ISSN (O) 3108-2246 https://doi.org/10.66328/ijprmh.2026.020101

International Journal of Public Research in Medicine and Health (IJPRMH)

Volume 2, Issue 1, Jan-Mar 2026

Editorial

Primary Health Care and Community-Based Approaches as the Foundation for Universal Health Coverage in India

Dr Richa Mahajan[1]

1. *Associate Professor, Department of Community Medicine, Shri Mata Vaishno Devi Institute of Medical Excellence, Kakryal, Katra. Email ID: dr.richamahajan27@gmail.com*

Universal Health Coverage (UHC) is best understood not as an insurance entitlement, but as a systemic guarantee that all individuals receive promotive, preventive, curative, rehabilitative, and palliative services of adequate quality without financial hardship. In India, where demographic diversity intersects with epidemiological transition and federal governance complexity, the pathway to UHC must be structurally anchored in primary health care (PHC) and community-based delivery models. Hospital expansion and insurance penetration, while necessary, are insufficient substitutes for a resilient primary care architecture.

Over the past decade, India has undertaken significant reforms to strengthen the health system's digital and financial backbone. The Ayushman Bharat Digital Mission has introduced a federated digital health ecosystem built on interoperable health accounts, unified interfaces, and portable electronic health records. Telemedicine platforms such as eSanjeevani and digital public health tools like CoWIN have demonstrated the scalability of technology-enabled governance. These initiatives collectively represent a transition toward digital public infrastructure in health—an approach that aims to reduce fragmentation, enhance continuity of care, and extend specialist access to remote populations.

Yet, digitalization must be evaluated through an equity lens. The proliferation of health IDs and teleconsultation platforms does not automatically translate into effective utilization. Variability in digital literacy, intermittent connectivity in peripheral areas, and infrastructural gaps at primary health centres risk creating a digital stratification of care. For digital health to function as an equalizer rather than an amplifier of inequity, investments must extend beyond software ecosystems to include reliable electricity, broadband penetration, hardware provisioning, cybersecurity safeguards, and workforce training.

Financial risk protection remains central to the UHC agenda. Insurance schemes targeting hospitalization have expanded coverage for vulnerable populations and reduced catastrophic expenditure for major inpatient events. Parallel initiatives to enhance pharmaceutical affordability through widespread distribution of quality-assured generic medicines have improved treatment adherence and reduced cost barriers. However, a structural imbalance persists: outpatient care, diagnostics, and

chronic medication—constituting a substantial share of out-of-pocket expenditure—remain inadequately covered.

This "missing middle" in financial protection pushes millions into poverty annually due to cumulative outpatient expenses. A recalibration of benefit packages toward comprehensive primary and ambulatory care is therefore imperative. Preventive screenings, chronic disease management, essential diagnostics, and long-term pharmacotherapy must be integrated into risk-pooling frameworks. Such an expansion, initially prioritized for the most socioeconomically vulnerable, would align financial protection with the actual epidemiological profile of the population.

India's epidemiological transition further reinforces the primacy of PHC. Non-communicable diseases (NCDs) now account for the majority of mortality, demanding longitudinal, protocol-driven management rather than episodic hospital care. Simultaneously, communicable diseases such as tuberculosis continue to require mission-mode interventions supported by community engagement and technological innovation. The dual disease burden necessitates a health system capable of managing acute infections alongside lifelong chronic conditions. Primary care teams—equipped with standardized treatment algorithms, decision-support tools, and referral linkages—are best positioned to deliver such integrated care.

Despite improvements in aggregate human resource numbers, distributive inequity remains acute. Rural and peri-urban facilities often experience critical shortages of specialists and allied health professionals. This maldistribution undermines service readiness at community health centres and compels patients to seek care at distant tertiary facilities. Incentive-based workforce policies—including rural service bonds, financial incentives, accelerated career progression, and context-responsive medical education—are essential to correct structural imbalances. Task shifting to mid-level providers and community health officers, when embedded within regulatory oversight and continuous training frameworks, can extend service coverage without compromising quality. Public health financing continues to present a structural constraint. Expenditure levels remain below policy aspirations, limiting the expansion of infrastructure, bed capacity, and diagnostic capabilities. In a federal system where health is primarily a state responsibility but policy direction often originates centrally, implementation fragmentation can dilute intended outcomes. Strengthening fiscal federalism, ensuring predictable resource flows, and building autonomous state-level capacities are critical to sustaining reforms beyond mission-mode initiatives.

