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Review Article

From policy to practice: An analysis of health system strengthening and universal health coverage in India

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Abstract

India's healthcare system continues to face significant challenges, particularly in rural regions, due to deep-rooted disparities in manpower, infrastructure, and access to services. These imbalances are most visible in the unequal distribution of resources between states and across urban and rural populations. Although Primary Health Centres (PHCs), envisioned under the "Health for All" framework of the Alma-Ata Declaration, are central to healthcare delivery, their effectiveness is constrained by insufficient staffing, inadequate infrastructure, and systemic inefficiencies, undermining the ability to provide comprehensive and equitable health care.

Traditionally, evaluations of India's health system have focused primarily on outcome indicators such as infant mortality and life expectancy. However, this approach often overlooks key elements such as health systems performance, delivery efficiency, and equity, all of which are essential for understanding disparities. The World Health Organization's broader framework emphasizes the need for responsive healthcare and equitable financial allocation to achieve improved health outcomes.

This paper critically explores the shift from policy design to practical implementation in India's pursuit of 'Universal Health Coverage (UHC)'. It argues that achieving UHC by 2030 requires renewed focus on revitalizing primary healthcare, strengthening human resource development, and addressing financial inequities. A comprehensive, performance-based evaluation framework that integrates both outcome measures and delivery efficiency is essential to bridge the gap between policy intentions and actual implementation. The paper concludes by offering targeted policy recommendations to strengthen the health system's resilience, efficiency, and equity. Furthermore, it advocates for the recognition of healthcare as a fundamental right, supported by assured funding and a rights-based policy environment, which is crucial for realizing UHC.

Keywords: Health for All, Health Rights, Health Systems Strengthening, National Health Policy, Primary Health Care, Universal Health Coverage (UHC)

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1. Introduction

Health systems in the 21st century India

Functional health systems are vital for improving population health in a country, serving as the key link between life-saving interventions and those who need them most. Their primary goal is to deliver better health outcomes equitably and responsively (Savigny et al., 2009). The effectiveness of a health system is reflected not only in health attainments like 'Infant Mortality Rate (IMR)', 'Life Expectancy at Birth (LEB)', and 'Human Development Index (HDI)', but also in performance relative to its potential. In India, rural healthcare is centred on publicly managed primary health centres following a primary health care approach based on 'Alma Atta Declaration on Health for All' (ICMR and ICSSR, 1981). These facilities are especially crucial in areas where private health care is scarce, aside from some traditional healers. As per the 'Indian Constitution', public health is a shared responsibility of central, state, and local governments, with service delivery primarily handled by its states. State and local governments contribute about 75 percent of public health spending, while the centre contributes the rest, though this varies across states (Nayar, 2012).[1-10]

The Indian health system can rightfully take credit for its numerous accomplishments over the past few decades, including the elimination of polio, guinea worm disease,

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yaws, and maternal and neonatal tetanus. Additionally, the 'Total Fertility Rate (TFR)' has significantly declined from 3.4 in 1992-93 to 2.2 in 2015-16. Contrary to expectations, India was able to accelerate the 'Millennium Development Goals' for the 'Maternal Mortality Ratio (MMR)', reaching a level of 130 against the target of 139, and nearly succeeded in meeting the target for under-5 child mortality. (Under 5 Mortality Rate level of 43 against a target of 42) (MoHFW, 2017). Despite notable progress, India's health system represents wide inter- and intra-state disparities, with disadvantaged groups facing the greatest barriers to access and quality care. The system is further strained by the dual burden of 'communicable' and rising 'Non-Communicable Diseases (NCDs)'. Fragmentation is evident across payers, providers, and digital infrastructure. Addressing these challenges requires concerted efforts to strengthen and integrate the existing health system.

Government health spending in India consisting of both the 'center and the states' is around 1.13 percent of GDP—far below international norms. Consequently, 62 percent of healthcare costs are borne by households through out-of-pocket expenses. With a billion annual healthcare transactions, mostly involving private providers, patients often face varied and unregulated pricing. Multiple government schemes further fragment the system, leading to small risk pools, lack of standardization in purchasing, and heavy compliance burdens for providers (National Health Systems Resource Centre (NHSRC), 2021).[11-15]

India's healthcare delivery remains inadequate in 'human resources for health' and highly fragmented, with over 98 percent of facilities employing ten or fewer people. This fragmented provider affects health systems landscape results in disjointed patient records—often manual or stored in non-standardized IT systems—limiting data sharing and policy-informed decision-making (NITI Aayog, GOI, 2019). These various layers of fragmentation are further intensified by market failures and governance challenges (Figure-1).

