INDIA VISION 2047

Four-Tier Healthcare System

FREQUENTLY ASKED QUESTIONS

Community Wellness Centers & Healthcare Reform Policy Brief | March 2026

OVERVIEW & RATIONALE

Q: What is the Four-Tier Healthcare System?

It is a proposed restructuring of India's public health system that adds Community Wellness Centers (CWCs) as a new foundational Tier 1 — sitting below the existing Primary Health Centres, District Hospitals, and Specialty Hospitals. The four tiers serve populations of 5,000 / 30,000 / 5–10 lakh / regional level respectively.

Q: What is deficient in the current three-tier system?

The existing system is structurally curative — it responds to illness rather than preventing it. It has no community-level wellness institution, is overwhelmed by preventable conditions (District Hospital occupancy exceeds 110% in 18 states), ignores India's NCD crisis (63% of deaths), fails urban populations, and does not leverage India's traditional wellness assets such as yoga, Ayurveda, and Siddha.

Q: Why add a fourth tier rather than improve the existing three?

The three-tier system will always be overwhelmed if no upstream community layer intercepts preventable illness. Improving curative infrastructure alone cannot solve a problem rooted in insufficient prevention. Adding CWCs reduces the demand on existing tiers, making their strengthening more achievable — these are complementary, not competing, goals.

Q: How does this align with India Vision 2047?

A healthy population is a precondition for a developed nation. The four-tier system operationalizes Vision 2047's healthcare aspirations: universal access at the community level, prevention-first philosophy, community empowerment, integration of traditional wellness wisdom, digital health infrastructure, and environmental sustainability.

THE COMMUNITY WELLNESS CENTER (CWC)

Q: What exactly is a Community Wellness Center?

A CWC (also called Preventive Wellness Center or PWC) is a formally institutionalized, community-anchored wellness facility serving 5,000 people. It is not a hospital, clinic, or Sub-Centre upgrade — it is designed to prevent chronic illness, promote health through lifestyle choices, and build community resilience before disease emerges.

Q: What services does CWC provide?

Each CWC offers daily yoga, pranayama, and fitness programs; Ayurveda, homeopathy, Siddha, and naturopathy consultations; nutrition counselling, organic food access, and medicinal plant gardens; meditation and stress management; preventive screenings (blood pressure, blood sugar, BMI, vision, hearing) with AI support; health education; and telemedicine nodes integrated with ABDM/ABHA digital health records.

Q: Who staffs a CWC?

Each CWC has four professionals: two Yoga Instructors, one Ayurvedic Practitioner, and one Community Health Worker. Staff are sourced from existing community health worker pools, yoga and Ayurveda graduates, and retrained AB-HWC employees. Total annual staff cost per CWC is ₹7,20,000.

Q: How does the CWC differ from Sub-Centres and ASHAs?

Sub-Centres are understaffed outreach posts, not wellness institutions. ASHAs are community health workers, not facility managers. Neither has the physical infrastructure, programmatic scope, governance mechanisms, or community ownership model of a CWC. The CWC is a qualitatively different institution — not a renaming of existing posts.

Q: What is the community participation model?

Members earn Non-Cash Activity Credits for attending yoga, volunteering, or bringing family members — a gamification model proven in Swachh Bharat. Credits compound for entire family participation. Walking infrastructure around the CWC serves as an organic entry point. With 25% of the budget sourced locally, every CWC is co-owned by its community — creating accountability that centrally delivered government services rarely achieve.

FINANCIAL FRAMEWORK

Q: How much does the entire CWC network cost?

The annual operating budget for 2,80,000 CWCs is ₹28,000 Crore — approximately ₹200 per person per year, or ₹16.67 per month. The one-time capital investment for ~1,35,000 additional centers is ₹25,300 Crore. Much of the infrastructure already exists and requires renovation rather than greenfield construction.

Q: Is Rs. 28,000 Crore affordable?

India's total public health expenditure is approximately ₹4.7 lakh crore annually. The CWC budget is ~6% of this — for a tier that serves 100% of the population. It is also less than 1% of the projected ₹420 billion +₹650 billion in annual healthcare savings and productivity gains the CWC tier is expected to generate.

Q: Who funds the CWCs?

