2. Citizen-Centred Healthcare - Polity

The Lancet Commission's new report charts a rights-based, citizen-centred roadmap for Universal Health Coverage in India**,** aligning with Viksit Bharat 2047

Overall thrust of the reforms (as per the report you summarised)

The reforms are positioned as a UHC-aligned reorientation of India's health system- community participation, transparency, equity, and affordability are treated not as add-ons but as system design principles. The report's central operational message is to strengthen public healthcare and integrate services across the primary–secondary–tertiary continuum, so care is continuous rather than episodic and disease-siloed. This implies a shift from "programs and facilities" to "people and pathways"- a citizen's health needs should be met through coordinated referral and follow-up, not through disconnected visits to separate schemes or facilities.

Citizen-centred system transition- what it practically means

From facility-centric to people-centric

1. Facility-centric systems optimise around hospital workload, specialties, and departmental targets; citizen-centred systems optimise around health needs over the life course (maternal, child, adolescent, adult, elderly).
2. Practical shift- strong primary care as first contact, with clearly defined referral linkages and back-referrals to primary care for follow-up and chronic disease management.

From reactive to preventive and promotive care - Reactive care treats illness after onset; comprehensive systems invest in health promotion, risk reduction, screening, early diagnosis, and long-term management.

Practical shift- primary care teams deliver immunisation + NCD screening + mental health support + nutrition counselling + health education as routine functions, not as periodic campaigns.

From fragmented to coordinated delivery - Fragmentation emerges when programs run in silos (TB, NCDs, maternal health) and when public-private interfaces lack coordination.

Practical shift- shared care plans, common patient records, standard referral protocols, and district-level care pathways that specify "who does what, when, and where."

"Citizens as rights-bearing agents" transition- institutional implications

From beneficiaries to rights-holders - The shift is about entitlements, accountability, and grievance redress rather than discretionary service delivery.

Practical shift- public display of service guarantees, time-bound grievance systems, patient rights charters, and community monitoring of service quality.

Community participation as a governance tool (not only awareness)

1. Participation becomes meaningful when communities can influence planning, budgeting, prioritisation, and oversight.
2. Practical shift- empowered local bodies/committees that can review facility performance, stock-outs, staff availability, and patient feedback, and escalate issues administratively.

Equity as a measurable outcome - Equity is treated as a "progress metric," meaning the system must track whether disadvantaged groups are catching up.

Practical shift- disaggregated indicators by geography, caste/tribe, gender, disability, income, and migration status; targeted outreach where gaps persist.

Competency-first workforce transition- why it matters for UHC

Beyond degrees- focus on competencies, ethics, and motivation

1. UHC requires reliable frontline delivery; credential-heavy models can still fail if providers lack skills, empathy, communication, and accountability.
2. Practical shift- competency-based training, periodic assessment, supportive supervision, clear protocols, and mentoring for frontline cadres (ANMs, ASHAs, CHOs, nurses).

Frontline worker empowerment as a system lever - Frontline workers are the "interface of trust"; their empowerment improves early detection, adherence, and community uptake.

Practical shift- defined scope of practice, decision-support tools, incentives aligned to quality (not just quantity), and protection from excessive administrative burden.

Mainstreaming Indian systems of medicine responsibly

1. The report's intent is to integrate practitioners (Ayurveda, Yoga, Unani, Siddha, Homeopathy) through a competency-and-ethics lens.
2. **Practical shift**- role clarity (wellness, prevention, supportive care), evidence-informed protocols, referral rules, and avoiding unsafe substitution for conditions needing allopathic emergency/critical care.

Ethical technology leverage transition- "responsible use" should include

Technology as an enabler of continuity and transparency

1. Digital tools should reduce fragmentation- shared records, referral tracking, follow-up reminders, and decision support.
2. Practical shift- interoperable health records, e-referrals, teleconsults linked to primary care, and dashboards for stock/HR management.

Ethical guardrails - Responsible tech means avoiding exclusion and harm.

Practical shift- privacy-by-design, informed consent, minimal data collection, bias checks in algorithms, accessibility for low-literacy users, and offline/assisted modes where connectivity is weak.

UHC in India- The "public system strengthening" emphasis is pivotal

Insurance-led expansion without strong public provisioning has limits

1. Insurance can increase access to hospital services, but if primary care is weak, the system becomes hospital-centric, costlier, and less preventive.
2. Public provisioning is essential for- preventive care, outbreak readiness, chronic disease continuity, and equity for groups the market underserves.

OOPE reduction requires both financing and service availability - Financial protection is not only "who pays," but also "whether services and medicines are available publicly."

Practical shift- reliable drug and diagnostics supply chains, functional primary care teams, and referral-linked secondary care.

Covid-19 lesson - The pandemic highlighted the need for a robust public health and primary-care backbone to manage surveillance, triage, home-based care, and equitable access.

Constitutional and federal dimensions- how they shape implementation

Constitutional grounding

1. DPSPs provide a normative basis for state action on health; decentralisation provisions (Panchayats/municipalities) enable community-level public health strengthening.
2. Practical shift- local planning for sanitation, nutrition, water, vector control, health awareness, and facility monitoring.

Federal constraint and opportunity - Health being a State subject with major central financing creates uneven outcomes.

Practical shift- flexible central funding with state-specific strategies; performance support rather than one-size-fits-all; harmonised standards with local adaptation.

Challenges in adopting UHC- deeper unpacking and what they imply

Resource constraints are not just "low spending"

1. Problem includes- skewed allocation toward tertiary care, limited primary care capex, and inadequate operational budgets.
2. Implication- UHC needs a financing mix that protects primary care first, then strengthens district hospitals, then optimises tertiary.

Infrastructure gaps are about functionality, not only buildings - Many facilities exist but face non-functional equipment, supply gaps, or staff shortages.

Implication- focus on "last-mile readiness" (drugs, diagnostics, power, water, ambulances, maintenance) and referral transport.

Workforce shortages intersect with distribution and working conditions - Rural/remote deficits often persist due to poor living conditions, safety, workload, and career stagnation.

Implication- rural postings need bundled incentives, housing, safety, supportive supervision, and clear career ladders.

Fragmented mix of public-private care creates quality variance - Private care is heterogeneous; without standards and purchasing discipline, costs rise and quality is inconsistent.

I**mplication**- strategic purchasing, standard treatment guidelines, audits, grievance redress, and transparent empanelment criteria.

Insurance-based access can still exclude - Exclusion errors, limited awareness, documentation barriers, and migrant/informal worker mobility issues reduce coverage in practice.

Implication- portability, simplified verification, assisted enrolment, and proactive outreach.

"Integrated services across levels" should look like in an ideal district model

Primary level - First contact, prevention, screening, basic diagnostics, essential medicines, chronic disease follow-up, counselling, community outreach.

Secondary level (sub-district/district hospitals) - Stabilisation, inpatient care for common conditions, emergency obstetric care, surgeries of defined complexity, specialist clinics with referral linkage.

Tertiary level - Complex care, advanced diagnostics/surgeries, teaching and research; also acts as a capacity builder for lower levels.

Key connector mechanisms - Structured referrals, shared records, standard protocols, patient navigation support, and feedback loops to primary care.

Source- https-//www.hindustantimes.com/india-news/with-public-trust-and-political-capital-india-must-seize-the-moment-for-health-reforms-robert-horton-101768936373082-amp.html