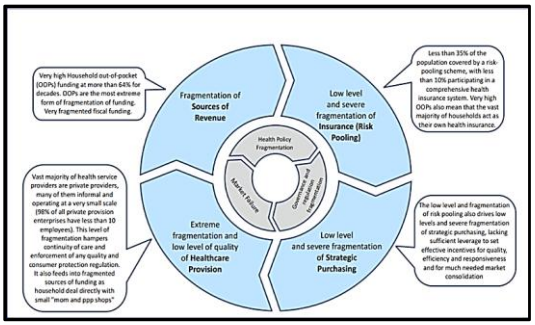

Figure 1: Health system governance impacting low health sector performance

Source: Health system for a new India: Building Blocks, NITI Aayog;2019

Alongside the strengthening of public health services under the NHM, the launch of 'Ayushman Bharat' is in the process of contributing to a stronger health system nationwide. Its twin pillars 'Health and Wellness Centres' for 'primary health care' and PM-JAY offering ₹5 lakh coverage to the bottom 40 percent for 'secondary and tertiary health care' address both prevention and treatment. This presents India with a significant opportunity to transform its health sector, tackle social determinants of health, and improve human development indices, which currently lag behind comparable economies. Such reforms can save millions of lives, prevent poverty from catastrophic health expenses, and boost overall human development (MoHFW, 2018).

The demand for affordable healthcare has been addressed globally through civil society activism since the early 21st century, alongside efforts by various governments to engage their populations in pursuit of Target 3.8 of the 'UN Sustainable Development Goals (SDGs)'. This target aims to achieve UHC by 2030 through 'financial risk protection and access to safe, effective, quality, and affordable healthcare services'—including 'essential medicines and vaccines'—for all. Despite these efforts, around 50 percent globally, or over 4 billion people, still in need of essential health services. Additionally, approximately 800 million people worldwide, including 90 million in India, spend at least 10 percent of their household income on healthcare for themselves or their families (Planning Commission of India, 2011)

2. Health Systems Governance in India

Although public health is included in the 'Directive Principles of State Policy' and placed under the State List for legislative and executive action, it is not recognized as a 'fundamental right' in the Indian Constitution. This has led to diverse healthcare models across states and varied implementation of national health policies and programmes, resulting in unequal access to health services. Population control, family welfare, drugs, and medical education fall under the 'concurrent list', while quarantine measures are under the 'union list' (Basu, 2024). Coordinating health programmes across central, state, and local levels poses significant challenges for administrative alignment and capacity building as central to health systems governance (Figure-2).

Figure 2: Health systems strengthening

Source: Systems Thinking, WHO

India faces major disparities in health worker distribution across rural-urban and public-private sectors. In 2020, while rural areas accounted for 66 percent of the population, they had only 38 percent of all health workers—with just 29 percent of doctors and 30 percent of nurses (WHO, 2021). The private sector provides 60% of inpatient and 70% of outpatient care. The density of India's health workforce remains significantly lower than the WHO-recommended benchmark of 44.5 skilled health workers per 10,000 people as essential for meeting the health SDG by 2030. Given the large number of poor and near-poor citizens, it is widely recognized that tax-funded public health financing must be prioritized. New National Health Policy (NHP) recommendations and proposals suggest increasing government health spending to 2.5–4 percent of GDP, with states expected to allocate 8 percent of their State Domestic Product (SDP) to healthcare funding (Balarajan et al., 2011).

Privatisation has made inroads in the healthcare sector since 1990s. Currently, privatization in healthcare has expanded significantly—from just 5 to 10 percent in the 1940s to 82 percent of outpatient visits, 52 percent of inpatient expenditures, and 40 percent of births occurring in private institutions by 2005 (D. Sharma, 2018). In rural areas, 42 percent of total hospitalizations took place in public hospitals, while the remaining 58 percent occurred in private facilities (NSSO, 2014). The government aims to enhance accessibility, affordability, and quality of care by strategically purchasing healthcare services from private facilities, while also recognizing the vital role of the private sector in supporting the country's pursuit of UHC (D. Sharma, 2018; Lahariya, 2018). India spends nearly 3.8 percent of its GDP on healthcare (Public and Private combined) amounting to Rs 5000 per person annually in which the central and state government shares are 32 percent and 68 percent respectively.

