficiency, transparency, and accountability**. It highlights the role of technology in tracking disparities and enabling informed decisions.
	The symbol emphasizes the **centrality of the health workforce** in delivering care. It reflects the need for **training, equitable distribution, and sustained support.** Strong health systems are built on **human capacity, trust, and relationships.**
	This represents the **tools for affordable drugs, diagnosis, and treatment** within healthcare, highlighting the importance of **access, affordability, and availability** of medical innovations. Without these, the promise of care remains incomplete and unequal.

The shield brings all elements together as a **cohesive and interdependent system.** As a unified form, it represents collective protection, where health equity is achieved through **coordinated and sustained action across all pillars.**

**Reiterated within the cover page's umbrella of assurance, these symbols represent the aligned pillars that together operationalize and accelerate universal health assurance.*

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FOREWORD

As the most populous country in the world accelerates its journey towards the destination *Viksit Bharat*, the most frequently discussed topic in public policy is the rate of economic growth. The desired level of growth cannot be achieved without investing in population health, if we have to reap the demographic and gender dividends that are still on offer. Population health becomes a very important lever for benefitting from these dividends.

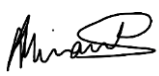
I have spent much of my professional life at the intersection of finance, institution-building and civil society; and have since spent considerable time with organisations working on education, governance and public health. Across all of it, the lesson that stays with me is a simple one: the quality of a society is ultimately measured not by the wealth it generates, but by the security it extends to its most vulnerable members. By that measure, India has unfinished business with its health system.

We are witnessing earnest efforts to strengthen the health systems, through increased financing and improved infrastructure. However, for hundreds of millions of Indian families today, a serious illness still remains a financial catastrophe waiting to happen. Many of the domestic workers, the small traders, or the daily-wage earners do not yet have a secure safety net when illness strikes. They borrow, they sell assets, they delay seeking care until it is too late, and they emerge from the experience poorer and more precariously positioned than before. This is the human reality behind the statistics in these pages.

That is why the Centre for Universal Health Assurance exists. At its core, Universal Health Coverage is not merely a technical undertaking. It reflects a fundamental choice about the kind of country we aspire to be: one where access to health care is not determined by place of birth, employment status, or ability to pay. The consensus, I believe, is clear. And the recommendations in this booklet offer a credible, evidence-grounded path toward making that answer a reality.

What gives me confidence is not just the quality of the analysis but the fact that India is not starting from scratch. The foundations are in place. What is needed now is the institutional commitment to build on them deliberately, equitably and with a clear-eyed understanding of who is being left behind and why.

I am grateful to Prof. K. Srinath Reddy and the team at CUHA for their rigour, their care and their persistence in pursuing the vision for health assurance for all Indians. This booklet is addressed to those who hold the levers of policy, and I hope it is received in the spirit in which it is offered: as a contribution from citizens who believe deeply in India's capacity to deliver on its most important promise. With a combination of political will, professional skill and people’s partnership, we can deliver this commitment to *Viksit Bharat*.



Luis Miranda
Chairperson and Co-founder
Indian School of Public Policy

CONTENTS

Glossary

Preface

- Section A: Health Financing and Financial Protection
- Section B: Human Resources for Health and Management
- Section C: Service Delivery and Quality
- Section D: Integrated Care and Continuity of Services
- Section E: Community Engagement, Participation and Accountability
- Section F: Medicines, Diagnostics and Technology

GLOSSARY

A

AAM: Ayushman Arogya Mandir
ABDM: Ayushman Bharat Digital Mission
ABHA: Ayushman Bharat Health Account
AB-PMJAY: Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana
ACSC: Ambulatory Care Sensitive Conditions
AI/ML: Artificial Intelligence / Machine Learning
AMR: Antimicrobial Resistance
AMSPs: Antimicrobial Stewardship Programmes
ANM: Auxiliary Nurse Midwife
ASHA: Accredited Social Health Activist
AWaRe: Access, Watch, Reserve

B

BPJS: Badan Penyelenggara Jaminan Sosial (Indonesia)
BPJS Kesehatan: Badan Penyelenggara Jaminan Sosial Kesehatan (Indonesia's Social Security Agency for Health)

C

CDSS: Clinical Decision Support System
CENABAST: Central Nacional de Abastecimiento (National Supply Center)
CHC: Community Health Centre
CMS: Centers for Medicare & Medicaid Services
CMSS: Central Medical Services Society
CoC: Continuum of Care
CPHC: Comprehensive Primary Health Care
CQC: Care Quality Commission (United Kingdom)

D

DIU: District Implementation Unit
DHS: District Health Authorities
DRG: Diagnosis-Related Group

E

EDL: Essential Diagnostics List
EHR: Electronic Health Record
EML: Essential Medicines Lists
ESF: Estratégia Saúde da Família (Brazil's Family Health Strategy)

F

FHIR (HL7 FHIR): Fast Healthcare Interoperability Resources

H

HBPs: Health Benefit Packages
HEP: Health Extension Program (Ethiopia)
HIE: Health Infromation Exchange

I

ICD: Integrated Care Delivery
ICMR: Indian Council of Medical Research
ICP: Integrated Care Pathway
IEC: Information, Education and Communication
IIPH: Indian Institute of Public Health
IPCHS: Integrated People-Centred Health Services

J

JAS: Jan Arogya Samiti
JKN: Jaminan Kesehatan Nasional (Indonesia)

K

KILA: Kerala Insitute of Local Administration

L

LMIS: Logistics Management Information System
LOINC: Logical Observation Identifiers Names and Codes

M

MD: Doctor of Medicine
MLHP: Mid-Level Health Provider

MoHFW: Ministry of Health and Family Welfare
MPH: Master of Public Health
MRI: MRI stands for Magnetic Resonance Imaging.

N

NABH: National Accreditation Board for Hospitals & Healthcare Providers
NACP: National AIDS Control Programme
NAFU: National Anti-Fraud Unit
NAP-AMR: National Action Plan on Antimicrobial Resistance
NCD / NCDs: Non-Communicable Disease(s)
NEDL: National Essential Diagnostics List
NFHS: National Family Health Survey
NFSA: National Food Security Act
NHA (Accounts): National Health Accounts (tracks India's health expenditure)
NHA (Authority): National Health Authority (implements PM-JAY)
NHCX: National Health Claims Exchange
NHM: National Health Mission
NHS: National Health Service (United Kingdom)
NHSO: National Health Security Office (Thailand)
NICE:National Institute for Health and Care Excellence
NIHFW: National Institute of Health and Family Welfare
NLEM: National List of Essential Medicines
NQAS: National Quality Assurance Standards
NSSO: National Sample Survey Office

O

OECD: Organisation for Economic Co-operation and Development
OOPE: Out-of-Pocket Expenditure

P

P4P: Pay-for-Performance
PBF/PBF Model: Performance-Based Financing / Funding
PHC: Primary Health Centre
PM-JAY: Pradhan Mantri Jan Arogya Yojana
PM-JAY+:Expanded PM-JAY model for the "missing middle"
PPSA: Patient Provider Support Agency
PREMs: Patient-Reported Experience Measures

R

RKS: Rogi Kalyan Samitis
RMSCL: Rajasthan Medical Services Corporation Limited
RSBY: Rashtriya Swasthya Bima Yojana

S

SEWA: Self-Employed Women's Association
SHA: State Health Agency
SHI: Social Health Insurance (Vietnam)
SHSRC/SHSRCs: State Health Systems Resource Centre(s)
SLA: Service Level Agreement
SNOMED CT: Systematized Nomenclature of Medicine
STG: Standard Treatment Guidelines
SUS: Sistema Único de Saúde (Brazil)

T

TB: Tuberculosis
TNMSC: - Tamil Nadu Medical Services Corporation
TMS: Transaction Management System

U

UCS: Universal Coverage Scheme (Thailand)
UHC: Universal Health Coverage

V

VHSNC: Village Health Sanitation and Nutrition Committee

W

WHO: World Health Organization

PREFACE

India stands at a consequential juncture in its journey toward Universal Health Coverage. The constitutional commitment to health as a fundamental right, the policy ambition of Ayushman Bharat, and the sustained expansion of public health infrastructure over the past decade have together created a foundation of genuine strength. **Yet the distance between what has been built and what the country's 1.4 billion citizens deserve in terms of access, quality and financial protection remains significant.**

> *The highest aspiration of any health system is that no citizen should forgo care because of cost, distance or the absence of a qualified provider.*

The recommendations contained in this booklet are offered not as a critique of the considerable progress made, but as an evidence-informed contribution to the next phase of reform. They emerge from sustained engagement with the health system across its many dimensions: financing, workforce, service delivery, medicines, integrated care and community participation. They spring from a recognition that advancing Universal Health Coverage in India requires simultaneous action on all of these fronts, pursued with coherence, urgency and long-term institutional commitment.

The most persistent and consequential gap in India's health system today is financial. **Despite PM-JAY's remarkable scale which covers over 500 million of the country's poorest citizens, out-of-pocket expenditure remains very high as a share of total health spending.** The burden falls not only on the uninsured poor but on the vast 'missing middle': the hundreds of millions of informal workers and self-employed households who are neither poor enough for public subsidy nor formally employed enough for contributory schemes. For this population, a serious illness remains what it has always been - a financial catastrophe that can undo years of careful household saving in a matter of weeks.

Beneath the financing gap lies a deeper structural challenge. **A health system is only as strong as the workforce that operates it, the primary care infrastructure that anchors it, the medicines and diagnostics that equip it, and the communities that trust it.** India's progress on each of these dimensions has been real but uneven. Health and Wellness Centres have extended the physical reach of primary care; but inadequate financing, vacant posts and outdated drug supplies limit what they can deliver. A large and distributed workforce of nurses, mid-level providers and community health workers exists; but regulatory frameworks have not kept pace with the competencies they possess or the roles they are capable of playing. While community engagement platforms have been established by policy, in the absence of legal backing and institutional support, they remain largely ceremonial in the absence of legal backing and institutional support. These limitations need to be addressed if Ayushman Bharat has to fulfil its promise and potential.

This booklet sets out recommendations across six interconnected domains: **health financing and financial protection; human resources for health and management; service delivery and quality; integrated care and continuity; community engagement and accountability; medicines,**

diagnostics and technology. Taken together, they constitute a reform agenda for the next decade of India's UHC journey. The title, *A GPS for UHC in India*, is deliberate. **Unlike a fixed roadmap, a GPS adapts to changing conditions while remaining anchored to a clear destination.** In a complex and evolving system such as India's, pathways to reform will necessarily vary across states and over time, but the goal of equitable, high-quality and financially protective care for all remains constant. One that builds on the foundations already laid, addresses the structural gaps that constrain the system's performance, and positions India to meet the health expectations of a population that is better informed, more demanding and more deserving of responsive governance than at any previous point in the country.

The recommendations are deliberately practical. Each is grounded in evidence, situated within India's existing institutional landscape and informed by the experience of states and countries that have navigated similar challenges. **They are not proposals for a new architecture to replace what exists, but are proposals for strengthening, aligning and completing what India has already begun to build.** Where new financing is required, the case for it is made. Where existing resources are being poorly deployed, the reforms needed to deploy them better are specified. Where governance arrangements are limiting the system's capacity to serve its population, the institutional changes that would unlock that capacity are described.

This booklet is addressed to those who hold the levers of change: members of Parliament who shape the legislative and budgetary framework within which the health system operates; Union and State Health Secretaries who design and implement national programmes; Finance Secretaries and Planning officials who determine how public resources are allocated; senior administrators and health system leaders who translate policy into the day-to-day functioning of facilities, schemes and workforces across the country.

The recommendations are offered with respect for the complexity of governance and the constraints within which policy is made. They are not presented as simple solutions to complicated problems. Health systems are among the most complex organisations that societies build and they must simultaneously sustain quality across an enormous range of settings and conditions. The reforms proposed here are attentive to that complexity. They suggest sequencing, identify entry points and point to the institutional arrangements, both within and across government, that can make implementation feasible.

What is asked of the reader is engagement: with the evidence on which these recommendations rest, with the experience of states and countries that have confronted similar challenges, and with the fundamental proposition that **the health of India's population is both a moral obligation of governance and a prerequisite for the country's social and economic future.** A population that is healthier is also more productive, more resilient and more capable of participating fully in the life of a democratic society. The case for investing in Universal Health Coverage is, ultimately, inseparable from the case for the Viksit Bharat that all its citizens deeply desire to be part of.

The Centre for Universal Health Assurance is grateful to the many experts, practitioners, community voices and policymakers whose knowledge and experience have informed this work. We commend these recommendations to the attention of those who carry the responsibility of governance, and express our confidence that India's health system, with the right policy choices and the sustained commitment of its institutions and its people, is capable of delivering on the promise of **'Health for All'**.

SECTION A: HEALTH FINANCING AND FINANCIAL PROTECTION

A.1 Expand Publicly Financed Health Benefits to Include Outpatient Care, Medicines and Diagnostics

WHAT

India's publicly financed health benefit packages have made significant strides in protecting households from the catastrophic costs of hospitalisation. **However, the architecture of financial protection must now be extended to cover outpatient consultations, essential medicines and diagnostics**, particularly for the growing burden of chronic, non-communicable conditions. This calls for a deliberate expansion of Health Benefit Packages (HBPs) to include bundled outpatient care, **moving beyond a hospitalisation-centric model toward one that reflects the full continuum of health need.**

> *The largest share of out-of-pocket expenditure in India arises from cumulative costs of routine interactions that patients have with outpatient services.*

WHY

Rs. 910 Avg. OOPE per outpatient visit (2018)[1]	**Rs. 8,811** Monthly outpatient OOPE for cancer patients	**Rs. 6,549** Monthly inpatient OOPE for cancer patients[2]

For millions living with diabetes, hypertension and cancer, **the financial burden is chronic,** recurring month after month, year after year. Among cancer patients, monthly outpatient costs exceed inpatient costs, a stark inversion of the assumptions that underpin hospital-focused insurance design. **Insurance models that cover only hospitalisation offer incomplete protection and may inadvertently mask forgone care.** Patients who cannot afford outpatient visits simply do not seek them, and their conditions worsen until hospitalisation becomes unavoidable. This is neither financially efficient nor clinically sound, and it runs counter to India's stated commitment to achieving UHC.

HOW

Addressing this gap requires both a design reform and an operational commitment. **The inclusion of outpatient care within HBPs under PM-JAY should be approached not as an addendum but as**

[1] Bidhubhusan Mohanty et al., "Health Index Scores and Health Insurance Coverage across India: A State-Level Analysis," *Global Health Action* 15, no. 1 (2022): 2114156, **https://doi.org/10.1080/16549716.2022.2114156.**

[2] Goyanka R, Yadav J, Sharma P, "Financial burden and coping strategies for cancer care in India", *Clinical Epidemiology and Global Health,* 2023; 20, https://doi.org/10.1016/j.cegh.2023.101259

a structural reconfiguration, a reform that positions primary and outpatient care as the foundation of financial protection rather than an afterthought to it. Key steps include:

- Develop **standardised, bundled outpatient packages** covering consultations, essential diagnostics and medicines as an integrated unit.
- Calibrate reimbursement rates through systematic costing studies, accounting for variation across levels of care from sub-district HWCs to district hospitals.
- **Leverage the existing PM-JAY empanelled infrastructure** of both public and private hospitals without creating parallel structures.
- Align AAM and NHM financing frameworks to ensure outpatient benefits reach the primary care level.
- **Integrate qualified AYUSH practitioners into primary care** service delivery within a clearly defined regulatory and quality assurance framework, including standardized treatment protocols.

The National Health Authority, in close coordination with State Health Agencies and MoHFW, must lead this effort. **The most immediate entry point is the existing HBP revision cycle of PM-JAY**, with pilot implementation in states with stronger empanelment infrastructure generating evidence for a phased national scale-up. Integration with the Ayushman Bharat Digital Mission (ABDM) and linking it with ABHA IDs would further support continuity, enabling patient records to follow individuals across outpatient visits.

WHO SHOULD IMPLEMENT: ·National Health Authority · State Health Agencies · MoHFW · Empanelled Providers

WHERE TO IMPLEMENT: ·HBP revision cycle of PM-JAY; ·States with stronger empanelment infrastructure for pilot implementation

MODELS TO LEARN FROM

India

Rajasthan: Mukhyamantri Nishulk Dawa and Jaanch Yojana

Providing free medicines and diagnostics at public facilities, Rajasthan documented measurable reductions in household OOPE and improved service utilisation among low-income populations.[3] Its success rested on centralised pooled procurement, a regularly updated formulary aligned with actual disease burden, and strict institutional accountability for stock-out prevention.

Global

Thailand: Universal Coverage Scheme (UCS)

Launched in 2002, the UCS extended comprehensive outpatient and inpatient coverage using a capitation-based model anchored in primary care.[4] Independent evaluations documented significant reductions in catastrophic health expenditure and improved equity across income quintiles. Thailand's trajectory offers both a strategic template and a proof of concept for the reforms proposed here.

[3] Dev, I. M., S. Ankita, and R. Singh. "Free drug distribution in Rajasthan". *Tropical Journal of Pharmaceutical and Life Sciences*, vol. 8, no. 1, Feb. 2021, pp. 29-35, doi:10.61280/tjpls.v8i1.62.

[4] Kirdruang P, Glewwe P. The Impact of Universal Health Coverage on Households' Consumption and Savings in Thailand. J Asia Pac Econ. 2018;23(1):78-98. doi: 10.1080/13547860.2017.1359893. Epub 2017 Aug 9. PMID: 29937685; PMCID: PMC6010062.

A.2 Increase and Prioritise Public Financing for Primary Health Care

WHAT

Robust and predictable public financing for primary health care is the cornerstone of any credible Universal Health Coverage strategy. This recommendation calls for the allocation of adequate, **ring-fenced funds to primary health care aligned with National Health Policy 2017 targets, and for the deliberate realignment of existing financing streams** under NHM, Ayushman Arogya Mandirs and PM-JAY toward first-contact care. The goal is not merely to increase the quantum of resources flowing to primary care, **but to ensure those resources are protected, predictably disbursed and operationally effective.**

> *The National Health Policy 2017 recommends 70% of public health spending on primary care. Current spending stands at approximately 50%; a gap that is not marginal but structural, and one that quietly constrains the system's ability to deliver on its stated ambitions. (National Health Accounts, 2022)*

WHY

The transformation of Sub-Health Centres and PHCs into Health and Wellness Centres (Ayushman Arogya Mandirs) represents a genuine policy commitment to repositioning primary care. **Yet the expansion of the platform has not been uniformly matched by the financing required to make it functional.** The consequences are visible across the care continuum:

- HWCs without reliable operational budgets cannot maintain staffing continuity, ensure uninterrupted medicine supply or sustain expanded service packages.
- **Where primary care is under-resourced, patients make a rational choice to bypass it**, seeking care directly at district hospitals where costs are higher and the system more congested.
- The resulting pressure on secondary and tertiary care is both inefficient and inequitable, falling hardest on those least able to bear it.