A 75:25 public-private split: the government contributes 75% (₹21,000 Crore/year); private sources — HNIs, foundations, NGOs, and corporate CSR — contribute 25% (₹7,000 Crore/year). India's annual CSR pool exceeds ₹35,000 Crore; channeling ~11% into CWC co-funding is achievable within the existing Companies Act 2013 framework.

Q: Does India need to build 2,80,000 new facilities from scratch?

No. Over 1,75,000 Ayushman Bharat Health and Wellness Centres (AB-HWCs) already exist and are convertible to CWC standard. An additional 20,000+ facilities are upgradable to PHC standard. The four-tier system is largely an architectural realization of infrastructure India has already invested in.

Q: What is the projected return on investment?

International evidence shows every ₹1 invested in preventive community health saves ₹3–8 in downstream curative expenditure (WHO, 2019). Projected outcomes include ₹420 billion in annual healthcare savings, ₹650 billion in productivity gains, and a reduction in the five crore households pushed below poverty each year by catastrophic medical costs.

IMPLEMENTATION

Q: What is the implementation timeline?

Phase 1 (Years 1–2): 1,000 pilot CWCs across 10 states — policy notification, IPHS norms, staff certification, RTG platform launch. Phase 2 (Years 2–3): 50,000 CWCs, AB-HWC conversion at scale, ABDM integration, National Wellness Campaign. Phase 3 (Years 3–4+): Full national coverage of 2,80,000 CWCs, national outcome evaluation, India positioned as a global South-South cooperation model.

Q: Where will the 11.2 lakh CWC staff come from?

India trains over 3 lakh yoga professionals annually. The requirement of 4 staff per center is met by drawing from existing yoga graduates, Ayurveda practitioners, and retrained AB-HWC community health workers. The human resource requirement is achievable within India's existing and pipeline wellness workforce.

Q: How will CWC quality and utilization be sustained?

Real-Time Governance (RTG) is built into the framework. An independent governing body will enable continuous monitoring of utilization and outcomes, peer learning between administrators, rapid correction of underperforming centers, and public dashboards that create community accountability.

Q: How does the CWC relate to Ayushman Bharat?

The CWC framework is directly complementary to Ayushman Bharat. The 1,75,000+ existing AB-HWCs can be repurposed and formally classified as Tier 1 CWCs — not a competing program but the logical institutional maturation of the AB investment. CWCs fill the critical pre-PHC community-level wellness gap that Ayushman Bharat leaves open.

EVIDENCE & ADDRESSING CONCERNS

Q: What international models validate this approach?

Thailand's four-tier system achieves near-universal coverage at ~3.7% of GDP, with its village-level tier credited for dramatic NCD mortality reduction. Japan's Hokenjo community centers produce among the world's highest life expectancy. Cuba's polyclinics match developed-nation outcomes at low cost. Brazil's community health worker tier reduced hospitalization rates by 28% in its first five years.

Q: What Indian precedent shows this can work at scale?

The Swachh Bharat Mission achieved over 100 million toilet constructions and measurably reduced open defecation by aligning with cultural values, offering direct personal benefit, and structuring social incentives correctly. The CWC replicates this model — walking infrastructure, activity credits, family participation multipliers, and locally embedded health champions.

Q: Will people use wellness centers if they are not sick?

The Swachh Bharat precedent directly refutes this concern. When activity is culturally resonant (walking, yoga), the benefit is personally tangible, and social incentives are structured correctly, mass participation follows. The CWC framework is designed around these behavioral insights — it does not ask people to visit a health facility; it invites them to walk, practice yoga, and socialize.

Q: What health outcomes are projected?

Based on comparative international evidence: 25–30% reduction in chronic diseases (diabetes, hypertension, cardiovascular); 50% reduction in stress-related disorders; 15–20% increase in workforce productivity; 25–30% reduction in curative care demand; and normalization of District Hospital bed occupancy currently exceeding 110% in 18 states.

POLICY RECOMMENDATIONS

Q: What are the immediate policy actions required?

1. Formally notify the Four-Tier Healthcare Classification under NHM.
2. Develop dedicated IPHS norms for CWCs.
3. Allocate Rs. 3,500 Crore for 1,000 pilot CWCs across 10 states.
4. Begin AB-HWC conversion to CWC standard.
5. Establish a National CWC Mission under MoHFW with an independent governing board.
6. Issue CSR guidelines recognizing CWC co-funding under Schedule VII of the Companies Act 2013.
7. Launch a National CWC Wellness Campaign.
8. Commission an independent outcome evaluation framework.