3. National Health Policies and Programs in the Era of SDGs

India is going through a triple transition— 'economic, demographic, and epidemiological' which presents both concerns and prospects for health sector transformation. Since attaining lower-middle-income status in 2009, the country has maintained steady annual growth rates exceeding 5 percent in real per capita GDP over the last three decades (D Acharya et al., 2011). Concurrently, India is experiencing a demographic shift, with a growing working-age population and an increasing elderly demographic. This shift is accompanied by a rising over half of the disease burden of NCDs, such as cancer, diabetes, hypertension, and cardiovascular diseases.

NCDs now make up over 60 percent of India's disease burden, driven by lifestyle changes, urbanization, and environmental issues like air pollution. Addressing this requires strategies for prevention, early detection, and management, along with efforts against communicable diseases. With economic growth, demographic strengths, and focused health policies, India can overcome current challenges and advance toward progress on UHC (NITI Aayog, GOI, 2019).

4. Health Policy Planning in India: Implication for National Health System

A nation's health system is a reflection of its historical context, cultural values, level of economic development, and prevailing political ideology, with its functional structure shaped by five key components: resources, organization, management, financing, and service delivery (Roemer, 1993). While these broader factors influence health systems which can be classified by the degree of market involvement permitted by the government. The shift toward user fees in public hospitals and increased privatization of secondary and tertiary care has created barriers to achieving better health outcomes for the poor, undermining the original vision of 'health for all' philosophy as outlined in the Alma Atta Declaration, 1978.

The 'Structural Adjustment Programs (SAP)' and the subsequent National Health Policies in 2002 and 2017 have shifted healthcare from a 'health for all' approach to a market-driven, consumer-oriented, curative interventions and urban specific model. This led to significant rural-urban disparities, with rural populations largely deprived of healthcare services. Stagnant rural health infrastructure, limited bed availability, and poor institutional functioning pushed many toward traditional/local healers (Mishra, 2012). Rising treatment costs further discouraged rural healthcare access and their affordability. In response, the government introduced policy corrections in 2005 to address the growing healthcare crisis since inception of NRHM.

5. Assessing Gaps in Policy- Practice: Issues of Health Systems Governance

The NRHM aims to revive primary healthcare by ensuring equitable access for rural populations through structural reforms. Its core principles include making health systems more horizontal, decentralizing programmes, adopting a comprehensive approach to disease, and integrating traditional medicine. NRHM promotes intersectoral coordination at the village level via Village Health Nutrition Sanitation Committees (VHNSCs), involving frontline workers (ASHAs, AWWs) and Panchayat members. Panchayats organize meetings; AWWs document proceedings and report to CHCs, while Accredited Social Health Activists (ASHAs) link communities with health services. NRHM ensures a continuum of care through regular outreach sessions like VHNDs, bridging preventive and curative services. It strengthens community participation in functional health systems decision-making and generates demand through education on health and nutrition (Mishra, 2012).

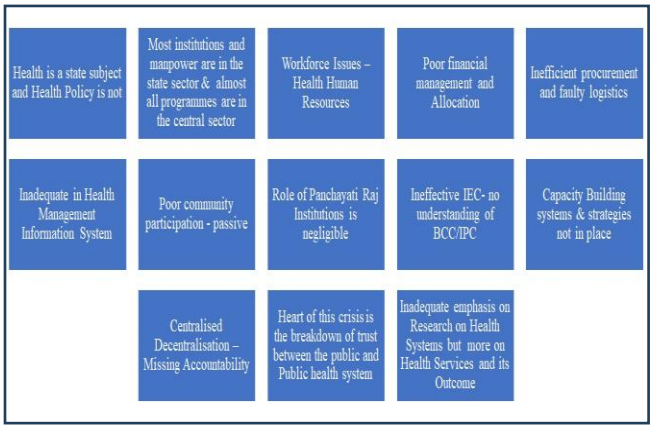

Figure 3: Overarching issues in health systems governance

Source: Authors

NRHM includes the mainstreaming of 'Ayurveda, Yoga, and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)' and the appointment of AYUSH practitioners in existing 'Primary Health Centers (PHCs)' and 'Community Health Centers (CHCs)' to strengthen indigenous medicine systems. AYUSH practitioners play a role in the early detection and management of diseases among children, particularly those registered in Anganwadi Centres (AWC) and government-aided schools (MoHFW, GoI, 2013). NRHM serves as an overarching framework for the convergence of health programmes in rural areas. Its key achievement is the creation of the ASHAs cadre, which has the potential to shift healthcare delivery through increased community participation and 'primary health care' approaches, aligning with the 'Health for All' declaration. In essence, it promotes a demand-driven health system, challenging the provisioning of traditional supply-driven model. Governance of HIV/AIDS responses, youth health policies, and political commitment guide strategies to strengthen, impact and sustain healthcare systems (Kar, 2014).