Weak primary care financing generates a compounding cost to households, to the system and to the broader UHC agenda.

HOW

- **Allocate at least 8% of state budgets to health**, with a minimum of 70% directed to primary and preventive care.
- Maintain ring-fencing through budget execution, not merely at the point of appropriation but with clear accounting mechanisms.
- **Release operational budgets for HWCs on a reliable, predictable schedule**, enabling facility managers to plan staffing and procure medicines without mid-year disruptions.

- Engage Finance Departments as equal partners in designing protected budget lines for primary care.
- **Rationalise and align NHM, AAM and PM-JAY financing streams** to eliminate duplication and fill gaps, under the stewardship of MoHFW and State NHM leadership.

The HWC network under Ayushman Bharat, now numbering over 1.8 lakh functional facilities, offers a ready infrastructure through which enhanced financing can be channelled, provided that operational accountability systems are simultaneously strengthened.[5] **Linking budget releases to verified service readiness indicators** at facility level would further ensure that increased resources translate into improved care.

WHO SHOULD IMPLEMENT: State Governments · MoHFW · Finance Departments · NHM Leadership

WHERE TO IMPLEMENT: ·Annual state budget and NHM Programme Implementation Plan cycles; · HWC network under Ayushman Bharat

MODELS TO LEARN FROM

India

Kerala: Family Health Centres

Kerala's transformation of PHCs into Family Health Centres through infrastructure investment, stable staffing and expanded services has progressively shifted utilisation patterns toward primary care. The results were improved continuity of care, higher patient satisfaction and reduced pressure on district hospitals. The returns on primary care investment were systemic, redistributing demand across the care continuum in ways that benefit both patients and the health system.

Global

Thailand: Capitation-Based Primary Care Financing

Thailand's UCS was designed around a capitation-based payment model that rewarded primary care providers for population-level outcomes rather than volume.[6] This incentivised prevention and chronic disease management, reducing unnecessary hospital admissions and catastrophic household expenditure. Thailand's experience demonstrates that the manner in which primary care is financed matters as much as the quantum.

[5] Ayushman Arogya Mandir, Ministry of Health and Family Welfare https://aam.mohfw.gov.in/
[6] V. Tangcharoensathien, R. Suphanchaimat, N. Thammatacharee, W. Patcharanarumol, *Economic & Political Weekly* 2012, *xlviI*, 53.

A.3 Strategically Engage Private Providers to Deliver Publicly Financed Primary Care in Underserved Areas

WHAT

India's private health sector is vast, dispersed and deeply embedded in everyday health-seeking behaviour but **represents an underutilised asset in the country's pursuit of Universal Health Coverage.** This recommendation calls for the structured empanelment of private sector doctors, solo practitioners and single-doctor clinics to deliver publicly financed primary health care where government provision is inadequate. **The objective is not to substitute public investment but to extend its reach**, deploying existing private capacity within a framework of standardised protocols, fixed rates and defined accountability.

> *In many underserved areas, the private sector already functions as the de facto primary care system. Ignoring this capacity perpetuates inequity. It does not protect the integrity of public provision.*

WHY

Despite significant expansion of public primary care infrastructure, large parts of rural, tribal and peri-urban India continue to experience acute shortages of accessible first-contact care. **Households turn to private providers not by preference but by necessity**, **paying entirely out of pocket for services that a well-functioning public system ought to deliver free of charge.** This represents a dual failure: patients incur avoidable expenditure while public financing fails to reach those most in need because the facilities through which it flows are absent, understaffed or inaccessible.

The private sector's limitations are real. Quality is variable and regulatory oversight is uneven. **But these are arguments for structured engagement with appropriate safeguards, not for exclusion.**

HOW

- Screen and empanel **quality-verified solo practitioners and single-doctor clinics** against minimum infrastructure and qualification standards.
- Govern services through **fixed, pre-determined rates** covering consultations and a defined essential medicines package, removing provider incentives to profit from medicine sales.
- **Integrate accredited pharmacies within the empanelled network** to support timely and reliable dispensing of **quality-assured** prescribed medicines.
- Adapt the **Patient Provider Support Agency (PPSA) model** for provider onboarding, training, performance monitoring and grievance redressal.
- Make **Standard Treatment Guidelines mandatory** for empanelled providers, with adherence subject to periodic audit.

State Health Agencies and District Health Authorities, working under the National Health Authority's framework, should lead empanelment and oversight at the local level. **The operational infrastructure of PM-JAY (empanelment processes, claims management systems and beneficiary identification frameworks) provides a ready foundation** that can be adapted without building parallel structures from scratch.

WHO SHOULD IMPLEMENT: State Health Agencies · National Health Authority · District Health Authorities

WHERE TO IMPLEMENT: Underserved rural, tribal and peri-urban areas; aspirational districts and areas with high government facility vacancy rates.

MODELS TO LEARN FROM

India

National TB Programme: PPSA Model

The Patient-Provider Support Agency framework brought private TB providers into a publicly financed, protocol-governed system through structured empanelment, mandatory STG adherence and performance-linked engagement.[7] It demonstrably improved treatment adherence and outcomes among privately treated patients. Its architecture, combining provider accountability with active facilitation support, translates well to the broader primary care context.

Global

Brazil: Family Health Strategy

Brazil's publicly financed family health teams, deployed across underserved communities including areas with limited public infrastructure, achieved significant reductions in infant mortality and hospitalisation for primary-care-amenable conditions over two decades.[8] The critical success factors were not the ownership status of providers but the clarity of the service mandate, the adequacy of financing and the rigour of the accountability framework.

[7] National TB Elimination Programme, "Patient Provider Support Agency [PPSA]: A Multipronged Approach to Engage the Private Sector," https://ntep.in/node/1169/CP-patient-provider-support-agency-ppsa-multipronged-approach-engage-private-sector.

[8] M. Bastos, D. Menzies, T. Hone, K. Dehghani, A. Trajman, *PLoS One* **2017**, *12*, e0182336.

A.4 Extend Health Insurance Coverage to the 'Missing Middle' Through Graded Co-Payment Mechanisms

WHAT

India's health financing landscape contains a significant and largely unaddressed gap. **A population of approximately 404 million people (nearly 30% of the country) falls outside any form of organised health coverage.** This recommendation calls for the introduction of an optional, income-linked co-payment model: **PM-JAY+,** extending PM-JAY's architecture and benefits to the uncovered middle segment through graded premiums and co-payments calibrated to household income, within a structured and pooled insurance framework.

> *The 'missing middle' is caught in a structural bind: too prosperous for full public subsidy, too economically precarious for adequate self-protection. For this population, a serious illness is frequently a financial catastrophe.*

WHY

404M[9]	**~180M**	**500M+**
People with no organised health coverage	Covered under private or employer-based insurance	PM-JAY beneficiaries at the lower end

The group engaged in informal employment, self-employment and petty trade relies on an overstretched public system or pays fully out of pocket. **As India's informal economy remains large and the transition to formal employment slow, this gap will persist without deliberate policy intervention.** A population this large, cycling between financial stress and foregone care, generates demand patterns that are inefficient for the system as a whole; delaying care until hospitalisation becomes unavoidable, crowding tertiary facilities and driving up costs.

HOW

The PM-JAY+ model rests on a clear design principle: **the level of financial contribution required from a household should be proportionate to its capacity to pay.** Key design features:

- **Income-graded premiums and co-payments** calibrated across income bands above the PM-JAY eligibility threshold but below formal sector coverage.
- **Voluntary opt-in and opt-out provisions**, reducing adverse selection risks while respecting household agency.
- **Pool PM-JAY+ contributions under the National Health Authority and State Health Assurance Societies**, integrated within the broader PM-JAY ecosystem enabling access to the same empanelled provider network, benefit packages and claims infrastructure.

[9] Health Insurance for India's Missing Middle, NITI Aayog, 2021

- Cross-subsidisation within the pool, where higher-income contributors partially support lower-income ones, **strengthening equity without requiring additional public subsidy.**
- Premium setting informed by willingness-to-pay studies and household expenditure surveys to ensure genuine affordability.

The PM-JAY digital and administrative infrastructure provides a ready platform (beneficiary identification, empanelment, claims management and grievance redressal) without necessitating parallel systems. Dynamic income verification mechanisms using Aadhaar-linked financial data and GST records will need to be developed and piloted. States with higher concentrations of informal sector workers should be prioritised for early implementation.

WHO SHOULD IMPLEMENT: National Health Authority · State Health Assurance Societies · MoHFW

WHERE TO IMPLEMENT: States with higher concentrations of informal sector workers and larger missing middle populations; PM-JAY digital ecosystem.

MODELS TO LEARN FROM

India

Karnataka: Arogya Karnataka

Karnataka extended coverage beyond PM-JAY through a co-payment mechanism for higher-income households within a unified framework.[10] The model demonstrated that tiered coverage is administratively feasible and does not compromise equity when co-payment levels are set with sensitivity to household income. Mizoram's state-funded top-ups offer a complementary lesson in how smaller states can move faster when political will and administrative systems are aligned.[11]

Global

Vietnam: Social Health Insurance

Vietnam developed distinct enrolment pathways for the poor, near-poor and informal workers, all pooled into a single national fund, achieving near-universal coverage with documented reductions in OOPE among informal sector households. *When contributory and subsidised streams are pooled rather than siloed, the system gains both financial resilience and equity.*

[10] P. Sancheti et al., "Road to Universal Health Coverage: Unique Model of Karnataka, India," *International Journal of Community Medicine and Public Health* 10, no. 5 (2023): 1947–54, https://doi.org/10.18203/2394-6040.ijcmph20231301.

[11] Press Information Bureau, "Government of India Signs $32 Million Loan with World Bank for Improving Healthcare Services in Mizoram," 24 June 2021, https://www.pib.gov.in/PressReleasePage.aspx?PRID=1730027&reg=3&lang=2.

A.5 Strengthen PM-JAY Purchasing, Quality Oversight and Provider Payment Systems

WHAT

PM-JAY has established one of the world's largest publicly financed health insurance programmes. **Realising its full potential requires moving beyond coverage expansion to strengthen the quality and integrity of what that coverage delivers**, reinforcing the programme's role as a strategic purchaser of care rather than a passive reimbursor of services. This calls for systematic improvements to hospital empanelment, quality monitoring frameworks, claims management and regulation of provider behaviour.

> *Coverage on paper and coverage in practice remain two different things. A PM-JAY card that cannot be used in an aspirational district offers financial protection in name only.*

WHY

PM-JAY's implementation across the majority of Indian states points to a set of recurring and addressable limitations that constrain its financial protection mandate:

- **Geographic skew**: Aspirational districts are systematically under-served as private hospitals cluster where commercial viability is highest.
- **Provider behaviour**: Double billing, inflated procedure costs and high readmission rates erode the scheme's financial integrity and beneficiary trust.
- **Claims delays**: Reimbursement lags deter provider participation, particularly among public hospitals and smaller private facilities that lack liquidity.
- **Outdated beneficiary data**: Static eligibility databases create exclusion errors and leakage, compromising targeting efficiency at the foundation.

HOW

Strengthening PM-JAY as a strategic purchaser requires action across four interconnected dimensions:

- **Empanelment equity**: Institute geographic criteria prioritising aspirational and underserved districts; offer flexible reimbursement rates for facilities in low-density areas to make participation commercially viable.
- **Payment reform**: Link provider payments to quality metrics (readmission rates, Standard Treatment Guidelines adherence and patient-reported outcomes) reorienting incentives toward clinical value over volume.
- **Claims efficiency**: Deploy AI-assisted claims adjudication, simplify documentation requirements and fully utilise the **National Health Claim Exchange (NHCX)** for standardised, accelerated claims flows with clear settlement timelines.

- **Beneficiary management**: Update identification using dynamic datasets (National Food Security Act rolls, Aadhaar-linked data); strengthen grievance redressal with accessible and time-bound complaint resolution channels.

Quality Assurance Bodies and clinical regulators must be more actively integrated into the oversight architecture, **moving beyond accreditation as a one-time entry condition to continuous monitoring of provider performance.**

WHO SHOULD IMPLEMENT: National Health Authority · State Health Agencies · Quality Assurance Bodies · Clinical Regulators

WHERE TO IMPLEMENT: PM-JAY implementation reforms across all states; states piloting quality-linked payments and advanced claims analytics.

MODELS TO LEARN FROM

India

Gujarat: PM-JAY Trust Model

Gujarat's direct state management of claims, rather than delegation to third-party insurers, enabled granular monitoring of provider behaviour, faster identification of billing irregularities and stronger STG enforcement.[12] The model illustrates how state-led strategic purchasing, backed by institutional capacity and political commitment, improves both the efficiency and integrity of scheme implementation.

Global

Thailand: NHSO Strategic Purchasing

Thailand's NHSO operates as an independent purchasing agency combining capitation for primary care with Diagnosis-Related Group-based hospital payments.[13] Independent auditing, provider performance monitoring and transparent public reporting demonstrate that the transition from passive reimbursement to active strategic purchasing is both technically feasible and essential to controlling costs and improving quality as a publicly financed scheme matures.

[12] A. Saxena, M. Trivedi, Z. C. Shroff, and M. Sharma, "Improving Hospital-Based Processes for Effective Implementation of Government Funded Health Insurance Schemes: Evidence from Early Implementation of PM-JAY in India," *BMC Health Services Research* 22, no. 1 (2022): 73, https://doi.org/10.1186/s12913-021-07448-3.

[13] National Health Security Office (NHSO), Thailand, *The National Health Security Office (NHSO), Thailand* (ASEAN Social Security Association, n.d.), https://www.asean-ssa.org/files/Organisation%20Profiles/NHSO%20Thailand.pdf.

A.6 Pool Fragmented Health Funds Across Schemes and Levels of Government

WHAT

India's health financing landscape is characterised by a multiplicity of schemes, funding streams and administrative structures that, despite shared objectives, **operate in considerable isolation from one another.** This recommendation calls for the progressive consolidation of fragmented public health financing spanning NHM, PM-JAY and state-sponsored insurance schemes, **into unified pools managed at the state level, operating increasingly through a capitation mode.** Consolidated pools would enable more rational resource allocation, stronger purchasing power and greater equity in the distribution of public health resources.

> *Fragmented pools mean fragmented purchasing power. When resources are dispersed across administrative silos, the state cannot negotiate effectively with providers, set rational prices or plan strategically for its population's health.*

WHY

India's public health financing architecture has evolved incrementally, layering scheme upon scheme without a corresponding rationalisation of the underlying structure. The consequences are systemic:

- Duplication of effort and conflicting provider incentives within the same facility network.
- Beneficiaries navigating a confusing and opaque landscape of eligibility conditions and entitlements.
- **Inequities when coverage varies by employment type, geography or administrative category**, leaving some populations multiply covered and others entirely excluded.
- **Fragmentation weakens the state's capacity to act as a strategic purchaser**. Dispersed resources cannot deliver the consolidated negotiating power or coherent quality signals that effective purchasing requires.

HOW

Consolidation is best approached as a phased process, **beginning with partial pooling at the state level** rather than an immediate and administratively complex national integration. Key steps:

- **Align benefit packages across NHM, PM-JAY and state schemes** by removing overlaps, filling gaps and establishing a coherent continuum of entitlements that follows a beneficiary from primary care through to tertiary hospitalisation.
- **Harmonise provider payment systems and shift progressively toward a capitation mode** under which providers receive a risk-adjusted per-capita payment for a defined enrolled population, aligning incentives with population health outcomes and rewarding continuity over episodic treatment.
- Introduce a **phased payment reform, beginning with DRG-based payments** for hospitalisation and **progressively transitioning toward capitation** for primary care as data systems and provider readiness improve.

- **Designate State Health Agencies as apex pooling and purchasing bodies** with clear mandates, ring-fenced fund management and the analytical capacity to translate consolidated resources into intelligent purchasing decisions
- **Leverage ABDM's digital infrastructure** (unique health IDs, shared provider registries and standardised claims data) to enable **real-time monitoring and analytics that strategic purchasing demands**

WHO SHOULD IMPLEMENT: MoHFW · State Health Agencies · National Health Authority
WHERE TO IMPLEMENT: State level; trust model states for initial pooling pilots; ABDM-enabled digital ecosystem

MODELS TO LEARN FROM

India

Andhra Pradesh: Aarogyasri Trust

By consolidating multiple state financing streams under a single trust-managed pool, Andhra Pradesh reduced administrative duplication, established unified provider empanelment and improved its capacity to monitor claims and enforce standards.[14] The model demonstrates the administrative and operational feasibility of pooling within India's federal health financing context.

Global

Indonesia: JKN* Reform
Thailand: NHSO

Indonesia's consolidation of fragmented schemes into a single national pool (BPJS Kesehatan) created genuine risk pooling, a unified payment system and measurable improvements in coverage equity. Thailand's NHSO further demonstrates how capitation-based purchasing through a unified pool can sustain both cost discipline and quality improvement over the long run.[15]

**JKN – Jaminan Kesehatan Nasional*

[14] Dr. NTR Vaidya Seva Trust, "ASRI Scheme," https://drntrvaidyaseva.ap.gov.in/asri.
[15] Alkayyis, M. Y. . (2024). Implementation of the National Health Insurance Programme in Achieving Universal Health Coverage in Indonesia. *Jurnal Jaminan Kesehatan Nasional*, *4*(2), 85–95. https://doi.org/10.53756/jjkn.v4i2.197

A.7 Shift from Volume-Based Payments to Value-Based and Outcome-Linked Financing

WHAT

The manner in which health systems pay their providers shapes, more powerfully than almost any other policy lever, the incentives that drive clinical behaviour, resource use and the quality of care that patients receive. This recommendation calls for a deliberate, phased transition away from fee-for-service payment models, which reward the volume of services delivered regardless of their appropriateness or effect, toward payment frameworks that link provider remuneration to outcomes, quality and continuity of care. **Within PM-JAY, this transition should be anchored in bundled payment pilots for NCDs**, supported by quality scorecards and progressively expanded as evidence and institutional capacity accumulate.

> *Volume-based payment does not merely incentivise overuse. It actively discourages the coordinated, longitudinal care that chronic conditions demand. As India's NCD burden grows, this misalignment becomes increasingly costly.*

WHY

Fee-for-service reimburses providers for doing (more procedures, investigations and admissions) irrespective of clinical necessity or patient benefit. **For patients managing chronic NCDs such as diabetes, hypertension and cardiovascular disease, the inadequacy of volume-based models is particularly acute.** These conditions require sustained, coordinated care across multiple providers and settings over extended time horizons. They are poorly served by a payment model that incentivises discrete, high-volume encounters rather than longitudinal health management. The result is overuse of high-margin procedures, fragmented care episodes and cost escalation that erodes the financial protection that insurance is designed to provide.