The predominance of the private sector in service delivery introduces additional complexity. While private providers contribute substantial capacity, regulatory oversight remains uneven. Price variation, irrational diagnostics, and procedure-driven care patterns reflect the absence of robust stewardship mechanisms. Strategic purchasing reforms—transitioning from fee-for-service reimbursement to capitation-based or bundled payment models—can align provider incentives with population

health outcomes. By linking payments to quality indicators and patient recovery metrics, governments can leverage private infrastructure while containing cost escalation.

A graduated referral system represents another pivotal reform. Positioning primary care facilities as mandatory first-contact points for non-emergency conditions rationalizes resource allocation and preserves tertiary infrastructure for complex cases. Effective gatekeeping reduces unnecessary specialist consultations, optimizes clinical pathways, and enhances continuity of care. However, such a model demands that primary facilities be adequately equipped with essential medicines, diagnostics, and trained personnel; otherwise, referral discipline risks becoming a bureaucratic barrier rather than a clinical safeguard. Community-based approaches remain indispensable to achieving UHC. Health is not solely produced within clinical walls; it is shaped by social determinants including nutrition, sanitation, education, and income security. Community engagement models—whether through accredited social health activists, local governance bodies, or civil society networks—enable culturally responsive outreach, early detection of disease, and sustained adherence to treatment. Embedding primary care within community structures strengthens trust and enhances accountability.

Artificial intelligence and data analytics offer emerging opportunities to augment diagnostic accuracy, predict disease outbreaks, and optimize resource deployment. However, AI-enabled health systems must be ethically governed, transparent, and contextually adapted. Infrastructure readiness, algorithmic validation, and data privacy safeguards are prerequisites for responsible deployment. Technology should augment, not displace, the relational core of primary care.

The path to Universal Health Coverage in India is therefore neither singular nor linear. It demands simultaneous strengthening of primary health infrastructure, expansion of financial protection to encompass outpatient and chronic care, strategic engagement with the private sector, equitable workforce distribution, and digitally inclusive innovation. Above all, it requires a normative commitment to equity—ensuring that geographic location, socioeconomic status, or digital access does not determine the quality of care received. Primary health care is not the lowest rung of the system; it is its foundation. When community-based services are adequately financed, digitally integrated, professionally staffed, and strategically governed, they become the engine of efficiency, equity, and resilience. In the Indian context, UHC will be realized not through episodic policy announcements but through sustained investment in the everyday architecture of primary care.

References

1. Radheshyam A, Ramani VK, Naik R. Achieving universal health coverage in India: a scoping review on the requisite public health actions. Front Public Health. 2025 Feb10;12:1366355. doi: 10.3389/fpubh.2024.1366355.
2. Endalamaw A, Mengistu TS, Khatri RB, Wolka E, Erku D, Zewdie A et

al. Universal Health Coverage-Exploring the what, how, and why using realist review. PLOS Glob Public Health. 2025 Mar 18;5(3): e0003330. doi: 10.1371/journal.pgph.0003330

3. Ranabhat CL, Acharya SP, Adhikari C, Kim CB. Universal health coverage evolution, ongoing trend, and future challenge: A conceptual and historical policy review. Front Public Health. 2023 Feb 3;11:1041459. doi: 10.3389/fpubh.2023.1041459
4. Khan MR, Mohammad KU, Rabbani MS. Impact of health expenditure on universal health coverage (UHC) (composite index): Global evidence. Health Promot Perspect. 2025 Nov 4;15(3):268-277. doi: 10.34172/hpp.025.43192.
5. Williams A, Sundewall J. Understanding policy commitments for universal health coverage: a framework for analysis. Health Res Policy Syst. 2025 Jul 16;23:93. doi: 10.1186/s12961-025-01370-4.

Cite this article: Mahajan R Primary Health Care and Community-Based Approaches as the Foundation for Universal Health Coverage in India. International Journal of Public Research in Medicine and Health. Jan-Mar 2026 (2)1: 1-4. https://doi.org/10.66328/ijprmh.2026.020101