Malnutrition and undernutrition contribute to nearly half of child deaths, making children vulnerable to infections and hindering their development. Meanwhile, obesity, unhealthy diets, and childhood undernutrition are major causes of non-communicable diseases, which account for 71 percent of global deaths, straining health systems (Blössner & Onis, 2005). Focusing on prevention is crucial. Integrating nutrition into UHC is key to reducing preventable child deaths and improving the health status of 'adolescent girls, pregnant, and lactating women'. Essential nutrition services rank among the most cost-effective health interventions, delivering an average return of $16 for every dollar invested (World Bank, 2019).

As governments acknowledge the widespread impact of malnutrition, integrating nutrition into health systems is seen as a cost-effective way to promote healthy diets and address malnutrition and related diseases. Limited earning opportunities reduce household purchasing power, affecting both food choices and access to healthcare. This often leads to poor micronutrient intake, especially in children, pregnant and lactating mothers. Interestingly, even households that can afford nutritious food often continue consuming customary diets most of the time (UN-SDGs, n.d.).

In remote villages, primary health workers report not having met Anganwadi Workers (AWWs) in over three months. Immunization coverage is poor, and services like health education, referrals, and pre-school checkups are largely absent. This suggests that Integrated Child Development Scheme (ICDS) is failing its mandates in tribal and disadvantaged areas. With community conditions fostering malnutrition and ICDS underperforming, the role of the health system becomes critical. However, government institutions are largely focused on curative care, rather than addressing underlying causes of malnutrition in children under six.

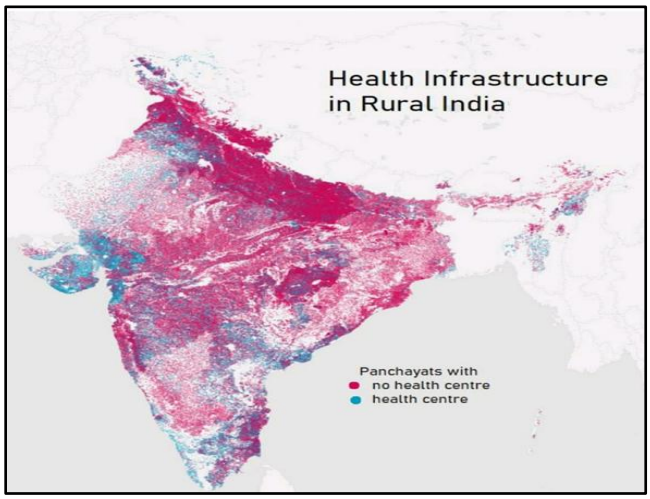

Figure 4: Health infrastructure in rural India

Source: Mission Antodaya Survey 2020 Ministry of Rural Development, GoI.

Health infrastructure in rural India represents Antenatal Care (ANC) and Postnatal Care (PNC) service coverage for pregnant and lactating women is nearly absent in remote tribal areas (Figure-4). 73 percent of villages in India do not have healthcare facilities or a functional health center, and nearly 9 crore people have to travel more than 10 kilometers to reach the nearest health sub-center. High neonatal and infant mortality rates are largely due to the lack of government health institutions at the village level and the distant location of PHCs and CHCs often 15–20 km away, and in some cases up to 60–70 km (Mission Antyodaya 2022-23, n.d.). Poor roads and transport further restrict access, pushing communities to rely on traditional healers as their first point of care. If that fails, they turn to "*Kavirajs"* (traditional healthcare practitioners) or nearby private clinics, depending on suitability (NITI Aayog, 2018).