HOW

The transition is best approached as a phased reform, beginning with targeted pilots that generate evidence and build institutional capacity before broader adoption:

- Introduce **bundled payments for defined NCD care pathways** - a single prospectively determined payment covering the full episode from initial diagnosis through ongoing management and complication prevention for conditions such as diabetes, hypertension and coronary artery disease.
- Deploy **quality scorecards** measuring STG adherence, readmission rates, patient-reported experience and follow-up completion rates, forming the evidentiary basis for outcome-linked payment adjustments.

- **Pay for continuity**: compensate providers for maintaining registered patients in active, ongoing care and not just for treating acute episodes, particularly relevant for HWCs and empanelled primary care practitioners
- Identify **2 to 3 NCD pilot conditions** in states with strong claims data systems, higher PM-JAY utilisation and more developed provider networks; systematically evaluate before scale-up. **Invest in ABDM digital infrastructure in parallel** longitudinal health records and interoperable claims data which are prerequisites for the cross-provider outcome tracking that value-based payment requires

The National Health Authority, working with State Purchasers and clinical regulators, should design and oversee these reforms. **Health Technology Assessment inputs must inform the process** to ensure that incentivised outcomes are clinically meaningful and payment levels are fiscally sustainable.

WHO SHOULD IMPLEMENT: National Health Authority · State Purchasers · Clinical Regulators · HTA Bodies

WHERE TO IMPLEMENT: PM-JAY pilot and innovation framework; states with strong claims data and developed provider networks.

MODELS TO LEARN FROM

India

Tamil Nadu: Performance-Linked Financing

Tamil Nadu linked facility financial allocations and staff incentives to service delivery indicators including immunisation, NCD screening and institutional deliveries.[16] This demonstrates that Indian health systems are capable of designing and administering outcome-linked payment models within existing institutional structures, and that providers respond when incentives are clearly defined, consistently applied and accompanied by adequate operational support.

Global

Rwanda: Performance-Based Financing
OECD: Value-Based Care

Rwanda's nationally scaled PBF model linked facility payments to verified outputs, documenting significant improvements in service utilisation, quality and health worker motivation, particularly in rural and underserved areas.[17] OECD experience further confirms that sustained investment in measurement, transparency and provider engagement is what determines whether the transition to value-based care delivers on its promise.[18]

[16] Press Information Bureau, "Press Release," https://www.pib.gov.in/Pressreleaseshare.aspx?PRID=1573446&reg=3&lang=2.
[17] Press Information Bureau, "Press Release," https://www.pib.gov.in/Pressreleaseshare.aspx?PRID=1573446&reg=3&lang=2.
[18] Tang B, Li Z, Liu Y, Zhu F. Transforming Healthcare Through Value: A Fiscal Perspective on OECD Countries. Risk Manag Healthc Policy. 2025 Feb 13;18:479-490. doi: 10.2147/RMHP.S504275. PMID: 39963541; PMCID: PMC11831919.

SECTION B: HUMAN RESOURCES FOR HEALTH AND MANAGEMENT

B.1 Establish Public Health and Health Systems Management Cadres in All States

WHAT

Effective public health governance demands a workforce skilled not only in clinical medicine but in epidemiology, health systems management, policy analysis, programme planning and community health. **This recommendation calls for the establishment of dedicated public health and health systems management cadres in all states**. Structured career streams that attract, develop and retain professionals with the multidisciplinary expertise that population-level health programmes require. The goal is to create an institutionalised leadership pipeline for public health that complements clinical services and strengthens the governance, planning and accountability functions on which a high-performing health system depends.

> *Public health programmes need multidisciplinary, health systems expertise that is distinct from the clinical expertise required for individual patient care. There is a persistent mismatch between clinical training and public health programme needs.*

WHY

India's public health system has historically been administered largely by clinicians whose training is directed toward individual patient care rather than population-level functions of surveillance, prevention, programme management and health systems governance. As the health system has grown in complexity, managing an expanding portfolio of national programmes, navigating a mixed public-private landscape and advancing a multidimensional UHC agenda in a federal system with **differentiated but partly overlapping roles and responsibilities**, **the limitations of a purely clinically oriented administrative structure have become increasingly apparent.**

Designing immunisation campaigns, analysing disease surveillance data, evaluating health financing schemes and leading district health planning processes all demand a different constellation of skills than those developed through clinical training. **When these functions are assigned by default to clinicians without dedicated preparation in health systems or public health management, the result is a structural mismatch**, not of intent but of expertise that manifests in uneven programme implementation, variable district health planning quality and persistent gaps between policy design and operational delivery.

HOW

Establishing public health cadres requires simultaneous action on three fronts: defining the cadre architecture, building the recruitment and training pipeline, and ensuring that the cadre is positioned with sufficient authority and career prospects to attract high-quality professionals.

- **Define cadre roles and responsibilities,** clearly distinct from those of clinical medical officers, spanning field-level public health management, district health planning, programme monitoring, health financing oversight and state-level policy analysis.
- Map **transparent career pathways from entry-level field postings through to senior leadership positions**, with clear promotion criteria and structured professional development opportunities.
- Draw from relevant qualifications: **MD Community Medicine, Community Health Administration, Masters in Public Health, and health management programmes** reflecting the genuinely multidisciplinary nature of public health work.
- Conduct recruitment through **dedicated examinations via State Public Service Commissions**, establishing merit-based entry and signalling institutional seriousness about the cadre's professional standing.
- **Make field postings at district and block level mandatory early in the career pathway**, ensuring cadre members develop grounded operational understanding before moving into planning and leadership roles.

WHO SHOULD IMPLEMENT: MoHFW · State Public Service Commissions · State Governments

WHERE TO IMPLEMENT: State public health cadres across all states; national standards and training through NIHFW and IIPH campuses.

MODELS TO LEARN FROM

India

Tamil Nadu, Odisha and Maharashtra: Public Health Cadres

Tamil Nadu's long-established public health cadre has provided a stable pipeline of trained public health leaders, contributing to the state's consistently strong performance on child and maternal mortality, disease surveillance and immunisation.[19] Odisha and Maharashtra have more recently introduced cadre structures, demonstrating replicability across diverse state contexts.

Global

Thailand: Institutionalised Public Health Management

Thailand's Ministry of Public Health has maintained a professional cadre of public health administrators distinct from its clinical workforce. This cadre has provided the administrative backbone for Thailand's successful UCS implementation in managing provider empanelment, quality oversight and health information systems with the technical sophistication that UHC governance demands.

[19] Priyadarshi M, Mishra SS, Singh A, Singhal A, Hashmi M, Neogi SB. Assessment of needs and gaps in public health cadre in India - a situational analysis. BMC Health Serv Res. 2023 Oct 26;23(1):1162. doi: 10.1186/s12913-023-10132-3. PMID: 37884946; PMCID: PMC10605757.

B.2 Address Shortages and Maldistribution of Health Workers

WHAT

A health system's capacity to deliver care is only as strong as the workforce available to provide it where it is needed most. This recommendation calls for concerted action to correct the persistent rural-urban and inter-state imbalances in health workforce availability that continue to undermine equitable access to care. Addressing this requires a combination of targeted recruitment, structured service obligations, financial and non-financial incentives and locally rooted workforce pipelines designed together as a coherent strategy rather than a collection of isolated measures.

> *India's workforce challenge is not simply one of numbers. It is more fundamentally, a challenge of distribution. The country trains substantial numbers of health professionals each year, yet their concentration in urban centres leaves large parts of rural and tribal India chronically under-served.*

WHY

Aspirational districts, high-burden states and tribal sub-plan areas (the geographies where health need is greatest) consistently struggle to attract and retain qualified health workers. Primary Health Centres and Community Health Centres in these areas operate below functional capacity not because of financing gaps alone but because specialist posts remain vacant and nursing positions go unfilled. **Patients who cannot access care close to home either forgo it entirely, with associated consequences for disease progression and avoidable mortality, or travel long distances at prohibitive cost.**[20]

The persistence of this problem in the face of repeated policy attention reflects the inadequacy of approaches that rely on obligation or exhortation alone, **without addressing the underlying professional, financial and social conditions that make rural postings unattractive** to health workers who have viable alternatives.

HOW

- Design **rural service incentive packages substantial enough to represent a genuine premium** over urban alternatives covering salary enhancements, housing, children's education, spousal employment support and periodic paid leave.
- Structure **bonded postings for government-funded medical graduates**, requiring a defined period of rural service as a condition of subsidised education, accompanied by adequate facility infrastructure and mentorship to make postings professionally meaningful.

[20] Dawkins et al., "What Factors Affect Patients' Ability to Access Healthcare? An Overview of Systematic Reviews," *Tropical Medicine & International Health* 26, no. 10 (2021): 1177–8, https://doi.org/10.1111/tmi.13651.

- Develop **local recruitment strategies** by actively recruiting health workers from the communities they will serve, through targeted admissions for students from underserved districts in state medical and nursing colleges.
- Invest in **community health worker programmes and locally trained mid-level providers** as a long-term investment in rooted workforce supply.
- Use **telemedicine platforms, including e-Sanjeevani**, to provide interim specialist support to underserved facilities while longer-term workforce distribution strategies take effect.

State Health Departments and Medical Education Departments must work in close coordination. **Workforce distribution is as much an education system challenge as a health administration one.** Incentive structures, bonding policies and local recruitment frameworks require alignment across both domains.

WHO SHOULD IMPLEMENT: State Health Departments · Medical Education Departments

WHERE TO IMPLEMENT: Aspirational districts, tribal sub-plan regions and areas with high government facility vacancy rates.

MODELS TO LEARN FROM

India

Chhattisgarh: Rural Workforce Incentives

Chhattisgarh developed targeted recruitment and incentive frameworks specifically designed for hard-to-reach areas by combining financial premiums, housing support and professional recognition to improve rural posting attractiveness.[21] The state also invested in building local health worker capacity through community-level provider training, significantly improving access in communities that had previously gone largely unserved.

Global

Brazil: Mais Medicos Programme

Launched in 2013, Brazil's Mais Medicos programme combined targeted recruitment of Brazilian and international doctors with structured support (supervised practice, continuing education and defined service periods) deploying over 18,000 physicians to underserved areas within its first two years.[22] Evaluations documented significant improvements in primary care access and reductions in preventable hospitalisation. The programme treated workforce redistribution as a system-level responsibility requiring proactive state intervention.

[21] National Health Systems Resource Centre, Public Health Resource Society, and State Health Resource Centre, Chhattisgarh, *Evaluation Report of Chhattisgarh Rural Medical Corps (CRMC), 2013–2014* (New Delhi: Ministry of Health and Family Welfare, 2014).

[22] T. Hone et al., "Impact of the Programa Mais Médicos (More Doctors Programme) on Primary Care Doctor Supply and Amenable Mortality: Quasi-Experimental Study of 5565 Brazilian Municipalities," *BMC Health Services Research* 20, no. 1 (2020): 873, https://doi.org/10.1186/s12913-020-05716-2.

B.3 Improve Recruitment, Retention and Motivation in the Public Health Workforce

WHAT

A health system's effectiveness is inseparable from the motivation, stability and professional fulfilment of the workforce that sustains it. This recommendation calls for a fundamental reorientation of public health workforce management away from the fragmented, insecure contractualization that has come to characterise much of India's public health employment, and toward **stable, merit-based careers with transparent progression pathways and performance-linked recognition.** Central to this reorientation is the reinstatement of the **family physician** as a valued and institutionally supported professional identity within the public health system.

> *High attrition and low morale among contractual health workers weaken service quality, erode institutional memory and disrupt the long-term patient relationships that effective primary and preventive care depend upon.*

WHY

Over the past two decades, the expansion of health programmes under NHM has been accompanied by significant growth in **contractual employment.** Contractual health workers face **persistent uncertainty about employment continuity, limited access to career advancement and a structural inequality** relative to regular government employees that breeds disengagement.[23] **High attrition rates disrupt service continuity, erode institutional memory and impose recurring recruitment and training costs.** For patients, frequent staff turnover means the absence of the sustained, trusting provider relationships that are central to effective chronic disease management.

Alongside contractualization, the erosion of the generalist family physician role has weakened the relational and continuity dimensions of primary care. **The progressive specialisation of medical training and the prestige hierarchy that positions specialists above generalists have made primary care an unattractive career destination** for many medical graduates; yet it is precisely the family-oriented, continuity-focused practitioner who is most needed at the first point of contact.

HOW

- **Progressively regularise contractual positions** that have de facto become permanent functional requirements of the health system; where immediate regularisation is not feasible, introduce **multi-year contracts** with defined renewal criteria and pathways to regularisation.
- Establish **regular, predictable recruitment cycles** with structured calendars for vacancy identification, examination scheduling and appointment, managed as a continuous administrative function rather than an episodic response to shortfalls.

23 Health Policy Watch, "Strike in Rural India Underscores Global Dependence on 'Precarious' Health Workers," accessed April 7, 2026, https://healthpolicy-watch.news/strike-in-rural-india-underscores-global-dependence-on-precarious-health-workers/

- Govern career management through **transparent, consistently applied promotion policies** that reward performance, competence and length of service in a manner that is visible and credible to the workforce.
- Design **performance-linked incentives**, financial and non-financial, that recognise excellence in service delivery, patient outcomes and programme management.
- Formally designate **family physician roles at the primary care level** with defined patient population responsibilities, supported by clinical protocols and linked to continuing education pathways in family medicine and community health.

WHO SHOULD IMPLEMENT: State Governments · Health Directorates

WHERE TO IMPLEMENT: Public health facilities across states; NHM Programme Implementation Plan cycle for workforce governance commitments.

MODELS TO LEARN FROM

India

Kerala: Family Health Centres and Workforce Reform

Kerala's transformation of PHCs into Family Health Centres repositioned the medical officer as a family health practitioner with a defined registered population, improving the professional environment of primary care employment.[24] The result has been improved workforce retention at the primary level, stronger patient-provider continuity and a measurable shift in utilisation patterns toward first-contact care.

Global

Thailand: Public Sector Career Pathways

Thailand's Ministry of Public Health has maintained a career civil service framework offering job security, structured promotion pathways and rural retention incentives including salary supplements, accelerated promotion and educational support for workers serving in remote areas. This framework has sustained provider presence in underserved geographies and maintained workforce morale through periods of significant health system reform.[25]

24 Government of Kerala, *Transforming Primary Health Centres into Family Health Centres: Guidelines and Orders Issued* (Thiruvananthapuram: Health & Family Welfare Department, 2017), https://dhs.kerala.gov.in/wp-content/uploads/2022/05/aardram_100817a.pdf.

25 P. Pagaiya et al., "Retention of Doctors in Rural Health Services in Thailand: Impact of a Rural Recruitment and Retention Programme," *Rural and Remote Health* 17, no. 3 (2017), https://www.rrh.org.au/journal/article/4344/.

B.4 Institutionalise Task-Sharing and Team-Based Care

WHAT

Delivering Universal Health Coverage across a country of India's scale cannot rest on the availability of physicians alone. This recommendation calls for the institutionalisation of task-sharing and team-based models of care formally enabling nurses, mid-level health providers and community health workers to deliver an expanded range of services within clearly defined protocols and supervised frameworks. The objective is not to substitute qualified care with less qualified alternatives, but to **deploy each level of the health workforce at the top of its competence**, freeing physicians to manage clinical complexity while ensuring that routine and predictable health needs are met efficiently at the appropriate level.

> *Physician-centric models are both inefficient and unsustainable at the scale India requires. The skills and presence of a large and widely distributed non-physician workforce are being underutilised at precisely the moment when their deployment is most needed.*

WHY

In rural, tribal and peri-urban areas where physician vacancies are high and patient loads are heavy, the insistence on doctor-led care for all services creates bottlenecks that delay treatment, demoralise ancillary staff and leave a significant proportion of patient need unmet. Nurses and mid-level providers who possess the competence to manage common conditions are prevented from doing so by **regulatory frameworks that have not kept pace with evolving models of care.** Community health workers such as ASHAs and ANMs lack the formal scope of practice and supervisory support that would allow their contributions to be systematically integrated into the care pathway.

The fully realised **Ayushman Bharat HWC model** was explicitly designed around a multidisciplinary primary care team and **yet the regulatory, protocol and training infrastructure needed to make this design intent operational remains incomplete.**

HOW

- **Formally expand the legally recognised scope of practice** for nurses, mid-level providers and community health workers through MoHFW and State Medical and Nursing Councils, specifying with precision what conditions they may manage, what medicines they may prescribe and what procedures they may perform independently versus under supervision.
- Develop **Standard Treatment Protocols for conditions most commonly managed at primary care level**, such as hypertension, diabetes, common infections, maternal and child health, mental health screening and palliative care, with clear escalation criteria.
- **Monitor protocol adherence as a quality indicator** with deviations triggering supervisory review in a learning environment rather than punitive action.

- Shift from periodic training events to **continuous mentoring by experienced community facilitators** through NGO partners, SHSRCs and district health teams while promoting building adaptive clinical skills progressively through practice.
- Draw on **WHO task-shifting guidelines** as an internationally validated framework, adapted to India's regulatory context, disease burden and workforce availability.

WHO SHOULD IMPLEMENT: MoHFW · State Councils · Training Institutes

WHERE TO IMPLEMENT: Ayushman Bharat Health and Wellness Centres; states with existing mid-level provider programmes as early learning platforms

MODELS TO LEARN FROM

India

Chhattisgarh: Rural Medical Assistant Programme

Chhattisgarh's three-and-a-half-year trained Rural Medical Assistants equipped with defined clinical competencies, standard treatment protocols and structured supervision managed a substantial proportion of common clinical presentations safely and effectively in areas where doctors were unavailable.[26] The programme's design philosophy of clear role definition, protocol-governed practice and active supervision offers a directly applicable model for HWC mid-level provider roles.

Global

Malawi: Clinical Officers

Malawi formalised clinical officers as a permanent, institutionally recognised cadre who were trained to perform a wide range of diagnostic, medical and surgical functions, making them the backbone of national health service delivery.[27] Malawi's experience demonstrates that task-sharing, when legally institutionalised, protocol-governed and supported by continuous training, is a structurally sound response to workforce realities in a large and resource-constrained health system.

[26] Garg S, et al., "A Clinical Vignette-Based Study in Chhattisgarh State," *BMJ Open* / PMC full text, 2022, https://pubmed.ncbi.nlm.nih.gov/35550154/.