The core philosophy guiding the Health Service System (HSS) remains consistent across India, with improvements in public health expected to enhance the overall effectiveness of HSS and progress toward UHC via primary care. However, national health policy implementation is hampered by coordination gaps between central and state levels. For instance, while the NHM drives 'primary health care', the 'National Health Authority' oversees health assurance, with no unified payer system linking 'primary, secondary, and tertiary health care'. Public procurement of medicines and equipment lacks standardization, and private healthcare remains under-regulated in terms of cost and quality, highlighting the need for stronger public-private partnerships. The Urban Health Mission is also inadequate across states. Persistent manpower shortages exist at all levels—20.5 percent at PHCs, 75 percent at CHCs, 60 percent for specialists in sub-district hospitals, and 45 percent in district hospitals. Despite longstanding recommendations, a dedicated public health management cadre is yet to be established in most states (MoHFW, 2024).

Out-of-Pocket (OOP) expenditure in India largely stems from purchasing medicines and diagnostics for non-hospitalised primary care, with drug costs making up the bulk of personal healthcare spending. Tamil Nadu has the lowest OOP expenditure due to its robust generic drug supply system, supported by a digitised inventory linked to district warehouses, allowing efficient procurement by PHCs and public hospitals. States like Rajasthan are adopting similar procurement models. Tamil Nadu has also led the way in creating a dedicated public health cadre and training nurses in medical colleges for deployment at PHCs—initiatives now being replicated by other states (Gangolli et al., 2014).

Promoting a skilled continuum with the involvement of ASHAs to mid-level healthcare professionals, along with multiskilling and standardising allied paramedical staff, is vital for effective healthcare delivery and health systems capacity. The promotion of holistic healthcare through the promotion of AYUSH has also proved to have made a difference to the outcome of the performance of existing health systems (Reddy, 2023). Combined with affordable, quality private-sector secondary and tertiary care, India can deliver UHC at significantly lower costs compared to other developing countries.[17-24]

Allocating even 2.5 percent of GDP to public health expenditure, as recommended by the NHP 2017, would significantly enhance public health and overall well-being in India. Since the implementation of NRHM in 2005, which has demonstrated effectively even one percent of GDP increase has brough down the IMR from 60:28 while the MMR dipped from 406:97. (OPHI, 2022). India has made significant progress in maternal and child health, with IMR dropping from 88 per 1,000 live births in 1990 to around 25 in 2025. Likewise, the MMR has decreased substantially from 556 per 100,000 live births in 1990 to 97 between 2018 and 2020. However, these gains have been uneven, as economically disadvantaged states still experience higher mortality rates. (Press Information Bureau, 2025).

Table 1: Decadal change in IMR and MMR during NRHM/ NHM Period

All India/States	IMR 2005	IMR 2020	MMR 2007-09	MMR 2017-19
India	58	28	212	103
Kerala	14	6	81	30
Tamil nadu	37	13	97	58
Assam	68	36	390	205
Odisha	75	36	258	136
Uttarpradesh	73	38	359	167

Source: MOHFW, GOI

Over 415 million Indians have exited multidimensional poverty in the last 15 years, yet the country trails G20 peers in human development, female workforce participation, and per capita income. Still, India can achieve UHC at a fraction of the 8 percent health spending as seen in most developed nations like the UK, Canada including Brazil (OPHI, 2022).

6. Crisis of India's Health System

India's health system faces major financial challenges due to persistent underfunding and the rising role of private providers, resulting in high OOP expenditures. These factors have contributed to high OOP expenditures for households, leading to substantial economic hardships. In 2022, OOP spending made up about 46 percent of total health expenditure—among the highest globally—causing around 17 percent of households to incur catastrophic health costs.[25-33] This financial burden pushes nearly 55 million people into poverty annually, with medicine expenses alone responsible for impoverishing 38 million (Deol, 2022).

Over the past two decades, India has expanded its medical and allied health education to strengthen its healthcare workforce. This expansion has led to increased numbers of healthcare professionals across various disciplines. However, despite increased training capacity, the density of health professionals remains below global standards. India currently has about 8.3 doctors and 17.4 nurses/midwives per 10,000 people—totaling 25.7—well below the WHO-recommended threshold of 44.5 per 10,000 for adequate health coverage (Chhabra, 2024).