[27] Clinical Officers in Malawi: Expanding Access to Comprehensive Emergency Obstetric Care. University of Cape Town, accessed April 7, 2026, https://open.uct.ac.za/server/api/core/bitstreams/2a081d23-1efc-4fa9-89e3-0d4c73b2b424/content

SECTION C: SERVICE DELIVERY AND QUALITY

C.1 Strengthen governance, role clarity and institutional capacity across PM-JAY implementation structures

WHAT

Establish a **clearly codified governance framework for PM-JAY** that delineates mandates, decision rights, reporting relationships, and accountability across the National Health Authority (NHA), State Health Agencies (SHAs), and District Implementation Units (DIUs).

> ***Accredit explicit responsibility for**:*
>
> - *core service delivery functions, provider empanelment and contracting, pre-authorisation, claims adjudication, quality oversight, fraud control, and grievance redressal.*
> - *strengthen the technical and managerial capacity of SHAs and DIUs to function as effective strategic purchasers of hospital services*

WHY

- Variation in service availability, utilisation, claims performance, and beneficiary experience across states reflects uneven institutional capacity and ambiguous role delineation.
- Weak governance leads to delays in empanelment and authorisation, high claims pendency, inconsistent enforcement of package protocols, and inadequate supervision of providers.
- These failures increase transaction costs for hospitals; discourage participation, particularly among tertiary facilities; and can result in denial or postponement of care for beneficiaries.
- Limited district-level oversight further constrains monitoring of informal payments, inappropriate referrals, or service refusal.
- Differences in implementation models (trust, insurance, hybrid) compound coordination challenges, necessitating clear accountability frameworks to ensure continuity of cashless service delivery and protection from out-of-pocket expenditure.

HOW

> *Expand and rationalise the Health Benefit Packages (HBPs) to address gaps arising from the current inpatient-dominant purchasing model and strengthen financial protection across the continuum of care.*

- Priority should be given to **incorporating high-impact non-covered services** that significantly influence outcomes but fall outside hospitalisation episodes such as rehabilitation, palliative care, structured follow-up, and tested non-pharmacological mental health interventions.
- Evidence shows that hospitalization-focused insurance provides limited financial protection, as outpatient care and medicines drive most out-of-pocket expenditure. Expanding benefit packages to **include essential outpatient services such as consultations, diagnostics, disease monitoring and referral-linked care** for chronic conditions such as NCDs, tuberculosis and mental health is therefore critical.
- Explicit coverage for maintenance medicines should be included where adherence determines disease control, particularly as pharmaceuticals constitute the largest share of out-of-pocket health expenditure in India (National Health Accounts 2019–20).

To improve effective access, introduce standardized support for non-medical costs such as transport and subsistence, particularly for remote and vulnerable populations. **Institutionalize periodic review of high-cost**, unspecified and low-utilisation packages using claims analytics and clinical audits to improve efficiency and avoid duplication with services financed under national programmes. Strengthen pricing through empirical costing, **Health Technology Assessment (HTA) and budget impact analysis** to align reimbursement with actual costs and reduce perverse incentives. Finally, ensure regular revision of the benefit basket based on epidemiological trends, technological advances and utilisation patterns to maintain responsiveness, equity and fiscal sustainability.

WHO SHOULD IMPLEMENT: ·NHA ·SHA ·DIU ·Empanelled public and private hospitals ·facility-level functionaries

WHERE TO IMPLEMENT: ·States and UTs with low ·Districts with weak administrative capacity ·Underserved provider markets.

MODELS TO LEARN FROM

India	Global
Within India, states with mature purchasing arrangements, such as **Tamil Nadu, Kerala, and Karnataka,** offer lessons on autonomous health agencies, IT-enabled claims systems, and district oversight.	**Thailand's Universal Coverage Scheme and Indonesia's Jaminan Kesehatan Nasional (JKN)** programme demonstrate governance mechanisms for large publicly financed provider networks, including centralised purchasing, standardised protocols, and performance monitoring.

C.2 Expand and rationalize PM-JAY benefit packages to improve financial protection and equity

WHAT

Expand and rationalise the Health Benefit Packages (HBPs) under the PM-JAY to ensure comprehensive financial protection across the continuum of care.
This requires: incorporating high-priority excluded services, particularly outpatient care components, chronic disease management, rehabilitation, mental health services, and long-term treatment support, while systematically revising existing packages to eliminate duplication, align with national programme financing, and reflect realistic provider costs.

> *The reform should also address major non-medical expenditures associated with hospitalisation, including transport, subsistence, and income loss, which frequently determine effective access among vulnerable populations.*

WHY

PM-JAY is designed as a publicly financed strategic purchasing mechanism for inpatient care, covering diagnostics, medicines and procedures, but largely excluding outpatient services (National Health Authority, PM-JAY Operational Guidelines). However, outpatient care and medicines constitute the largest share of household health spending in India, with medicines alone forming a dominant component of out-of-pocket expenditure (National Health Accounts, 2019–20). As a result, hospitalization-focused coverage leaves beneficiaries exposed to significant financial risk.

Evidence from earlier publicly financed insurance schemes such as RSBY shows limited reduction in catastrophic expenditure when outpatient services are excluded, as households continue to incur high costs on routine care. This gap is particularly critical for chronic conditions such as non-communicable diseases, tuberculosis and mental health disorders which require sustained outpatient management. Lack of coverage leads to delayed treatment initiation, poor adherence and avoidable hospitalisations, undermining both clinical outcomes and cost efficiency.

Financial protection is further weakened by indirect costs, including transport, accommodation for carers, food and wage loss, which disproportionately affect vulnerable populations. In addition, the current benefit structure shows allocative inefficiencies, with overlaps in some areas and gaps in others such as rehabilitation, palliative care and non-pharmacological therapies. Periodic rationalisation based on disease burden, utilisation and cost-effectiveness is therefore essential to ensure that the benefit basket remains equitable, relevant and fiscally sustainable.

HOW

Expand Health Benefit Packages (HBPs) to incorporate high-priority non-covered services that substantially influence outcomes but do not require hospitalization, including rehabilitation, follow-up care, palliative services and non-pharmacological mental health interventions. Evidence shows that effective financial protection depends on coverage across the continuum of care rather than episodic hospitalisation alone. (WHO, Universal Health Coverage Monitoring Reports). **Integrate**

essential outpatient components for chronic disease management including consultations, diagnostics and continuity of care along with coverage for maintenance medicines, given that pharmaceuticals account for a major share of out-of-pocket expenditure in India. (National Health Accounts 2019-20)

Introduce standardized mechanisms to offset non-medical costs associated with transport, accommodation and subsistence, which remain key access barriers for rural and low-income households even when treatment costs are covered. **Periodically review high-cost, unspecified and low-utilisation packages** using advanced claims analytics to improve efficiency, while rationalising packages that duplicate services financed through vertical national programmes to ensure clear delineation of purchasing responsibilities. Strengthen pricing through **empirical costing studies, Health Technology Assessment and budget impact analysis** to align reimbursement with actual costs and cost-effectiveness. Finally, institutionalise regular updates to the benefit basket based on epidemiological trends, technological advances in diagnostics and treatment, and evolving clinical standards to ensure responsiveness, equity and fiscal sustainability over time.

WHO SHOULD IMPLEMENT: ·NHA ·SHA ·Health Technology Assessment India (HTAIn) ·Clinical expert committees ·Professional bodies to guide clinical appropriateness and quality of care

WHERE TO IMPLEMENT: ·States and UTs with low ·High-burden districts with weak administrative capacity ·Underserved regions.

MODELS TO LEARN FROM

India

Tamil Nadu - PM-JAY Merger: Tamil Nadu implemented the state's health insurance scheme by merging it with PMJAY. This **expanded the coverage** in terms of health packages provided under both the schemes for families. The impact was a reduction in **out-of-pocket expenses** and **catastrophic health expenditures** for costly treatments like **cancer** and **cardiovascular care**.

Global

Thailand - Universal Coverage Scheme (UCS): A tax-funded scheme providing comprehensive coverage across outpatient, inpatient, preventive, rehabilitative, and long-term care services. Inclusion of essential medicines and primary care has been associated with low catastrophic health expenditure and high utilisation of necessary services.

Indonesia - Jaminan Kesehatan Nasional (JKN): National social health insurance covering outpatient and inpatient services across all levels of care, including chronic disease treatment and advanced procedures. Benefit design decisions are informed by formal HTA processes and fiscal considerations.

C.3 Strengthen demand-side mechanisms to improve awareness, equity and uptake

WHAT

Strengthen demand-side systems under the Pradhan Mantri Jan Arogya Yojana to convert nominal population coverage into effective, equitable utilisation of entitled services.

> *This requires systematic: improvements in beneficiary identification, awareness generation, scheme navigation, facilitation at point of care, grievance redressal, and trust-building mechanisms across the care continuum, from eligibility verification and e-card issuance to admission, discharge, and post-treatment follow-up.*

Interventions should explicitly target populations facing structural access barriers, including women, scheduled tribes, migrant and informal workers, elderly persons, and residents of geographically remote or underserved areas, where administrative inclusion often coexists with functional exclusion.

WHY

Despite the expansion of PM-JAY, coverage has not translated uniformly into utilisation, with persistent disparities across regions and socio-economic groups. Wide variation in hospitalisation and claims rates suggests that **demand-side constraints** beyond **supply availability** limit scheme uptake.

At the household level, limited awareness and weak scheme literacy hinder effective access, with many **beneficiaries lacking clarity on entitlements, empanelled providers and cashless processes.** Lessons from the Rashtriya Swasthya Bima Yojana and early PM-JAY assessments further reinforce that **nominal enrolment does not ensure service uptake** in the absence of awareness and facilitation mechanisms (Karan et al., 2017; NITI Aayog, 2021). These gaps are compounded by **documentation constraints**, **limited digital access, low health insurance literacy**, and **gendered restrictions on mobility and intra-household decision-making.** Certain groups, particularly **migrant households** and **urban informal workers**, face heightened risks of exclusion due to **static beneficiary databases** which fail to capture dynamic population movements. In addition, **low trust in public systems**, often shaped by prior experiences of delays or denial of services, further discourages utilisation.

At the system level, **IEC strategies remain largely standardised and supply-driven**, limiting its effectiveness across diverse linguistic and regional contexts. Global evidence shows that **coverage expansion alone does not ensure equitable access without targeted outreach and facilitation.** (World Health Organization & World Bank, 2017). Conversely, **community engagement and social accountability mechanisms** in the form of community monitoring and citizen feedback platforms, have been shown to improve utilisation, responsiveness and patient satisfaction. Experimental and quasi-experimental studies in Uganda show that **participatory approaches** like **community scorecards, public hearings, and citizen oversight** can reduce information asymmetry and strengthen accountability relationships.

Together, these factors highlight that financial coverage alone is insufficient, and that context-sensitive demand-side interventions combining targeted outreach, beneficiary facilitation and community engagement are essential to translate coverage into effective utilisation under PM-JAY.

HOW

Strengthen beneficiary inclusion by integrating PM-JAY databases with dynamic administrative registries such as the National Food Security Act (NFSA) and other social protection datasets to better capture migration, demographic shifts and newly vulnerable households, thereby reducing exclusion errors. Implement sustained, context-specific IEC strategies that combine mass media, digital and interpersonal channels, with locally adapted and repeated messaging through trusted sources.

Institutionalise community-based facilitation through ASHAs, VHSNCs, self-help groups and Panchayati Raj Institutions to support awareness, enrolment and care navigation, complemented by peer champions and social accountability mechanisms (social audits, community monitoring and feedback forums) to enhance transparency and trust.

Strengthen hospital-level facilitation by building the capacity of Ayushman/Arogya Mitras to ensure timely authorisation and cashless care, alongside **targeted insurance literacy** on eligibility, entitlements, referral pathways, portability and grievance redressal to address demand-side barriers.

WHO SHOULD IMPLEMENT: ·SHA ·District Administration ·Community- level institutions ·Civil society organisations

WHERE TO IMPLEMENT: ·Districts with low utilisation claims ·Geographical targeting to underserved regions.

MODELS TO LEARN FROM

India

The Self-Employed Women's Association's **SEWA Shakti Kendras (SSKs)** function as integrated community resource centres providing documentation support, entitlement counselling, grievance assistance, and peer mobilisation, significantly improving access to social protection among informal women workers.

The nationwide **ASHA programme** itself represents one of the largest examples of community-embedded health outreach contributing to increased maternal and child health service uptake.

Global

Brazil's Family Health Strategy – Estratégia Saúde da Família (ESF) – assigns multidisciplinary primary care teams, including community health workers, to defined catchment populations, leading to increased service utilisation and reductions in health inequalities.

Ethiopia's Health Extension Program (HEP) employs locally recruited workers providing door-to-door health education and service linkage, substantially improving awareness and uptake in rural areas.

C.4 Improve supply-side readiness, quality assurance and ethical provider behaviour

WHAT

Strengthen **supply-side readiness** and **regulatory oversight** under PM-JAY by ensuring that empanelled facilities meet defined minimum service delivery standards, are geographically aligned with population needs, and adhere to enforceable quality and ethical norms. This includes standardising facility readiness criteria, correcting spatial inequities in empanelment, embedding quality-linked purchasing, and instituting credible deterrence against provider misconduct.

WHY

PM-JAY has scaled rapidly by empanelling both public and private facilities, including carry-over providers from earlier schemes such as RSBY. However, **facility readiness and service capability remain heterogenous**, particularly across district hospitals and smaller private providers, resulting in variable quality of care.

Empanelment patterns are geographically skewed, with a high concentration of private hospitals in urban and peri-urban clusters, while rural, tribal, and aspirational districts remain under-served. NHA analyses have shown that a significant share of claims originates from a limited set of districts and facilities, indicating concentration of service provision and access inequities.

Provider behaviour under case-based bundled payment systems has raised additional concerns. Evidence highlights risks of upcoding, **unnecessary procedures**, **cherry-picking** of low-risk cases and **denial of high-cost patients**. **High readmission rates** in certain specialties further suggest gaps in clinical quality, discharge practices and continuity of care.

Weak quality assurance, poor enforcement of standard treatment guidelines and limited regulatory oversight distort provider incentives under strategic purchasing, prioritising service volume over appropriateness and outcomes, and resulting in inefficiencies, compromised patient safety and reduced trust.

HOW

- **Introduce mandatory, standardised facility readiness assessments** linked to empanelment and periodic revalidation, covering infrastructure, human resources, diagnostics, critical equipment, and service-specific capability. Align these with NQAS and map them to package requirements to ensure only capable facilities are empanelled**.**
- **Adopt a needs-based empanelment strategy** using geospatial and service-gap analyses to prioritise onboarding of providers in underserved districts, complemented by targeted

incentives like differential pricing, viability gap funding and assured volumes to attract and retain providers in low-density and high-need areas.

- **Strengthen provider regulation and anti-fraud** systems through risk-based claims analytics, medical audits and field verification, with clear, time-bound protocols for suspension and de-empanelment in cases of fraud, balance billing, unnecessary procedures or patient rights violations.
- **Embed quality-linked purchasing** by tying a share of payments to indicators such as adherence to STGs, complication rates, readmissions and outcomes, supported by robust data systems. Evidence from value-based purchasing models shows that payment adjustments tied to quality metrics can reduce avoidable readmissions and improve clinical practices when supported by reliable data systems.
- **Operationalise and enforce STGs** through independent clinical audit mechanisms. This should include routine review of case sheets, procedure appropriateness, and package utilisation patterns to reduce unwarranted clinical variation and prevent overuse or under-provision of services.
- **Leverage real-time digital monitoring systems** to track provider performance indicators, procedure mix, length of stay, readmission rates, and claims rejection patterns, and flag outliers for targeted intervention. Integrate these systems with regulatory bodies to ensure that enforcement actions are evidence-based, timely, and proportionate.

WHO SHOULD IMPLEMENT: ·NHA ·SHA ·Quality assurance bodies (e.g., NQAS/NABH-linked institutions) should support accreditation, **clinical audits**, and validation of quality metrics ·Regulatory authorities at central and state levels

WHERE TO IMPLEMENT: ·Aspirational districts, rural and tribal regions ·Areas with low provider density ·States and districts with high readmission rates and urban clustering

MODELS TO LEARN FROM

India

India's **NQAS framework** demonstrates the feasibility of structured facility certification linked to performance improvement in public health facilities. PM-JAY's own anti-fraud and claims analytics systems provide emerging evidence on the effectiveness of data-driven surveillance in identifying provider misconduct.

Experiences from **state-level trust models** (e.g., Tamil Nadu CMCHIS) show the value of strong government oversight and medical audit systems in controlling provider behaviour.

Global

Thailand's Universal Coverage Scheme (UCS) integrates empanelment with mandatory accreditation and continuous quality monitoring through the Healthcare Accreditation Institute, linking provider participation to quality compliance.

The United Kingdom's Care Quality Commission (CQC) provides an example of independent inspection and public rating of providers, strengthening accountability and patient trust.

C. 5 Leveraging Digital Systems and Payment Reforms to Enhance Efficiency, Transparency, and Care Coordination under PM-JAY

WHAT

Strengthening the digital and financial architecture of AB-PMJAY requires a shift toward an interoperable, data-driven and strategically purchasing-oriented platform, with end-to-end digitisation of the claims value chain anchored in standards-based health information exchange. Integration with the Ayushman Bharat Digital Mission, through ABHA IDs, consent-based data sharing and longitudinal EHRs, can enable continuity of care and population-level analytics.

At the same time, **provider payments** should move from static package rates to output- and outcome-linked mechanisms, including case-based bundled payments, Diagnosis-Related Groups (DRGs), capitation and pay-for-performance, supported by real-time analytics, automated claims processing and AI-enabled fraud detection to improve allocative and technical efficiency.

WHY

Despite its scale, PM-JAY's **efficiency is constrained by fragmented digital systems, limited interoperability and misaligned provider incentives**. Claims processing times often exceed 30-45 days, creating cash flow constraints, increasing transaction costs and reducing provider trust (NHA Annual Report, 2022–23).

Weak digital integration contributes to information asymmetry, supplier-induced demand and fraud, including upcoding, unnecessary admissions and duplicate claims, as flagged by the National Anti-Fraud Unit (NAFU). Global evidence suggests such inefficiencies can account for up to 10% of health expenditure (Organisation for Economic Co-operation and Development, 2017; Centers for Medicare & Medicaid Services, 2022). At the same time, **poor integration between PM-JAY and primary care** services leads to fragmented pathways and avoidable hospitalisations, which effective primary care could reduce by up to 30% (WHO, 2018). **Limited interoperability with ABDM further restricts longitudinal patient data,** constraining continuity of care, surveillance and planning. International experience shows that integrated digital systems can reduce administrative costs by 10–20% while improving governance and accountability (World Bank, 2021).

HOW

A central pillar of reform is building scalable, modular and interoperable digital infrastructure **aligned with ABDM, integrating HIE-CM frameworks, ABHA-linked records and standardised data formats**, with universal provider onboarding for **e-KYC**, e-preauthorisation, clinical documentation and e-claims to reduce inefficiencies and improve data integrity. Continuous provider capacity building in digital health remains essential.

- **Claims processing** must be re-engineered through automation and standardisation using rule-based adjudication, **Clinical Decision Support System** (CDSS) and **STGs,** with time-bound

SLAs (e.g., 15-21 days) to improve accountability. Advanced analytics and AI can enable real-time, risk-based fraud detection. Operationalising the **National Health Claims Exchange (NHCX)** can further support interoperable, multi-payer claims processing and reduce fragmentation.

Provider payment reforms should adopt blended models combining DRGs, capitation and pay-for-performance, with quality-linked metrics to strengthen clinical governance. **Strengthening continuity of care** requires interoperable referral systems, shared registries and digital linkages between AAMs and empanelled hospitals to enable structured referrals, follow-up and reinforce primary care as the first point of contact.

WHO SHOULD IMPLEMENT: ·NHA ·SHA ·Technological partners ·Public and Private insurers

WHERE TO IMPLEMENT: ·Core PM-JAY transaction platforms ·TMS and claims processing modules with full integration into ABDM's digital ecosystem ·High-burden and high utilisation states should be prioritised for advanced analytics deployment and interoperability pilots ·Provider level

MODELS TO LEARN FROM

India

The integration of **digital health infrastructure** and **strategic purchasing** reforms is fundamental to enhancing the efficiency, transparency, and accountability of PM-JAY.

By embedding interoperability, automation, advanced analytics, and incentive-aligned payment systems, PM-JAY can transition toward a high-performing, learning health system capable of delivering cost-effective, high-quality, and continuous care.

Global

Estonia's digital health ecosystem demonstrates the feasibility of secure, interoperable, population-scale EHR systems.

Thailand's UCS highlights the effectiveness of DRG-based payments and electronic claims systems in achieving efficiency and equity.

The United Kingdom's NHS offers insights into blended payment models and integrated care systems.

SECTION D: INTEGRATED CARE AND CONTINUITY OF SERVICES

D.1 Strengthen Reliable and Enforceable Referral and Counter-Referral Pathways Across Levels of Care

WHAT

India's transition to integrated, people-centred care requires a **reliable, enforceable referral and counter-referral architecture** to regulate patient movement across levels of care. This system should be protocol-driven, digitally enabled and aligned with STGs, Integrated Care Pathways and the ABDM ecosystem.

It should include **standardised referral documentation**, **interoperable digital exchange and real-time tracking with mandatory acknowledgement** to ensure referrals are clinically justified, information-complete and system-visible. Equally, **closed-loop counter-referral** must be institutionalised, requiring higher-level facilities to return patients to primary care with **digitally transmitted discharge summaries, medication reconciliation and longitudinal care plans**. PHCs and HWCs should anchor continuity, follow-up and population-level care, acting as longitudinal care custodians.

WHY

The absence of a functional referral system represents **a first-order system design failure, producing demand distortion, care fragmentation, and inefficiencies that cascade across the health system**. India's current architecture operates with **de facto open access**, where patients self-navigate across levels, weakening clinical governance and system efficiency.

Empirical evidence reinforces this distortion. The NSSO 75th Round (2017–18) shows that 63% of rural and 70% of urban outpatient care is sought in private sector, often bypassing primary care, with high out-of-pocket expenditure (~48% of total health spending) linked to fragmented pathways. WHO guidance identifies **failures in continuity and coordination** as key drivers of **patient harm, avoidable hospitalisations, suboptimal health outcomes and systemic inefficiencies.**

> *The reform redefines referral systems as **core instruments of clinical governance, resource allocation, and system accountability,** ensuring care transitions are governed by **clinical thresholds, risk stratification, and service capability** rather than patient discretion or fragmented incentives*

Three structural failures emerge:

1. ***Allocative inefficiency and demand misalignment****: Higher-level facilities manage low-complexity conditions, leading to congestion and reduced productivity.*
2. ***Breakdown of information continuity****: Lack of interoperable systems results in duplication, inconsistent care and rising costs.*
3. ***Failure of longitudinal care****: Weak counter-referral leading to poor follow-up, especially for chronic conditions, and a shift toward episodic, hospital-centric care*.

WHO's *Continuity and Coordination of Care: A Practice Brief (2022)* highlights that fragmented care pathways lead to **information discontinuity, duplication of services and breakdowns in follow-up**, undermining quality and increasing costs. This is reinforced by the *Framework on Integrated People-Centred Health Services*, which identifies **functional referral systems as a foundational mechanism for integrated care**, enabling **appropriate utilisation, longitudinal tracking and coordinated decision-making**. The *Global Patient Safety Report 2023* reinforces that poor care transitions and weak communication across providers are major contributors to **medical errors, adverse events and system inefficiencies**, particularly in systems lacking structured referral linkages.

HOW

Strengthening referral pathways requires alignment between clinical governance, digital systems and institutional accountability, making referral a regulated, traceable and enforceable function. Referral decisions should be embedded within **STGs and Integrated Care Pathways**, with defined **clinical thresholds and risk stratification**, supported by standardised templates to ensure complete information exchange and continuity of care.

Digitally, referral systems should operate through **ABDM-compliant interoperable platforms** leveraging **ABHA-linked unique health identifiers** for **real-time generation, tracking and acknowledgement**.

- India's digital health ecosystem, with **over 67 crore ABHA IDs and 42 crore linked records,** enabling longitudinal health records and continuity of care.

Referral Systems as a Core Governance Mechanism

- *Acts as an **allocative instrument**, aligning demand with appropriate levels of care*
- *Ensures **continuity and longitudinal management across providers***
- *Reduces **clinical uncertainty and information asymmetry***
- *Improves **efficiency by optimising case-mix across facilities***
- *Embeds **accountability for care transitions within the system architecture***

- Counter-referral must be institutionalised as a **mandatory and standardised discharge process**, including diagnosis, treatment details and follow-up plans, with digital transmission to reintegrate patients into **primary care-led longitudinal management**.
- Referral performance should be integrated into **performance management frameworks, quality assurance and payment systems**, using indicators such as **referral appropriateness, completion rates and follow-up adherence** to align incentives.

- Telemedicine platforms such as e-Sanjeevani can further support **triaging, specialist access** and reduce unnecessary referrals, particularly in underserved areas.

WHO SHOULD IMPLEMENT: ·NHA within ABDM and PM-JAY ·State Health Departments ·DHA ·DHS · Public and empanelled private providers

WHERE TO IMPLEMENT: ·District Health System level ·PHC ·HWCs ·CHCs ·District hospitals ·Empanelled private providers

MODELS TO LEARN FROM

India

The **ABDM** demonstrates the feasibility of **interoperable, consent-based health information exchange at scale**, enabling longitudinal records and continuity across providers.

The **e-Sanjeevani telemedicine platform** illustrates how **digital consultation layers can be embedded within referral pathways,** improving triage and access, particularly in resource-constrained settings.

Emerging **hub-and-spoke models anchored at district hospitals**, demonstrate early gains in **rationalising patient flows and improving utilisation patterns,** highlighting the importance of aligning primary care strengthening with referral reform.

Global

The **United Kingdom's NHS** demonstrates how primary care-led gatekeeping regulates access and optimises system efficiency.

Integrated systems in the **United States** show that **closed-loop referral combined with accountability mechanisms reduces avoidable hospital utilisation**.

D.2 Strengthen Functional Capacity of Primary Care to Anchor Integrated Care

WHAT

Strengthening primary care in India requires a decisive shift from **nominal service expansion to demonstrable functional capability,** ensuring that PHCs and HWCs operate as **clinically competent, service-ready nodes within an integrated system.** This entails equipping primary care facilities with assured access to essential diagnostics, **uninterrupted drug availability, adequately trained multidisciplinary teams, and embedded clinical governance mechanisms**.

*This enables them to perform **three foundational system functions:***
1 first-contact access,
2.gatekeeping, and
3.longitudinal care coordination.

The reform repositions primary care from a **low-intensity, episodic service delivery platform to a population-based, continuously engaged care model**, especially for **NCDs, preventive health services, and chronic disease management.** In doing so, PHCs and HWCs are envisaged as the **anchor of integrated care pathways**, capable of managing a substantial proportion of health needs at the first point of contact while ensuring **appropriate referral, continuity, and follow-up.**

WHY

The limited functional capacity of primary care constitutes a binding constraint to health system integration in India, affecting efficiency, equity, and quality. Despite policy commitments under Ayushman Bharat to operationalise **Comprehensive Primary Health Care (CPHC)**, utilisation patterns and facility readiness continue to reveal persistent structural and functional gaps.

Global evidence underscores that strong primary care systems are central to achieving UHC.

- ***WHO** identifies primary care as the most effective platform for delivering **equitable, efficient, and people-centred health services**.*[28]
- *The Lancet Commission on High-Quality Health Systems demonstrates that weak primary care contributes to **avoidable mortality and poor-quality care**, even in contexts where service coverage has expanded.*[29]

NSSO data (75th round) indicate that **over 60% of outpatient care in rural areas and nearly 70% in urban areas is accessed through private providers**, indicating low reliance on public primary care.[30] This bypass behaviour results in **disproportionate outpatient load at higher-level facilities**, leading to case-mix distortion, congestion, and inefficiencies in resource utilisation. Facility-level assessments under the NHM and related programme evaluations

[28] World Health Organization, *Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report* (Geneva: WHO, 2019).
[29] Margaret E. Kruk et al., "High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution," *The Lancet Global Health* 6, no. 11 (2018): e1196–e1252.
[30] Ministry of Statistics and Programme Implementation (MOSPI), *Health in India: NSS 75th Round (July 2017–June 2018)* (New Delhi: Government of India, 2019).

consistently highlight deficits in **diagnostic availability, essential drug supply, and trained human resources**, particularly for NCD management and preventive care.[31]

These gaps have cascading effects: **weakened gatekeeping, fragmented care for chronic conditions, overcrowding at higher-level facilities and poor adherence** with inadequate follow-up, increasing avoidable hospitalisations. Evidence indicates that **well-functioning primary care can reduce avoidable hospitalisations by 25-30%**, improve disease control and enhance efficiency. In India, strengthening primary care is therefore a **system-level reform which is essential for improving efficiency, financial protection and health outcomes.**

HOW

- **Assure essential diagnostics at the point of care**: basic laboratory services, blood glucose, HbA1c, lipid profile, renal function tests, haematology, supported by functional equipment, trained personnel and quality assurance, integrated within routine clinical workflows
- **Strengthen procurement and supply chains** through pooled procurement, standardised essential drug lists and IT-enabled inventory management to eliminate stock-outs and ensure treatment continuity, Tamil Nadu demonstrates that robust procurement systems significantly improve drug availability and treatment adherence
- **Build multidisciplinary, team-based care capacity** through sustained investment in NCD management, preventive care and task-shifting to **Mid-Level Health Providers (MLHPs)** for routine management of chronic conditions under clinical protocols and supervision
- **Embed Standard Treatment Guidelines and clinical governance mechanisms** to reduce unwarranted variation, ensure evidence-based practice and improve quality across facilities
- **Leverage ABDM digital infrastructure and e-Sanjeevani**, integrating electronic health records, clinical decision-support tools and telemedicine, to enhance provider capacity, standardise decision-making and enable continuity across levels, with teleconsultation reducing unnecessary referrals.

Core Functional Attributes of High-Performing Primary Care Systems

- *Availability of essential diagnostics at the point of care*
- *Uninterrupted supply of essential medicines, particularly for NCDs*
- *Protocol-driven clinical management aligned with Standard Treatment Guidelines*
- *Team-based care delivery models with effective task-sharing*
- *Digitally enabled systems supporting decision-making and continuity of care*

[31] Ministry of Health and Family Welfare (MoHFW), *Rural Health Statistics and NHM Facility Assessments* (New Delhi: Government of India, various years).

WHO SHOULD IMPLEMENT: ·State Health Departments ·DHS ·NHM ·ABDM along with associated technology partners

WHERE TO IMPLEMENT: ·AB-HWCs ·PHCs ·District-level referral networks

MODELS TO LEARN FROM

India

Tamil Nadu demonstrates the impact of **robust procurement and supply chain systems** in ensuring high levels of drug availability and system efficiency.

Kerala illustrates how strong primary care networks and better workforce distribution can support **high utilisation and continuity of care.**

Experiences from **Telangana and Andhra Pradesh** highlight the role of **expanded HWCs and telemedicine integration** in improving screening coverage, service utilisation, and system responsiveness.

Global

The **United Kingdom's NHS** demonstrates the effectiveness of primary care-led gatekeeping and continuity models, while
Brazil's Family Health Strategy shows how **team-based, community-oriented primary care can significantly reduce hospitalisations for ambulatory care-sensitive conditions.**

Thailand's UHC model underscores the importance of sustained investment in primary care infrastructure and workforce in achieving **equitable access, improved health outcomes, and system efficiency**.

D.3 Embed Digital Tools Directly Within Clinical Workflows to Enable Seamless Integration

WHAT

Achieving integrated care requires the systematic embedding of **interoperable, standards-based digital health systems within routine clinical workflows** across the continuum of care. Leveraging ABDM's federated architecture, the goal is to transition from fragmented, stand-alone digital applications to **workflow-integrated, patient-centric platforms** supporting real-time health information exchange, ABHA-linked longitudinal records and closed-loop care coordination. Digital systems must function as **core clinical infrastructure**, seamlessly integrated across registration, consultation, diagnostics, referral, discharge and follow-up, rather than as parallel administrative overlays.

> *Embedding digital tools within clinical workflows is not a technological upgrade, it is a structural reform necessary to operationalise integrated, accountable and patient-centred care. Lack of interoperability leads to 20-30% duplication in diagnostic testing, increased OOPE and delayed treatment initiation.*

WHY

Despite foundational progress under ABDM, digital health deployment in India remains **heterogeneous in design, uneven in adoption, and insufficiently embedded within clinical workflows**, limiting its ability to enable integration. A large proportion of existing systems are **programme-specific, facility-bound, or administratively oriented**, resulting in **data silos, low interoperability, and limited clinical utility at the point of care**.

This fragmentation manifests in several systemic inefficiencies:

- **Discontinuous health information flows** across providers, impairing coordination and clinical continuity
- Lack of **accessible, longitudinal patient records**, constraining evidence-based decision-making
- Continued reliance on **paper-based or patient-mediated data exchange**, leading to information loss and delays
- High prevalence of **duplicate diagnostics, polypharmacy, and inconsistent treatment pathways**, particularly in multi-provider care journeys

> *The **WHO** emphasises that interoperable digital systems are foundational to **integrated, people-centred health services**, particularly in mixed-provider systems where coordination challenges are inherently complex.*

Empirical evidence indicates that **lack of interoperability can lead to 20–30% duplication in diagnostic testing**, alongside increased out-of-pocket

expenditure and delayed treatment initiation.[32] More importantly, the absence of digitally enabled care transitions, particularly **referral, discharge, *and follow-up loops, undermines accountability***, as continuity of care remains dependent on patient behaviour rather than system design.
Embedding digital tools within clinical workflows is therefore not a technological upgrade, but a structural reform necessary to operationalise integrated, accountable, and patient-centred care pathways.

HOW

Reform should embed digital systems as operational infrastructure for integrated care across four interconnected dimensions:

- **Workflow-integrated health information exchange**: real-time, standards-based exchange of structured clinical data across providers, anchored in FHIR interoperability protocols which enable auto-population of patient data, clinical history, diagnostics and care plans across encounters, reducing duplication and administrative burden.
- **Closed-loop digital referral and care transition systems**: end-to-end tracking, acknowledgement and completion of every referral; electronic transmission of structured discharge summaries and follow-up plans; automated alerts and escalation protocols to reduce loss to follow-up.

Core Design Principles for Workflow-Embedded Digital Systems

- *Clinical workflow alignment: Systems must mirror real-world care processes*
- *Interoperability by default: Seamless, standards-based data exchange across providers*
- *Single-point data capture: Eliminate redundancy through auto-population*
- *Continuity of care: Enable longitudinal patient tracking across providers and time*
- *Provider-centric design: Minimise administrative burden and optimise usability*
- *Privacy and trust: Consent-based, secure, and accountable data governance.*

- **Clinical Decision Support Systems (CDSS) within provider interfaces**: integration of STGs, clinical pathways and algorithm-based decision tools enabling real-time guidance, reducing unwarranted variation, enhancing diagnostic accuracy, rational prescribing and referral appropriateness, with advanced analytics supporting risk stratification and NCD cohort management.
- **e-Sanjeevani telemedicine as a routine care layer**: embedded within clinical workflows rather than operated as standalone services by supporting continuity, accessibility and cost-effective delivery, particularly in underserved geographies.

All digital systems must adhere to ABDM-aligned interoperability standards: FHIR for data exchange, SNOMED CT for clinical terminology, LOINC for laboratory data; with consent-based

[32] Office of the National Coordinator for Health Information Technology (ONC), *Benefits of Interoperability in Healthcare Systems* (Washington, DC: U.S. Department of Health and Human Services, 2019).

data sharing frameworks, robust privacy protocols and audit trails. **Strong governance is essential to prevent data fragmentation, vendor lock-in and non-standardised proliferation.** Real-time analytics should enable continuous monitoring of care transitions, referral adherence and service utilisation by transforming digital infrastructure into a tool for system stewardship rather than passive data collection.

WHO SHOULD IMPLEMENT: ·State Digital Health Mission ·DHA ·Facility administrators and clinical teams ·Technology partners

WHERE TO IMPLEMENT: ·ABDM-enabled districts with functional digital infrastructure including ABHA registries and HIE layers

MODELS TO LEARN FROM

India

The **ABDM** demonstrates a **federated, interoperable architecture** enabling longitudinal records and cross-provider data exchange. The national telemedicine platform **e-Sanjeevani** illustrates how digital tools can be embedded within routine care delivery to improve access and continuity.

States such as **Karnataka and Andhra Pradesh** have operationalised integrated digital ecosystems combining hospital information systems, telemedicine, and patient record platforms, demonstrating improvements in **care coordination, utilisation, and system efficiency**.

Global

The **United Kingdom's NHS** has established integrated electronic health record systems enabling **real-time data sharing across levels of care**, supporting coordinated and continuous care delivery.

Estonia's digital health system represents a mature model of **end-to-end interoperability**, with universal electronic health records, e-prescriptions, and secure exchange frameworks.