A major challenge in India's healthcare system is the uneven distribution of health workforce. While only 31 percent of the population lives in urban areas, they host about 77.4 percent of qualified health professionals. In contrast, rural areas, home to 69 percent of the population, face critical shortages—with only 3.0 health workers per 10,000 people compared to 22.7 in urban areas (Arora, 2024). The gap is stark across professions, with the density of allopathic doctors over 11 times higher in urban than rural areas. Similar disparities exist for nurses, midwives, dentists, and other healthcare providers. Several factors contribute to this

imbalance, including better infrastructure, professional opportunities, and living conditions in urban areas. Conversely, rural regions often lack adequate facilities, resources, and incentives to attract and retain healthcare professionals. Addressing these disparities is crucial for achieving equitable healthcare access across India. Strategies may include targeted investments in rural healthcare infrastructure, incentive programs for rural postings, and policy reforms aimed at balanced workforce distribution (Desiraju, 2021).

India's healthcare system has a dual structure, with the private sector delivering about 70 percent of out-patient and 58 percent of in-patient care, while the public sector provides the rest (Baru & Nundy, 2020).[34-35] Though the private sector has expanded access, weak regulation has led to inconsistent quality and higher patient costs. The public sector, despite its essential role in health promotion, prevention, and medical education, faces significant challenges due to chronic underfunding and weak regulatory mechanisms. The underfunded public sector struggles, and impacts especially in rural areas. Nonetheless, initiatives like the NRHM have improved infrastructure and services for underserved population (Vellakkal et al., 2017).

Access to essential medicines, vaccines, and diagnostic facilities remain a key concern in India. Inadequate funding, coupled with inefficient procurement and supply chain systems, often results in shortages in public health facilities. While the private sector ensures better physical access, the high cost of essential drugs makes them unaffordable for (GOV.UK, 2023). Despite India's role as the "pharmacy of the global south," branded generics remain out of reach for large segments of the population. Weak regulatory oversight also hampers control over irrational prescribing and misuse of medicines, further straining the healthcare system.

7. Discussion

Way forward to strengthen India's public health system

1. **Substantially Increase Public Health Investment and Strengthen Peripheral Infrastructure**
   India must significantly raise public expenditure on health to address chronic underfunding, especially in primary health care. This includes enhancing infrastructure, ensuring an equitable distribution of resources across regions, and improving peripheral health institutions with adequate skilled personnel, essential medicines, diagnostic services, and emergency obstetric care. Strengthening these grassroots facilities is vital for accessible, functional health system and effective healthcare delivery.
2. **Reform Health Systems Governance and Strengthen Accountability Across Sectors**
   A comprehensive health systems governance reform strategy is essential to address systemic issues such as infrastructure gaps, unreliable data, and the imbalance between public and private providers. This should be supported by robust accountability mechanisms in both sectors, including regular audits, transparent reporting structures, and community feedback systems. Stronger regulatory oversight is needed to enforce quality standards, curb exploitative practices, and ensure transparency in healthcare service delivery.
3. **Foster Cooperative Federalism and Implement National Health Policy Effectively**
   Addressing fiscal and governance asymmetries between the Centre and States requires improved federal coordination. The Centre must take a proactive role in setting national standards, providing financial support, and ensuring uniform implementation of health programs. Strategic implementation of the National Health Policy (2017) is crucial—emphasizing a primary healthcare-based system aligned with the UHC recommendations.
4. **Strengthen Digital Health Ecosystems and Information Systems**
   Investing in digital health platforms such as CoWIN, eSanjeevani, and the Ayushman Bharat Digital Mission is vital to expand coverage and improve care quality. Simultaneously, the Health Management Information System (HMIS) must be enhanced for accurate, data-driven decision-making through capacity-building and digital infrastructure development. These advancements will contribute to a unified, community-centric health ecosystem.
5. **Leverage Indigenous Strengths and Promote Sustainable Health Systems**
   India must capitalize on its pharmaceutical and vaccine manufacturing capabilities to ensure domestic supply and contribute to global health security. Reducing dependence on imported medical equipment through policy incentives and public-private partnerships will enhance healthcare self-reliance. Public-private collaborations with civil society should be strategically reoriented to complement health system and services without compromising equity or accessibility, aligning all reforms toward the broader goal of achieving UHC through strengthened infrastructure, workforce, equipment, essential medicines, and community engagement.

8. Conclusion

Advocating for legislating the 'Right to Health' in India requires a strategic and well-grounded approach. Making health a fundamental right is a bold and necessary step toward achieving universal health coverage in the country. It will further ensure state responsibility to guarantee access to equitable, affordable and quality healthcare for all as practiced in Sweden, Brazil, Finland, Norway, Thailand and so on. However, this move must be anchored in infrastructure readiness, fiscal sustainability, cooperative federalism, and a strong regulatory framework targeting all stakeholders. A well-designed Health Rights Bill can serve as a transformative instrument for delivering equitable and inclusive healthcare. The following recommendations are therefore crucial and timely in advancing health systems

strengthening reforms and supporting the effective implementation of the National Health Policy to realise the vision of UHC.