Integrated delivery systems such as **Kaiser Permanente (USA)** demonstrate that embedding digital tools within workflows reduces duplication, improves outcomes, and enhances overall system efficiency.

D.4 Create District-Level Mechanisms for Structured Public–Private Collaboration

WHAT

India's transition to integrated, equitable healthcare requires a **fundamental restructuring of how the public system engages with the private sector**. This recommendation proposes institutionalised, district-level mechanisms that **embed private providers within publicly governed, coordinated care networks** aligned with population health needs and UHC objectives. Rather than treating private providers as peripheral or transactional actors, this approach repositions them as **contracted agents within a regulated, networked delivery system**, operating under defined service roles, referral pathways, interoperable data systems and enforceable accountability frameworks. **The district becomes the locus of health system integration**, where strategic purchasing, provider alignment and care coordination converge.

> *The core challenge is the absence of district-level governance mechanisms to align it with public health goals. Integration is principally a function of governance, not ownership structure.*

WHY

India's health system is characterised by a **structural dualism**, wherein a dominant private sector operates alongside a fragmented and capacity-constrained public system. Empirical evidence underscores the scale and implications of this imbalance. The **NSSO 75th Round** reports that **over 55% of hospitalisations occur in private facilities**, reflecting sustained reliance on private providers for secondary and tertiary care.

- Simultaneously, **out-of-pocket expenditure continues to account for nearly half of total health spending**, indicating persistent gaps in financial protection and effective risk pooling.[33]
- The expansion of publicly financed insurance through PM-JAY, covering over 500 million beneficiaries, has further increased reliance on private providers, with evidence indicating a **4.6 percentage point shift towards private hospital utilisation among beneficiaries**.[34]

While this reflects improved access, it also exposes systemic weaknesses:

- **Integration without coordination:** Private providers are empanelled but remain outside **formal referral networks and continuum-of-care frameworks**
- **Purchasing without stewardship:** Public financing flows to private providers without adequate **alignment** to **district health priorities or epidemiological needs**

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[33] National Health Systems Resource Centre (NHSRC), *National Health Accounts Estimates for India 2019–20* (New Delhi: Ministry of Health and Family Welfare, Government of India, 2022).

[34] Shankar Prinja et al., "Impact of India's Publicly Financed Health Insurance Scheme on Hospitalisation and Financial Protection," *Health Economics, Policy and Law* (2023). (Taylor & Francis Online)

- **Access without financial protection:** Despite insurance coverage, patients incur substantial residual costs, with recent evidence indicating **average out-of-pocket expenditure of ~Rs. 53,965 per hospitalisation in private facilities under PM-JAY**[36]

> *Global evidence, including analyses published in **The Lancet and WHO frameworks on mixed health systems**, consistently demonstrates that **private sector engagement improves system performance only when embedded within strong public stewardship, strategic purchasing, and regulatory oversight mechanisms**.*[35]

Evidence from implementation studies highlights **low and uneven private sector participation, geographic clustering of empanelled hospitals and weak contract enforcement**. Global evidence confirms that private sector engagement improves system performance only when embedded within strong public stewardship, strategic purchasing and regulatory oversight.

In the absence of such institutionalisation, private provision tends to amplify inequities and inefficiencies rather than mitigate them. The core challenge, therefore, is not the presence of the private sector, but the **absence of district-level governance mechanisms to align it with public health goals**.

HOW

Repositioning Public–Private Engagement within a Strategic Purchasing Framework: Aligning PM-JAY and other financing instruments with district health plans and burden of disease profiles, ensuring purchasing decisions are population-responsive and outcome-oriented rather than scheme-driven.

Conceptual Shift in Public–Private Collaboration

- *From transactional empanelment → to strategic, performance-linked purchasing*
- *From parallel provider systems → to integrated, network-based care delivery*
- *From weak oversight → to data-driven governance and clinical accountability*

Embedding Private Providers within Integrated Care Pathways: Requiring mandatory adherence to standardised referral protocols, clinical pathways and structured discharge and counter-referral systems, particularly for chronic disease management where discontinuity drives adverse outcomes.

Institutionalising District Health Market Intelligence: Mapping private sector capacity, service mix and utilisation patterns to enable evidence-based contracting, identification of supply-demand mismatches and optimisation of resource allocation.

Leveraging Digital Public Infrastructure for System Integration: The ABDM provides a foundational layer for integrating private providers into **interoperable health information ecosystems**. Embed private providers within **HIE** frameworks and ABHA-linked longitudinal

[35] Sweta Dubey et al., "Evolution of Government-Funded Health Insurance for Universal Health Coverage in India," *The Lancet Regional Health – Southeast Asia* (2023); World Health Organization, "India Health System Profile." (PubMed)

[36] NITI Aayog, *Evaluation Study on Centrally Sponsored Health Schemes* (New Delhi: Government of India, 2026); reported in "₹54K Expenses per Hospitalisation in Private Facilities under PM-JAY," *The Indian Express*, March 8, 2026. (The Indian Express)

records to enable real-time tracking of patient journeys, enhances continuity of care, and strengthen **transparency in claims management and provider performance**.

Strengthening Clinical Governance and Regulatory Enforcement, public–private collaboration must be underpinned by **robust clinical governance frameworks**, ensuring adherence to STGs, quality standards, and ethical practices. Evidence of **fraudulent claims, over-provision, and unnecessary procedures in publicly financed schemes** highlights the need for strengthened **audit systems, utilisation reviews, and regulatory oversight mechanisms**, particularly at the district level.

Reinforcing District Health Authorities as System Stewards: With enhanced capacity for contract management, performance monitoring and inter-provider coordination, supported by real-time dashboards tracking utilisation, referral flows, quality indicators and financial performance.

WHO SHOULD IMPLEMENT: ·DHS ·SHA ·NHA ·State Health Departments ·Private Providers

WHERE TO IMPLEMENT: ·Districts with high private sector utilisation and provider density

MODELS TO LEARN FROM

India

Indian state experience demonstrates that **effective public–private collaboration is contingent on state capacity and governance design**.

Tamil Nadu's institutional strength in procurement and provider management, **Andhra Pradesh and Telangana's** experience with insurance-based purchasing, and **Gujarat's** targeted PPP models collectively highlight the importance of **strategic purchasing, contract enforcement, and monitoring systems**.

Global

Comparative evidence from the **United Kingdom (NHS)**, **Thailand's Universal Coverage Scheme**, and

Brazil's Unified Health System (SUS) illustrates that private providers can be effectively integrated within publicly governed systems, provided there is strong state stewardship, regulatory oversight, and alignment with care pathways.

These models reinforce that **integration is a function of governance, not ownership structure**

D.5 Institutionalize Care Coordination and Accountability for Integrated Care

WHAT

Achieving integrated care in India requires a deliberate shift from **structural alignment to functional integration**, anchored in **clear institutional responsibility for coordinating patient care across providers and levels**.

This approach recognises that integration does not occur automatically through expanded coverage or infrastructure, but must be **actively governed, managed, and monitored**. It seeks to embed responsibility for **continuity of care, adherence to clinical pathways, and patient follow-up** within the system, rather than leaving coordination to patients or informal provider networks. By doing so, the health system transitions towards a model of **longitudinal, patient-centred care**, particularly for populations requiring sustained engagement across the continuum.

WHY

India's health system continues to operate in a largely **episodic and provider-centric manner**, with limited mechanisms to ensure continuity of care across time and settings. While Ayushman Bharat and PM-JAY have expanded access, they have not sufficiently addressed the coordination failures that undermine quality, efficiency and outcomes. The systemic gaps manifest in weak referral and counter-referral adherence; limited post-discharge follow-up for chronic conditions; **absence of shared accountability for patient outcomes across providers**; and high reliance on patients, often with limited health literacy, to navigate fragmented care pathways. These challenges disproportionately affect populations with NCDs, multimorbidity and socio-economic vulnerability. Evidence links poor coordination in these populations to higher OOPE, repeated hospitalisations and poorer health outcomes.

HOW

Institutionalising Care Coordination as a Core Health System Function: with dedicated human resources and clearly defined roles. Introducing care coordinators at PHCs, HWCs and district hospitals to actively manage patient pathways, referral facilitation, follow-up tracking and treatment protocol adherence.

Shifting from Episodic Care to Longitudinal Patient Management: establishing mechanisms to track patients across episodes, ensure continuity between providers and maintain engagement over time, particularly for NCDs and complex conditions, embedded within continuum-of-care frameworks.

Reframing Integration as System Accountability

- *From patient-driven navigation of fragmented systems → to system-managed coordination across care pathways*
- *From episodic, encounter-based care delivery → to longitudinal, patient-centred care management*
- *From diffuse accountability for outcomes → to clearly assigned responsibility for continuity and quality of care*

Embedding Integration Metrics within Performance and Monitoring Systems: Integration must be rendered visible and measurable through **clearly defined, integration-sensitive performance indicators**. These include **referral completion rates, counter-referral compliance, follow-up adherence, care continuity indicators, and utilisation of teleconsultation services**.

Strengthening District and Facility-Level Accountability Mechanisms: Mandating District Health Societies and Rogi Kalyan Samitis to monitor care pathways, review patient flow data and address systemic bottlenecks, positioning these bodies as active stewards of integration rather than passive administrative entities.

Leveraging Digital Health Systems for Real-Time Coordination: ABHA-linked longitudinal records enabling real-time patient journey tracking, information continuity and proactive follow-up; supported by decentralised, data-driven district reviews for context-specific problem-solving and continuous system improvement.

Enabling Decentralised, Data-Driven Problem-Solving: Given the heterogeneity of health system challenges across districts, care coordination mechanisms must be supported by **decentralised governance and adaptive management**. Routine district-level reviews, supported by data analytics and performance dashboards, should enable **context-specific problem-solving, iterative course correction, and continuous system improvement**. This ensures that coordination is not only institutionalised but also **responsive to local realities**.

WHO SHOULD IMPLEMENT: ·State Health Departments ·District Administration · DHS ·NHA

WHERE TO IMPLEMENT: ·District hospitals ·High burden Primary care units

MODELS TO LEARN FROM

India	Global
India's experience with **HWCs** demonstrates the potential of **team-based primary care and community-level follow-up mechanisms** in improving continuity. States that have strengthened **NCD programmes and referral linkages** offer important lessons on integrating coordination within existing service delivery structures	The **United Kingdom's NHS** employs **care coordinators and case managers within primary care networks** to manage complex patients, improving outcomes and reducing hospital admissions. Integrated delivery systems such as **Kaiser Permanente (USA)** demonstrate how **proactive care coordination and longitudinal management reduce costs and improve quality**.

SECTION E: COMMUNITY ENGAGEMENT, PARTICIPATION AND ACCOUNTABILITY

E.1 Institutionalise Community Engagement as a Legally Enforceable, Rights-Based Component of the Health System

WHAT

Community engagement in health is not merely consultation exercise but is a governance imperative. **This recommendation calls for the repositioning of community engagement from a programmatic activity carried out at the discretion of implementing agencies, to a legally recognised and enforceable right of citizens** embedded in the planning, implementation and oversight of the health system. Through state-specific legislative and policy frameworks, community platforms must be accorded formal roles in health system governance with defined mandates, structured feedback mechanisms and clear institutional accountability for acting on what communities say.

> *Without legal backing, community inputs remain advisory at best and ceremonial at worst. Health systems that are genuinely accountable to their communities are better positioned to identify service gaps, build trust and sustain the social legitimacy on which long-term UHC progress depends.*

WHY

India's health system has a long tradition of community engagement in name of VHSNCs, Jan Arogya Samitis and a range of NHM-mandated platforms have been established across the country. **Yet, in most states, the distance between the existence of these platforms and their meaningful influence on health system decisions remains considerable.** Community engagement continues to function largely as a programmatic requirement: meetings are held, registers maintained, consultations conducted, but the feedback generated rarely influences resource allocation or results in the accountability actions that would give communities a genuine stake in system performance.

In the absence of legal backing, district and state health officials have no enforceable obligation to respond to community feedback and no consequence for the failure to act. **The result is a form of engagement that satisfies procedural requirements without delivering the substantive participation** that transforms a health system's relationship with its population.

HOW

- **Enact state-level legislation or policy mandates** formally recognising community engagement as a citizen right within the health system, specifying the platforms through which this right is exercised and the obligations of health system actors to receive, document and respond to community inputs.

- **Define formal roles for community platforms** like VHSNCs, Jan Arogya Samitis, urban health committees in health planning and monitoring cycles, integrating community feedback into District Health Action Plan preparation.
- **Mandate compilation and structured presentation of community inputs** to decision-makers at district and state levels, with designated officials accountable for documenting their response.
- Build the **capacity of community platforms through training, information-sharing and facilitation support** including access to relevant data on budget allocations, service utilisation and entitlements so that participation is informed rather than merely formal.

India's own legal tradition offers relevant precedents beyond the health sector. The Right to Information Act, MGNREGA's social audit provisions and the Forest Rights Act's community consent mechanisms all demonstrate that legally enforceable citizen participation in governance is constitutionally grounded and administratively feasible.

WHO SHOULD IMPLEMENT: ·State Governments ·State Health Departments ·District Administrations ·Legislatures

WHERE TO IMPLEMENT: ·State and district health systems under NHM and UHC frameworks; building on existing rights-based governance approaches.

MODELS TO LEARN FROM

India

Maharashtra: Community Monitoring Initiatives

Maharashtra's structured community monitoring platforms and public hearings enabled community-generated evidence on facility performance to be presented directly to health officials and district administrators.[37] The process created a forum in which community data confronted institutional performance in a structured and documented setting, generating accountability pressure that informal consultations could not produce.

Global

Uganda: Community Scorecards

Uganda's community scorecard process in which community members assess facility performance against defined indicators, present findings to health workers and jointly develop improvement plans has been evaluated across multiple districts and found to generate significant improvements in provider attendance, medicine availability and utilisation of maternal health services.[38] Accountability effects are strongest when the process is structured, regular and linked to a formal response obligation.

[37] A. Shukla et al., "Community Based Monitoring and Planning in Maharashtra" (COPASAH, 2015), https://copasah.net/wp-content/uploads/2025/02/case_study_5.pdf

[38] *Lessons from a Community Score Card Project in Uganda*, PMC, 2021, https://pmc.ncbi.nlm.nih.gov/articles/PMC7802338/; and *Estimating the Cost of Implementing a Facility and Community Score Card in Uganda*, PMC, 2021, https://pmc.ncbi.nlm.nih.gov/articles/PMC7777411/

E.2 Strengthen State-Level Institutional Anchors to Lead and Sustain Community Engagement

WHAT

Meaningful and sustained community engagement does not emerge from goodwill alone. **It requires dedicated institutional infrastructure to anchor, professionalise and continuously improve the processes through which citizens participate in health governance.** This recommendation calls for the deliberate strengthening of state-level institutions such as State Health Systems Resource Centres, state institutes of rural and urban development and allied training bodies to serve as permanent, knowledge-holding anchors for community engagement across the UHC architecture.

> *Community engagement is often driven by short-term projects or individuals rather than institutional capacity, leading to inconsistency and loss of learning. When the committed individuals leave or the project cycle ends, the knowledge leaves with them.*

WHY

Community engagement in India's health system has produced genuine achievements, but these have struggled to outlast the projects and external funding cycles that generated them. **This pattern reflects a fundamental vulnerability: it rests more on persons than on institutions.** The knowledge of how to facilitate effective participation, how to translate community feedback into programme inputs and how to manage the political dynamics of accountability processes is held by individuals and organisations rather than embedded in state systems.

For a UHC agenda that depends on reaching the most marginalised populations (tribal communities, urban slum dwellers, persons with disabilities) **the absence of robust institutional capacity for community engagement is not a peripheral limitation; it is a structural barrier to equity.**

HOW

- **Nurture State Health Systems Resource Centres with dedicated mandates, sufficient financing and professional staffing** including specialists in participatory research, community facilitation, social auditing and multisectoral collaboration.
- Strengthen state institutes of rural and urban development as **complementary institutional anchors**, particularly for community engagement spanning health and social sectors.
- Design institutions as **autonomous but government-linked bodies** with independent governing boards, protected operational budgets and flexibility to engage civil society and academic partners based on the design principle demonstrated by the most effective state resource institutions in India.
- Ensure **multi-year, ring-fenced financing for institutional capacity development** within NHM frameworks allowing institutions to plan and invest beyond annual budget cycles.

- Build capacity for **participatory planning, multisectoral collaboration and learning** by bridging the gap between policy and practice and scaling context-specific community engagement models.

WHO SHOULD IMPLEMENT: ·State Governments ·SHSRCs ·State Training Institutes ·Health and Panchayati Raj Departments

WHERE TO IMPLEMENT: ·States with existing SHSRCs and training institutes as priority platforms; NHM appraisal cycle for accountability.

MODELS TO LEARN FROM

India

Kerala: Institute of Local Administration (KILA)

Established to support Kerala's decentralisation reforms, KILA developed into a professional institution with a sustained mandate for training, research and facilitation in participatory governance and local planning.[39] Its longevity, integration into Kerala's Panchayati Raj system and continued relevance across successive political administrations reflect the key design principles: autonomous governance, professional staffing, a clear mandate and sustained public financing.

Global

Thailand: National Health Commission Office

Established under Thailand's National Health Act of 2007, the NHCO organises **National Health Assemblies** which are annual deliberative forums bringing together government, civil society and community representatives, and supports health impact assessment processes incorporating community perspectives.[40] The NHCO's institutionalisation within a legal and financial framework has sustained community engagement across changes in government, demonstrating that dedicated institutional infrastructure converts engagement from a periodic event into a permanent governance feature.

[39] Government of Kerala, Local Self Government Department, "KILA - LSGD Kerala," https://lsgd.kerala.gov.in/en/about-the-department/aligned-institutions/kila/.

[40] D. Rajan et al., "Lessons from Nine Years of the National Health Assembly in Thailand," *Global Health Action* 4, supp. 7 (2019), https://gh.bmj.com/content/4/Suppl_7/e001769; and "National Health Act, BE 2550 (2007)," Thailand National Health Commission Office, https://old.nationalhealth.or.th/sites/default/files/upload_files/dmdocs/nationalhealth_act_en.pdf

E.3 Institutionalise District-Level Leadership and Adaptive Implementation for Community Engagement

WHAT

The district is where health policy meets lived reality, where national commitments and state frameworks are translated, or fail to be translated, into the service delivery experiences of ordinary citizens. This recommendation calls for the **creation of dedicated leadership and structured review mechanisms at the district level to drive, monitor and continuously adapt community engagement** processes in health. By designating clear institutional responsibility, establishing routine review cycles and integrating community feedback into district health planning, the health system can ensure that community engagement finds its most consequential expression at the interface between governance and community.