India must consider enacting a 'Right to Health Bill' that makes healthcare a justiciable fundamental right, similar to the Right to Education. Such legislation should ensure legal accountability while being backed by institutional readiness and infrastructure. It must define the scope clearly—whether to enforce public health standards, guarantee individual healthcare access, or ideally, both. A phased, assurance-based rollout with sustained public funding and capacity-building is essential for practical implementation of public health systems.

A thorough assessment of the healthcare system is needed before enacting such a law. This includes evaluating doctor-patient, nurse-patient, and patient-bed ratios to ensure equitable access across regions as per the recommendations of 'Health Human Resources Framework' WHO. Inclusivity should be central, with a focus on marginalized populations, addressing rural-urban disparities and social determinants such as poverty, gender, literacy, and nutrition.

In India's federal structure, where health is a state subject, the legislation must adopt a cooperative federal approach. It should empower and align with state-level initiatives rather than override them. Rajasthan's Right to Health Care Act (2022) offers a valuable example, ensuring free access to public healthcare services, and can serve as a model for other states.

Strong regulatory and governance frameworks are needed to define roles and responsibilities among governments at all level starting from the panchayats, providers, insurers, and patients.

The National Health Policy (2017) emphasizes a comprehensive primary healthcare approach, which should guide implementation. A resilient, equitable and sustainable health system requires strong governance, increased public investment and community centred innovations involving achievements in the performance and accountability of functional health systems. Theses reforms can drive progress towards UHC in India.

9. Source of Funding

None.

10. Conflict of Interest

None.

Reference

1. Arora M. Reduced burden on urban hospitals by strengthening rural health facilities: Perspective from India. *J Fam Med Primary Care*, 2024;13(4):1178–82.
2. Balarajan Y, Selvaraj S, Subramanian S. Health care and equity in India. *The Lancet*, 2011;377(9764):505–15.
3. Baru, R. V., & Nundy, M. (2020). History and characteristics of public private partnerships (PPPs) in the health service system in India. Critical Reflections on Public Private Partnerships, 179–213.
4. Basu R. Public Health in India: How Far are we from Universal Health Coverage? Indian J Pu Adminis.2024;70(4):920–5.
5. Blössner M, Onis M. Malnutrition quantifying the health impact at national and local levels. World Health Organisation.2005. https://iris.who.int/bitstream/handle/10665/43120/9241591870.pdf?sequence=1
6. Chhabra, H. S. Bridging the gap: Revolutionising post-graduate medical education in India. Hindustan Times. 2024: https://www.hindustantimes.com/education/features/bridging-the-gap-revolutionising-post-graduate-medical-education-in-india-101727276618599.html
7. D Acharya, Vaidyanathan G, Muraleedharan VR, Dheenadayalan DS, & Dash U. (2011). Do the Poor Benefit from Public Spending on Healthcare in India? Results from Benefit (Utilisation) Incidence Analysis in Tami Nadu and Orissa. Unpublished. https://doi.org/10.13140/2.1.1448.2567
8. Sharma D. Health Care for India's 500 Million. Harvard Public Health Review, 2018;18:1–14.
9. Deol, T. (2022, September 22). India's persistently high out-of-pocket health expenditure continues to push people into poverty. Down To Earth. https://www.downtoearth.org.in/health/india-s-persistently-high-out-of-pocket-health-expenditure-continues-to-push-people-into-poverty-85070
10. Desiraju, K. Issues in Public Health in India—Keynote address by Keshav Desiraju, Former Secretary of Health and Family Welfare to the Government of India. *J Public Health*, 2021;432):3–9.
11. Gangolli DL, Duggal R, Shukla D. A. (2014). Review of Healthcare in India. Working Papers, Article id: 6372. 2014: Avalble From: https://ideas.repec.org//p/ess/wpaper/id6372.html
12. GOV.UK. (2023). Country policy and information note: Medical and healthcare provision, India, April 2023 (accessible). GOV.UK. https://www.gov.uk/government/publications/india-country-policy-and-information-notes/country-policy-and-information-note-medical-and-healthcare-provision-india-april-2023-accessible
13. ICMR and ICSSR. (1981). Health for All An Alternate Strategy. Indian Institute of Education, Pune.
14. Kar, M. (2014). Governance of HIV/AIDS: Implications for health sector response. International Journal of Health Policy and Management, 2(1), 39–44. https://doi.org/10.15171/ijhpm.2014.07
15. Lahariya, C. (2018). "Ayushman Bharat" Program and Universal Health Coverage in India. Indian Pediatrics, 55(6), 495–506.
16. Mishra A. The role of the Accredited Social Health Activists in effective health care delivery: Evidence from a study in South Orissa. BMC Proceedings, 2012;6(S):1753-6561
17. Mission Antyodaya 2022-23. (n.d.). Ministry of Rural Development. Retrieved May 14, 2025, Available From: https://missionantyodaya.nic.in/
18. MoHFW. (2017). National Family Health Survey (NFHS-4), 2015–16: India Fact Sheet. International Institute for Population Sciences (IIPS). 2017: Available From: https://dhsprogram.com/pubs/pdf/FR339/FR339.pdf
19. MoHFW. (2018). Ayushman Bharat for a new India. Government of India. Available From https://www.india.gov.in/spotlight/ayushman-bharat-pradhan-mantri-jan-arogya-yojana
20. MoHFW. Home | Ministry of Health and Family Welfare | GOI. Available From:https://mohfw.gov.in/
21. MoHFW, GoI. Rashtriya Bal Swasthya Karyakram (RBSK) Child Health Screening and Early Intervention Services under NRHM.2013; Available From: https://pmposhan.education.gov.in/Files/School%20Health%20Programme/Nutrition_Support/Rastriya_Bal_Swaasthya_Karyakram.pdf
22. National Health Systems Resource Centre (NHSRC). (2021). National Health Accounts Estimates for India (2017–18). Ministry of Health and Family Welfare, Government of India. https://nhsrcindia.org/