> *Community engagement consistently weakens below the state level because it has rarely been assigned as an explicit and accountable function within district health governance. Without a designated focal point, it is consistently crowded out by more immediate operational demands.*

WHY

State-level policies on community participation are drafted with care; yet by the time these commitments reach the district and block level they frequently encounter unclear ownership, inadequate facilitation support and the absence of anyone whose specific responsibility it is to ensure that community engagement happens and produces consequences. **Community platforms may formally exist while functioning episodically at best**, generating neither the sustained participation nor the accountability feedback that their design intends.

In aspirational and high-need districts, where the gap between community health need and system responsiveness is greatest, **the absence of meaningful community engagement leaves the most vulnerable populations without an effective voice** in the decisions that affect their health.

HOW

- **Designate a district-level official with explicit responsibility for community engagement in health** with the function clearly defined, adequately resourced and reflected in the official's performance assessment.
- Establish **routine district-level review meetings**, convened by the District Health Officer or District Collector, assessing platform functioning, reviewing community feedback received, identifying patterns in community concerns and tracking responses to previous inputs.
- Create **upward flows of community intelligence** from district to state level through State Health Society meetings, enabling systemic issues appearing across multiple districts to inform state health planning.

- **Authorise adaptive implementation**: grant district health managers the operational flexibility to adjust service delivery in response to community feedback within a timeframe that demonstrates to communities that their engagement has effect.
- **Integrate community engagement review into District Health Action Plan preparation**, with documented evidence that community inputs have been considered in prioritisation decisions.

WHO SHOULD IMPLEMENT: ·District Collectors ·District Health Officers ·State Health Departments

WHERE TO IMPLEMENT: ·District Health Societies and district planning platforms; aspirational and high-need districts as priority sites

MODELS TO LEARN FROM

India

Aspirational Districts Programme

The programme's architecture is centred on empowering District Collectors as accountable leaders, supported by real-time data monitoring through the Champions of Change dashboard and subjected to regular high-level review.[41] This has generated measurable improvements in health and nutrition indicators in some of India's most challenging districts. Extending these principles explicitly to community engagement would represent a natural and high-impact evolution of the programme's architecture.

Global

Indonesia: Decentralised Health System

Following Indonesia's decentralisation reforms, districts that developed strong community engagement mechanisms such as regular *musyawarah* planning forums, community health surveys and structured feedback channels has demonstrated greater responsiveness to local health needs, more equitable resource allocation and stronger community trust. Indonesia's experience illustrates that decentralisation creates the structural conditions for meaningful community engagement, but that realising this potential requires deliberate investment in leadership capacity and review processes.[42]

41 R. Gaitonde et al., "Community Action for Health in India's National Rural Health Mission," *Social Science & Medicine* (2017), and C. Lahariya et al., "Community action for health in India: evolution, lessons and the way forward," *WHO* (2020)

42 Heywood P, Choi Y. Health system performance at the district level in Indonesia after decentralization. BMC Int Health Hum Rights. 2010 Mar 5;10:3. doi: 10.1186/1472-698X-10-3. PMID: 20205724; PMCID: PMC2839983.

E.4 Revitalise Strategic Partnerships with NGOs and Community-Based Organisations

WHAT

Civil society organisations occupy a position in India's health landscape that no government system can easily replicate: **they are present in communities that public institutions struggle to reach, trusted by populations that have historically been marginalised by formal systems and skilled in the facilitation and relationship-building that meaningful community engagement requires.** This recommendation calls for the development of structured, long-term partnerships between government health systems and credible civil society organisations, moving away from transactional, short-term contracting toward relational partnerships in which NGO roles in facilitation, capacity building and community feedback are clearly defined, adequately financed and sustained over timeframes that allow trust to accumulate.

> *Organisations that have spent years building trust with tribal communities or marginalised women's groups find themselves operating under perpetual annual contract uncertainty. This drives the most capable organisations toward donor funding and away from government partnership, weakening the civil society ecosystem available to the public health system.*

WHY

The dominant model of government-NGO partnership in health remains transactional and short-term. Annual contracts for defined deliverables, competitively tendered on cost rather than relationship quality and renewed on the basis of administrative processes that have little to do with the depth of community trust an organisation has built. **For NGOs, this arrangement creates a planning horizon too short to invest in the community relationships, staff capacity and institutional learning that sustained engagement demands.** For communities, it means that engagement processes carefully built over multiple years must be reconstructed from scratch when contracts end.

HOW

- Shift toward **multi-year partnership frameworks of three to five years minimum** for community engagement functions which would be long enough for NGOs to invest in community relationships and contribute to institutional learning.
- Move from annual competitive tendering to **multi-year empanelment of experienced NGOs at state level**, assessed against criteria of community credibility, facilitation capacity, track record and geographic presence.
- **Use NHM's provision of up to 5% of programme funds** for contracting civil society support functions, reforming allocation processes to enable multi-year commitments rather than annual renewals.

- Clearly define NGO roles as **facilitation and capacity-building partners** rather than service delivery agents substituting for government functions like supporting VHSNCs and community platforms rather than replacing them.
- Develop **mentoring-based partnerships** in which experienced NGOs support the development of newer community-based organisations and local self-help groups, building a layered and self-sustaining ecosystem of community engagement support

WHO SHOULD IMPLEMENT: ·State Health Departments ·NHM ·District Health Societies ·Empanelled NGOs

WHERE TO IMPLEMENT: ·NHM-supported districts and sub-districts; states with established civil society ecosystems as priority early platforms.

MODELS TO LEARN FROM

India

National AIDS Control Programme

NACP's engagement of NGOs working with high-risk populations was characterised by structural commitment and role clarity that distinguished it from more transactional partnerships elsewhere in the health system.[43] NGOs were given defined mandates for outreach, peer education and community mobilisation within a government accountability framework, with financing mechanisms that provided sufficient duration for community trust to be built and maintained. Significant reductions in HIV prevalence among high-risk groups reflect the returns on this partnership investment.[44]

Global

Bangladesh: BRAC

BRAC's health programme built over decades through community health workers, village organisations and women's groups with genuine community ownership has contributed to transformative improvements in maternal and child health, TB treatment, family planning and nutrition across Bangladesh.[45] The lesson for India: the returns on long-term, relationship-based civil society partnership are not linear. They compound over time as trust deepens, community capacity grows and the feedback loops between communities and health systems become genuinely productive.

[43] National AIDS Control Organization (NACO), "NACP IV Planning Process," *National AIDS Control Programme*, https://naco.gov.in/nacp-iv-planning-process-0

[44] S. K. Dandona et al., "Strengthening India's Response to HIV/AIDS Epidemic Through NACP," *PMC* (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9449298/.

[45] BRAC, "Strengthening primary healthcare," *BRAC Bangladesh*, https://www.brac.net/solutions/development/expanding-health-coverage/strengthening-primary-healthcare/.

E.5 Strengthen Financing, Platforms and Frontline Capacity for Inclusive and Sustained Community Engagement

WHAT

Community engagement is only as strong as the resources, platforms and people that sustain it. This recommendation calls for a comprehensive strengthening of the enabling conditions for inclusive and sustained community engagement including adequate and flexible financing that **responds to local priorities**, revitalised community platforms **that reach the full diversity of the population**, and protected capacity for the frontline health workers whose daily presence in communities is the human foundation of meaningful participation.

> *Community engagement is under-financed, overly programme-driven and places heavy reporting burdens on frontline workers such as ASHAs and ANMs. This limits meaningful participation of adolescents, elderly persons, urban vulnerable groups, patients and caregivers; the very populations whose voices matter most.*

WHY

Community engagement in India's health system suffers from structural underfunding. Allocations are frequently inadequate, inflexibly tied to specific programme deliverables and subject to budget pressures that disproportionately affect the softer, less visible components of health investment. **ASHAs in particular face a widening range of community mobilisation, data collection and programme implementation functions while managing heavy reporting obligations that consume the time available for genuine community interaction.** The progressive accumulation of programme-specific reporting requirements has transformed a role designed around community relationship and trust-building into one dominated by form-filling, **a shift that serves administrative accountability at the expense of the community accountability ASHAs were created to embody.**

Critically, **the diversity of populations whose participation is essential such as adolescents, elderly persons, persons with disabilities, patients and caregivers is poorly reflected** in the membership and functioning of existing platforms, which default toward the most accessible and administratively convenient community representatives rather than the most marginalised.

HOW

- **Create dynamic community engagement budgets responsive to local priorities**, empowering District Health Societies to allocate funds flexibly within broad national parameters reflecting that what tribal communities in aspirational districts need from engagement processes differs from what urban slum populations require.
- Protect **long-term, ring-fenced financing for NGO facilitation partners and SHSRCs**, insulated from annual budget uncertainties that constrain planning and staffing.

- **Revitalise VHSNCs and urban health platforms** ensuring platform members have access to relevant health system information (budgets, performance data, entitlements) and actively recruiting the participation of underrepresented groups.
- **Conduct a systematic review of ASHA and ANM reporting requirements** identifying duplications and low-utility data collections that can be consolidated or eliminated with the explicit goal of restoring time for genuine community engagement.
- Shift from one-time training to **continuous mentoring by experienced community facilitators**, building adaptive skills in social negotiation, participatory facilitation and community mobilisation progressively through practice.

WHO SHOULD IMPLEMENT: ·State Governments ·District Health Authorities ·NGOs ·Frontline Health Workforce

WHERE TO IMPLEMENT: ·VHSNCs, urban health platforms and PHC catchment areas; states with strong community mentoring models as learning sources.

MODELS TO LEARN FROM

India

VHSNCs: Platform with Unrealised Potential

States that have invested in making VHSNCs genuinely functional by means of adequate untied funds, regular facilitation support and integration into district health planning demonstrate that the platform can generate meaningful community engagement when enabling conditions are present.[46] These states offer practical lessons in what the combination of flexible financing, active facilitation and platform integration can produce.

Global

Brazil and Thailand: Decentralised Financing and Community Platforms

Brazil's constitutional Health Councils at federal, state and municipal levels with mandates to participate in health policy formulation and oversight have sustained community participation across decades and political transitions.[47] Thailand's locally governed community health funds, providing communities direct control over health promotion budgets with participatory planning processes, demonstrate how financial autonomy at the community level transforms the quality and sustainability of engagement by giving communities genuine agency.[48]

[46] S. Nair et al., "Village Health, Sanitation and Nutrition Committees: reflections on strengthening community health governance in India," *Global Health: Science and Practice* 3, no. Suppl 3 (2018), https://gh.bmj.com/content/3/Suppl_3/e000681.
[47] Juliana José Patrício Bispo et al., "Community participation: Lessons and challenges of the 30 years of the Brazilian Unified Health System," *PMC* (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8005309/.
[48] N. Promthong et al., "Participatory Health Impact Assessment for Health and Well-being in Thailand," *PMC* (2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC12256213/.

SECTION F: MEDICINES, DIAGNOSTICS AND TECHNOLOGY

F.1 Guarantee uninterrupted availability of essential medicines and diagnostics across all public facilities

WHAT

The state should guarantee the **uninterrupted, free availability of essential medicines and diagnostics** across all public health facilities by institutionalising a **unified, state-wide supply assurance architecture** as a core health systems function. This architecture should be anchored to the **National List of Essential Medicines (NLEM)** and the **Essential Diagnostics List (EDL)**, and embedded as a **non-negotiable service guarantee** within publicly financed healthcare.

The conceptual basis for such a guarantee is articulated in the **Aushadi Adhikar Karyakram (2012)**, which frames access to essential medicines and diagnostics as a **basic public entitlement** rather than a market-mediated outcome. This is a critical shift in policy thinking: effective access depends not only on nominal availability, but on **affordability, quality, and reliability at the point of care**.

Operationally, this requires moving away from fragmented, facility-driven provisioning toward a **system-level supply architecture** in which **procurement, quality assurance, warehousing, logistics, and dispensing** are functionally integrated under a single accountability framework. The objective is to ensure that clinical care delivered within the public system is consistently backed by the medicines and diagnostics required to deliver it.

WHY

Uninterrupted availability of essential medicines and diagnostics constitutes a foundational entitlement within publicly financed healthcare; without it, both coverage and quality remain structurally incomplete.

The absence of assured access to medicines and diagnostics remains a **major structural weakness** in India's health system and a key driver of **financial vulnerability**. OOPE continues to account for a substantial share of total health spending, with medicines and diagnostics comprising a dominant component, a burden sufficient to push vulnerable households into poverty.

This burden persists even within the public system: patients covered under AB-PMJAY are frequently compelled to purchase medicines and diagnostics privately, **reflecting systemic provisioning failures rather than simple access barriers.** These failures disrupt **treatment adherence** for chronic conditions, drive informal referrals that fragment care pathways, and erode the credibility and utilisation of public facilities. The *Aushadi Adhikar Karyakram* places a clear obligation on the public system to ensure universal, free and uninterrupted provisioning by means of **financial protection, quality of care and effective service delivery, which are all contingent on assured input availability**.

HOW

Guaranteeing uninterrupted availability requires a **systemic reorganisation of supply-side governance**, anchored in **centralised, professionalised procurement** and integrated commodity management:

- Establish **autonomous State Medical Services Corporations** modelled on Tamil Nadu (TNMSC) and Rajasthan (RMSCL) model. Enable pooled bulk procurement of **generic essential medicines** and diagnostics through **transparent, competitive processes** with manufacturer prequalification, generating economies of scale, price rationalisation and standardised quality assurance.

Stock-outs are not primarily a problem of insufficient supply, but of fragmented governance, weak logistics discipline, and absence of enforceable accountability.

- Build **responsive, information-driven logistics systems** with **continuous stock monitoring, threshold-based automated replenishment, dynamic redistribution across facilities and interoperable logistics information systems**. Typically maintaining a norm-based buffer stocks of at least three months at district and facility levels.
- Integrate **diagnostics (equipment, reagents and consumables)** within the same procurement and logistics framework, aligned to facility-level service norms, so diagnostic availability matches clinical mandate.
- Anchor the system in **standardised clinical and pharmaceutical practice**. **Essential Drug Lists, formularies and STGs to define procurement priorities** and guide prescribing, alongside quality assurance through certified manufacturers, structured pre- and post-supply testing and quality control systems
- Govern availability as a **measurable and enforceable system outcome** supported by logistics information systems, facility-level oversight, prescription audits and administrative review processes with clear accountability at each tier**.**

WHO SHOULD IMPLEMENT: State Health Departments · Procurement and Logistics Agencies · District Health Administrations · Facility Pharmacists · MoHFW · National Health Authority

WHERE TO IMPLEMENT: Multi-tiered: state procurement corporations; district drug warehouses and logistics hubs; PHC, CHC and hospital-level drug stores; specialised tertiary institutions

MODELS TO LEARN FROM

India	Global
The **Tamil Nadu Medical Services Corporation (TNMSC)** remains the strongest domestic example of a **centralised, autonomous procurement model**, combining competitive tendering, supplier prequalification, quality testing, and IT-enabled inventory control to achieve low-cost procurement and minimal stock-outs.	In **Thailand**, the **National List of Essential Medicines** is embedded within the **Universal Coverage Scheme** and supported by **pooled procurement, central price negotiation, and HTA**.

F.2 Regularly revise and effectively implement Essential Medicines and Diagnostics Lists aligned with disease burden

WHAT

India should institutionalize a **systematic, evidence-based, and enforceable mechanism** for the regular revision and implementation of **Essential Medicines Lists (EMLs)** and **Essential Diagnostics Lists (EDLs)** across the public health system. These lists should not function as static technical annexures or procurement checklists, but as **core instruments of health system governance** that define the minimum therapeutic and diagnostic capacity the state must guarantee.
At the national level, this requires a structured and recurring process for updating the **National List of Essential Medicines (NLEM)** and the **National Essential Diagnostics List (NEDL)**. At the state level, it requires timely adaptation into **State EMLs and EDLs**, followed by alignment with **procurement, inventory systems, facility formularies, and service packages**. In effect, EMLs and EDLs must be treated as **living public health instruments** that evolve with **disease burden advances and changing models of care**.

> The relevance of the lists lies not only in what they include, but in whether they determine what public facilities are actually able to provide. A modern essential list architecture should therefore be **dynamic, periodically reviewed, operationally enforceable, and embedded within financing, procurement, and clinical governance**.

WHY

The case for reform is rooted in India's ongoing **epidemiological transition**. The country's burden of disease has shifted decisively toward **NCDs (chronic respiratory illness, cardiovascular disease, diabetes, cancers, neurological disorders, and mental health conditions)**.[49] Yet the architecture of medicines and diagnostics provisioning in many parts of the public system has not kept pace, creating a widening disconnect between **disease burden and service readiness**.

This misalignment directly weakens **health system performance**. Where EMLs and EDLs are outdated or weakly implemented, public facilities become less **clinically relevant**, particularly at the level of **PHCs and HWCs**, which are expected to anchor **comprehensive primary healthcare**. If these facilities cannot reliably provide essential chronic disease medicines or basic diagnostic support, patients are pushed toward **private purchase**, increasing **out-of-pocket expenditure**, disrupting continuity of care, and weakening trust in the public system.[50]

[49] J. S. Thakur and A. T. Merchant, "Burden of Noncommunicable Diseases and Implementation Challenges of National NCD Programmes in India," Medical Journal, Armed Forces India 76, no. 3 (2020): 261–67.
[50] Erin Hannah et al., "Access to Medicines in the Indian Public Health System – What Works and What Does Not? A Review of the National Health Mission Common Review Mission Reports (2007–2021)," Journal of Global Health Reports 7 (2023): e2023054.

WHO consistently maintains that essential medicines and diagnostics should be selected based on **public health relevance, disease prevalence, efficacy, safety and comparative cost-effectiveness.**[51] In India, where medicines remain a major driver of household health expenditure, weak public provision directly undermines the goals of **UHC, financial risk protection, and equitable access**.[52] At a systems level, EMLs and EDLs are not just product lists, they are instruments through which health systems determine what care will be prioritised, where it will be delivered, and how resources will be allocated.

Strategic Public Health Value of EML/EDL Reform

*A well-governed **EML/EDL framework** can strengthen public healthcare across four critical dimensions:*

➢ ***Clinical relevance:** ensures facilities are equipped for current patterns of disease burden*

➢ ***Financial protection:** reduces household dependence on private purchase of medicines and diagnostics*

➢ ***Allocative efficiency:** improves prioritization and procurement within constrained budgets*

➢ ***System credibility:** strengthens trust in **PHCs and HWCs** as meaningful first-contact providers*

HOW

This reform should be operationalised through **governance reform, technical revision, procurement alignment, and implementation accountability**.