23. Nayar KR. Three decades of ICSSR-ICMR Committee Report & the re-assertion of social determinants of health.Indian J Med Res, 2012;136(4):540–3.
24. NITI Aayog. Aspirational Districts. https://www.niti.gov.in/sites/default/files/201812/AspirationalDistricts-Book.pdf
25. NITI Aayog, GOI. (2019). Health System for a New India: Building Blocks, Potential Pathways to Reform. NITI Aayog. https://niti.gov.in/sites/default/files/201911/NitiAayogBook_compressed.pdf
26. NSSO. (2014). 71st National Health Survey. Government of India. https://mospi.gov.in/NSSOa
27. Global Multidimensional Poverty Index 2022: Unpacking Deprivation Bundles to Reduce Multidimensional Poverty | OPHI Available From: https://ophi.org.uk/Publications/GMPI13-2022
28. Press Information Bureau. India witnesses a steady downward trend in maternal and child mortality towards achievement of SDG 2030 targets. Available From: https://www.pib. gov.in/www.pib. gov.in/Pressreleaseshare.aspx?PRID=2128024
29. Reddy KS. Decoding and Delivering Public Health. Social Change, 2025;53(4):439–47.
30. Roemer MI. National Health Systems throughout the World. Annual Review of Public Health, 1993;14(1):335–53.
31. Savigny, D. de, Adam, T., Alliance for Health Policy and Systems Research, & World Health Organization. (2009). Systems thinking for health systems strengthening / edited by Don de Savigny and Taghreed Adam. Pour Une Approche Systématique Du Renforcement Des Systèmes de Santé / Édité Par Don de Savigny et Taghreed Adam, 107.
32. UN-SDGs. (n.d.). THE 17 GOALS | Sustainable Development. Retrieved May 14, 2025, from https://sdgs.un.org/goals
33. Vellakkal S, Gupta A, Khan Z, Stuckler D, Reeves A, Ebrahim S, Bowling A, Doyle P. Has India's national rural health mission reduced inequities in maternal health services? A pre-post repeated cross-sectional study. *Health Pol Plan.* 2017;32(1):79–90.
34. WHO, P. (2021). Health workforce in India: Why, where and how to invest? World Health Organisation and Public Health Foundation of India. https://images.hindustantimes.com/images/app-images/2021/9/health-workforce.pdf
35. World Bank. (2019). Nutrition: The key to achieve Universal Health Coverage and unleash Human Capital. World Bank Blogs. https://blogs.worldbank.org/en/health/nutrition-key-achieve-universal-health-coverage-and-unleash-human-capital.

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