- Institutionalise a **regular, time-bound, criteria-based review mechanism** for NLEM and NEDL: a **two-to-three-year revision cycle** as a practical benchmark, with flexibility for earlier review in response to epidemiological shifts or therapeutic advances.
- Lead revisions through a **standing multidisciplinary technical body** under MoHFW: with **clinicians, pharmacologists, diagnostics experts, public health specialists, state procurement representatives and health economists**, governed by explicit inclusion criteria including burden of disease, efficacy, safety, cost-effectiveness, budget impact and implementation feasibility.
- Integrate **Health Technology Assessment (HTA)** through HTAIn to support evidence-based inclusion decisions and strengthen value-for-money within **finite public budgets.**[53]
- **Strictly align all public procurement systems with revised EMLs and EDLs** including **tender schedules, rate contracts, inventory systems,** warehousing plans and facility formularies; translate diagnostics lists into operational functionality through provision of reagents, consumables, maintenance, calibration and trained personnel.

[51] World Health Organization, "Essential Medicines," fact sheet, January 26, 2026, https://www.who.int/news-room/fact sheets/detail/essential-medicines.
[52] World Health Organization, "Essential Medicines – Policy, Access and Use," WHO India, accessed March 27, 2026, https://www.who.int/india/health-topics/pharmaceuticals/essential-medicines-policy-access-and-use
[53] Health Technology Assessment in India (HTAIn), "About HTAIn," Department of Health Research, Government of India, accessed March 27, 2026, https://htain.dhr.gov.in/about-htain.php

- Make implementation **mandatory and measurable at facility level**: minimum availability norms, stock standards, routine reporting on stock-outs, integration into STGs, prescribing protocols, provider training and digital decision-support systems, monitored through NHM review mechanisms and state dashboards.

Implementation Failure Usually Happens After the List Is Published

Common breakdowns in essential list implementation include:

- *revised lists are issued, but* ***procurement catalogues are not updated***
- *diagnostics are included, but* ***reagents, maintenance, and consumables are not financed***
- ***state adaptation is delayed or inconsistent***
- ***facility-level compliance is not monitored***
- *essential lists are not linked to* ***STGs, training, or prescribing behaviour***

WHO SHOULD IMPLEMENT: · MoHFW ·Department of Pharmaceuticals ·DGHS · HTAIn ·State Health Departments ·State Drug Committees ·State Medical Corporations ·Clinical Experts

WHERE TO IMPLEMENT: ·National: NLEM and NEDL revision cycles. ·State: adaptation into State EMLs and EDLs. Facility: availability compliance and prescribing alignment

MODELS TO LEARN FROM

India

Tamil Nadu and Rajasthan demonstrate how **procurement-linked essential list systems** can improve availability and reduce fragmentation. More recently, **Gujarat's 2025–26 Essential Drugs List revision** illustrates how **subnational adaptation** can better respond to changing patterns of disease burden when linked to procurement cycles.

These examples reinforce a central lesson: essential lists are most effective when embedded within a functioning governance, procurement, and service delivery architecture.

Global

At the global level, the strongest reference point remains the **WHO Model List of Essential Medicines** and the broader **WHO framework for essential medicines and diagnostics governance**, which demonstrate the value of **regular revision, transparent** expert review, and alignment with disease burden and health system need.

F.3 STRENGTHEN PUBLIC PROCUREMENT, LOGISTICS AND LAST-MILE SUPPLY SYSTEMS

WHAT

A modern health supply chain must be **resilient, transparent and integrated**, shifting procurement from a **back-end function to a core health system capability**. This means building a full-cycle system that links d**emand forecasting, pooled procurement, supplier management, quality assurance, warehousing, inventory tracking and last-mile delivery under unified governance.** In practice, this implies real-time data-driven systems (e.g. barcode-based tracking and electronic Logistics Management Information System (e-LMIS) so that orders and stock movements are visible end-to-end. For example, JSI notes that "integrating barcode-based tracking and electronic **LMIS platforms can strengthen visibility across the chain"** from central stores to the point of care. In short, supply reliability must be built into the architecture in tandem with infrastructure and workforce, so that essential medicines and diagnostics flow predictably to patients.

*The **COVID-19** crisis starkly exposed these vulnerabilities; shortages of medical oxygen and critical drugs overwhelmed the system in 2021. Opaque or manual procurement processes are prone to cost escalation and leakages. By increasing transparency and standardisation, we reduce the risk of overpricing or corruption and ensure that public funds buy real value.*

WHY

In India today, fragmented and reactive supply chains cause frequent **stock-outs, procurement delays and unequal distribution** of medicines. National reviews (NHM Common Review Missions) repeatedly document that facilities often run out of generics or receive near-expiry products, forcing patients to buy medicines out-of-pocket. Such interruptions undermine service continuity and drive-up household spending. Weak forecasting and slow procurement lead to chronic shortages, even when budgets are available.

These problems are especially **dangerous for non-communicable diseases: continuity of therapy for diabetes, hypertension,** etc., depends on uninterrupted supplies; stock-outs can precipitate complications and higher downstream costs.

HOW

- Implement **end-to-end e-procurement platforms**: online tendering, competitive bidding and contracting with full audit trails and real-time status tracking, shortening lead times and reducing price variation; mandate all public procurement through transparent digital marketplaces.

- Build **robust quality assurance**: prequalify and accredit suppliers, require batch-level certification via WHO prequalification or national laboratories, conduct random testing before distribution, governed by transparent pre-defined criteria ensuring efficiency gains do not come at the expense of product quality.
- Roll out **statewide e-LMIS** that records stock on hand, issues and expiries with barcode or QR tracking from central stores to facility shelves by creating real-time visibility with automated alerts triggering reorders before stock-outs; integrated dashboards enabling policy-makers to audit entire supply flows.
- Strengthen **last-mile delivery**: define fixed delivery cycles and minimum stock norms for each facility tier; invest in decentralised warehouses closer to communities; give district supply officers clear protocols and training on requisitioning and redistribution; Tamil Nadu's TNMSC model of three-month buffer stocks at 32 district warehouses provides a directly applicable benchmark
- Bolster **cold chain and diagnostics networks**: expand cold-storage capacity, introduce temperature-monitored transport, create contracts for reagent supply and on-site biomedical maintenance for diagnostics equipment

WHO SHOULD IMPLEMENT: · MoHFW ·Central Medical Services Society ·State Medical Services Corporations ·District Supply Officers ·Warehouse Managers ·Pharmacists ·Lab Technicians

WHERE TO IMPLEMENT: · National: CMSS for pooled procurement of vaccines and specialised programmes. ·State: Medical Services Corporations for tenders, warehousing and LMIS. ·District and facility: inventory control and last-mile dispensing

MODELS TO LEARN FROM

India	Global
Tamil Nadu: **TNMSC** provides a ready model in India. It is a state-owned corporation that runs a centralized, IT-based drug procurement and distribution system. TNMSC pre-qualifies suppliers, tenders in bulk, and maintains full inventory visibility to all its 32 district warehouses. As noted above, its transparent, system-driven model **"ensured no shortage of medicines"** in government facilities and even **cut drug costs by over a third.** Its success has led other states (and the national CMSS) to emulate its practices in budget, IT systems and quality control.	Chile: **ChileCompra** (the Chilean government procurement agency) pioneered a fully digital procurement marketplace (Mercado Público) that captures demand centrally and puts it out to competitive bidding. By opening data to public scrutiny, ChileCompra boosted supplier participation by ~180% and **created "the largest virtual store in the country".** Purchases for the health sector (through the **CENABAST subsidiary**) have used this system to aggregate buying power, reduce prices, and limit direct-awards without competition.

F.4 Promote Rational Use of Medicines and Diagnostics to Improve Quality and Curb Antimicrobial Resistance (AMR)

WHAT

India should institutionalise the **rational use of medicines and diagnostics as an enforceable function of clinical governance**, embedded within financing, regulation, and digital health systems. This requires moving beyond advisory approaches toward a system in which **what is prescribed and what is tested are subject to structured oversight, audit, and accountability**.

Operationally, this entails embedding **STGs**, EMLs, and diagnostic protocols into provider workflows and linking adherence to **empanelment, reimbursement, and claims adjudication**, particularly under **PM-JAY**. These protocols should be delivered through **digital clinical decision support and audit layers** within **ABDM**, enabling real-time guidance and retrospective review. At the facility level, antimicrobial stewardship and diagnostic governance mechanisms should be institutionalised to ensure that clinical decisions are aligned with evidence, cost-effectiveness, and patient safety.

WHY

The persistence of irrational prescribing and diagnostic overuse in India reflects a **systemic gap in clinical governance**, rather than isolated provider behaviour. In a setting characterised by heterogeneous provider practices, weak enforcement, and limited data visibility, clinical decision-making often remains **unregulated at scale**.

The financial implications are equally significant. Medicines account for **over 50-55% of OOPE** in India (NHA 2019**),** making irrational prescribing a major driver of financial burden. On the diagnostics side, international evidence suggests that **20-40% of tests may be unnecessary** or o**f low clinical value**, particularly in systems with weak utilisation controls and provider-driven incentives.[56] In India, studies of private sector utilisation have highlighted **overuse of imaging and laboratory tests**, particularly in the absence of standardised clinical pathways.

> *India is one of the largest consumers of antibiotics globally, accounting for **approximately 20% of total human antibiotic consumption**.[54] More concerning is the pattern of use: a significant and growing share involves **"Watch" and "Reserve" category antibiotics** under the WHO AWaRe classification, which are associated with a higher risk of resistance.[55]*

[54] Klein, Eili Y., Thomas P. Van Boeckel, Elena M. Martinez, Suraj Pant, Sumanth Gandra, Simon A. Levin, Herman Goossens, and Ramanan Laxminarayan.
"Global Increase and Geographic Convergence in Antibiotic Consumption between 2000 and 2015." *Proceedings of the National Academy of Sciences* 115, no. 15 (2018): E3463–E3470.
[55] World Health Organization. *WHO AWaRe Classification of Antibiotics for Evaluation and Monitoring of Use*. Geneva: WHO, 2019. https://cdn.who.int/media/docs/default-source/essential-medicines/2021-eml-expert-committee/other-matters/o.1_aware-update.pdf?sfvrsn=a6f155d3_4
[56] World Health Organization. *The Pursuit of Responsible Use of Medicines*.https://apps.who.int/iris/handle/10665/75828 OECD. *Tackling Wasteful Spending on Health*.https://doi.org/10.1787/9789264266414-en

HOW

- **Formalise and enforce STGs** by integrating them into **PM-JAY empanelment criteria, claims processing rules and reimbursement conditions** so that adherence is operationally required, not optional. Embed protocols into **ABDM-enabled systems** for clinical decision support at the point of care, shown to improve prescribing behaviour in high-volume settings.

- **Implement prescription and diagnostic audits** using facility-level review and claims-based analytics. Audit-and-feedback mechanisms can reduce inappropriate prescribing by 10-30%, particularly when combined with benchmarking and peer comparison.[57]

- **Scale Antimicrobial Stewardship Programmes (AMSPs)** across secondary and tertiary care. Global evidence shows **AMSPs achieve 19-36% reductions in antibiotic consumption** while improving prescribing appropriateness without compromising outcomes.[58]

> ***Key Risk:***
> *If stewardship efforts focus narrowly on antibiotics, providers may shift toward* ***greater use of diagnostics and procedures****, resulting in limited net efficiency gains*

- **Digitise pharmacy transactions and link dispensing data to surveillance systems**, enabling real-time monitoring of antibiotic sales, strengthening **Schedule H1 enforcement** and creating a more effective regulatory environment for antibiotic prescribing.

- **Introduce protocol-based diagnostic pathways** with pre-authorisation mechanisms for selected high-cost investigations under PM-JAY.

- Integrate rational use and AMR into National Medical Commission **curricula, licensing and continuing professional development,** ensuring stewardship becomes a standard component of clinical practice and targets provider behaviour and professional norms.

WHO SHOULD IMPLEMENT: ·MoHFW · National Health Authority ·State Health Agencies ·State Drug Controllers ·National Medical Commission ·Hospital Quality Committees

WHERE TO IMPLEMENT: ·MoHFW ·National Health Authority ·State Health Agencies ·State Drug Controllers ·National Medical Commission ·Hospital Quality Committees

[57] Ivers, Noah, et al. "Audit and Feedback." *Cochrane Database* (2012). https://doi.org/10.1002/14651858.CD000259.pub3

[58] Baur, Daniel, et al. "Effect of Antibiotic Stewardship on the Incidence of Infection and Colonisation with Antibiotic-Resistant Bacteria." *The Lancet Infectious Diseases* 17, no. 9 (2017): 990–1001. https://doi.org/10.1016/S1473-3099(17)30325-0

MODELS TO LEARN FROM

India	Global
The **National Action Plan on Antimicrobial Resistance (NAP-AMR)** and **Indian Council of Medical Research (ICMR)-led surveillance networks** provide a strong policy and data foundation. **Kerala offers a leading example of implementation**, with early adoption of a State AMR Action Plan and efforts to institutionalise stewardship through clinical guidelines, infection control systems, and hospital-level antimicrobial stewardship programmes.	The United Kingdom National Health Service (NHS) demonstrates how **clinical guidelines, prescribing audits, and financial incentives** can be integrated within a unified governance framework to promote rational use of medicines. Evidence-based guidelines are embedded into routine care through electronic prescribing systems, audit dashboards, and provider-level performance monitoring, enabling continuous oversight of prescribing behaviour.

F.5 Strengthen Regulation, Pricing Oversight, and Transparency in the Private Pharmaceutical and Diagnostics Market

WHAT

India should establish a **comprehensive and enforceable regulatory architecture for pricing oversight, market transparency, and quality assurance** in the private pharmaceutical and diagnostics ecosystem. This reform must be positioned as a **central pillar of financial protection and strategic purchasing**, rather than a narrow extension of existing regulatory functions.

Operationally, this requires integrating pharmaceutical price regulation, diagnostic pricing frameworks, billing transparency norms, accreditation standards, and digital transaction monitoring into a unified governance system. These mechanisms must be explicitly aligned with publicly financed schemes, particularly **PM-JAY** to ensure that public purchasing is supported by **credible price discovery, cost containment, and provider accountability**. The approach should move beyond static price controls toward a **dynamic regulatory model** combining price ceilings, reference pricing, audit-based enforcement and real-time data analytics.

WHY

The private pharmaceutical and diagnostics market in India exhibits **persistent structural inefficiencies**, characterised by high price dispersion, limited transparency, and uneven regulatory enforcement. Medicines remain the single largest component of out-of-pocket health expenditure, accounting for approximately **50–55% of OOPE** (NHA 2018-19). Despite price controls for essential medicines, empirical evidence continues to show **substantial inter-brand price variation for the same molecule and dosage, often exceeding 100% and, in some cases, several-fold differences**.[59] [60]

In the diagnostics market, the absence of formal pricing regulation allows **wide inter-provider variation in test charges**, even within the same geographic market. Evidence from both OECD and WHO analyses indicates that **20-40% of diagnostic testing may be unnecessary or of low clinical value**. These distortions are compounded by **opaque billing practices and significant information asymmetry**. **Patients facing non-itemised billing, differential pricing and mark-ups on medicines and implants**. Within PM-JAY, these dynamics translate into systemic risks of cost inflation, upcoding and supplier-induced demand, limiting strategic purchasing and driving passive reimbursement.

> *Where pricing and billing are opaque, health markets tend to become **provider-driven and cost-escalatory**, weakening both financial protection and purchasing efficiency*.

[59] Selvaraj, Sakthivel, A. Karan, and A. S. Mahal. "Access to Medicines in India: Pricing, Procurement and Distribution." *Economic and Political Weekly* 53, no. 1 (2018): 60–68.
[60] National Pharmaceutical Pricing Authority. *Annual Report 2022–23*. New Delhi: Government of India.

HOW

Reform should establish a **multi-layered regulatory ecosystem** combining price control, transparency and data-enabled enforcement across three pillars:

- The first pillar is **stronger pharmaceutical price regulation** anchored in the **NLEM** and enforced by the **NPPA**. Targeted price ceilings can substantially reduce patient costs (price capping of **coronary stents** in 2017 achieved up to **85% cost reduction**). Price controls must be backed by **active market surveillance**, to detect manufacturer responses through substitution, reformulation, or shifts toward non-regulated categories.

- The second pillar is a **structured diagnostic pricing framework**. Combining **reference price bands, bundled tariffs, and package rates** for high-volume and high-cost diagnostics, particularly within **PM-JAY**. OECD evidence suggests that **reference pricing**, combined with **utilisation review and audit**, can reduce unnecessary expenditure while preserving access.
- The third pillar is **enforceable billing transparency**. **Mandatory itemised billing, standardised charge descriptions, and disclosure of unit prices** are essential to reduce **information asymmetry** and strengthen patient awareness, purchaser verification, claims adjudication, and fraud detection.

> ***Key Risk:***
> *Partial regulation, such as price caps without transparency or enforcement, may lead to **cost shifting, informal payments, or substitution toward unregulated services**, limiting overall system impact.*

A critical enabler is the use of **digital monitoring and advanced analytics**. Integrating provider billing systems, pharmacy transactions, and insurance claims data within the **ABDM ecosystem** for real-time surveillance of pricing patterns, utilisation intensity, and billing anomalies

Finally, **accreditation and regulatory enforcement** should be strengthened. Incorporating pricing transparency, adherence to standard treatment and diagnostic protocols, and ethical billing practices as core criteria, expanding accreditation from **structural compliance** to broader governance of **clinical and financial behaviour.**

WHO SHOULD IMPLEMENT: ·National Pharmaceutical Pricing Authority ·State Drug Regulators ·National Health Authority ·State Health Agencies ·Consumer Protection Bodies

WHERE TO IMPLEMENT: ·All private sector interfaces with patients and public financing: PM-JAY empanelled hospitals and labs (priority); standalone diagnostics centres; pharmacy and retail interfaces; high-volume urban and peri-urban markets

MODELS TO LEARN FROM

India	Global
Within India, existing instruments such as **NLEM-based price controls and NPPA regulation** have demonstrated that **targeted price ceilings can significantly reduce costs of essential medicines**. However, their impact has been constrained by **limited scope (excluding large segments of the market), variable enforcement, and absence of integration with diagnostics and billing systems**. Similarly, PM-JAY's package rates represent an important step toward **standardised pricing**, but require stronger **audit mechanisms, transparency requirements, and linkage with provider behaviour** to fully realise their potential.	The **United Kingdom** provides a mature example of how **centralised tariff-setting, reference pricing, and strong purchaser oversight** can collectively regulate costs within a mixed provider system. Under the NHS, **standardised tariffs for procedures and diagnostics, combined with routine audit and public reporting**, create a high degree of price predictability and limit provider discretion in billing. Importantly, these mechanisms are reinforced by robust data systems, enabling continuous monitoring of cost and utilisation patterns.

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