Q: How does this align with the National Health Policy 2017?

NHP 2017 targets raising government health expenditure to 2.5% of GDP and calls for reorienting the health system toward health promotion and disease prevention. It explicitly recognizes yoga and traditional medicine in preventive health — precisely what CWCs deliver at scale. The CWC tier is the institutional vehicle through which NHP 2017 goals become operational reality.

Q: What funding is already available for the pilot?

The 2025–26 Union Budget has allocated ₹1 lakh crore for healthcare. The pilot budget of ₹3,500 Crore represents a small fraction of this allocation and is identified as the primary capital funding source for Phase 1 rollout.

"At Rs.200/year per person, CWC is a great investment for a healthy India that slowly translates to a wealthy India."

— CWC Financial Framework, India Vision 2047 Health care

PRIVATE HEALTHCARE & THE FOUR-TIER ENTITLEMENT

Q: Won't a public healthcare entitlement make private practice economically unviable?

The opposite is true — and ten developed nations confirm it. In every country with a strong public entitlement — Germany, France, Australia, Canada, the Nordic countries — private practice not only survives but often grows. Public entitlements eliminate distress-driven demand (people forced to see a private doctor because the public system is inaccessible) and replace it with voluntary, value-driven demand (people choosing private care for speed, comfort, and specialization). India's ₹6.5 lakh crore annual out-of-pocket burden is not a private market — it is a disaster. Eliminating it creates a stable, voluntary private healthcare economy.

Q: What is the fundamental principle governing private practice under the four-tier system?

The four-tier public entitlement covers universal baseline care. Private practitioners compete on differentiation — faster access, superior experience, specialized expertise, and premium amenities. They do not compete with the public system on access; they complement it where the public system

structurally cannot excel: speed, choice, and depth of specialization. This is the operating model in Germany, France, the UK, Australia, and every Nordic country.

Q: Does the four-tier system legally prohibit private healthcare?

No. The four-tier system is a public entitlement framework — it guarantees every Indian access to a defined care package at zero cost. It does not prevent anyone from seeking or providing private care. It defines a National Entitlement Package (NEP): a floor of public coverage above which private practitioners compete freely. Canada's Canada Health Act, the world's strictest public entitlement, still has 29% of all healthcare spending flowing privately.

Q: How do private practitioners fit into each tier specifically?

Tier 1 (CWC): Private yoga studios, Ayurveda clinics, organic food producers, and health technology firms are empaneled as CWC service providers — contracted to deliver sessions and billing the community wellness fund. Tier 2 (PHC): Private GPs are empaneled as Tier 2 providers — private businesses billing the public fund at standardized tariffs for PM-JAY beneficiaries, exactly as in Canada and Denmark. Tier 3 (District Hospital): Private hospitals receive PM-JAY referrals at standardized tariffs; premium patients are served simultaneously in designated private wings at disclosed additional cost. Tier 4 (Specialty Hospital): Private apex hospitals serve PM-JAY patients at contracted rates while simultaneously serving privately insured patients at market rates.

HOW PRIVATE PRACTITIONERS SURVIVE AND THRIVE

Q: What are the six proven strategies for private practitioners to thrive?

1. Empanelment and Dual Practice: Register as a contracted Tier 2, 3, or 4 provider. Treat PM-JAY beneficiaries at public tariffs; treat private patients at market rates — exactly as German SHI-contracted physicians operate.

2. Gap Fees and Supplementary Insurance: Charge a regulated gap fee above the public package for premium amenities — covered by a supplementary private insurance market modelled on France's mutuelle and Nordic employer-funded plans.

3. Specialization and Niche Excellence: Build distinctive premium practices in areas the public system does not replicate — orthopedics, ophthalmology, cosmetic procedures, fertility, sports medicine, dental implants.

4. Concierge and Membership Models: Annual memberships (₹500–2,000/month) for direct physician access, same-day appointments, and four-tier care coordination — revenue fully independent of government reimbursement.

5. CWC Ecosystem Partnerships: Contract with CWCs as yoga, Ayurveda, organic food, or health technology providers — 2,80,000 CWC nodes are an unprecedented commercial distribution platform.

6. IPA/CIN Collective Contracting: Form Independent Practice Associations to pool bargaining power with the National Health Authority — proven in Belgium, Netherlands, and the US.

Q: Can private practitioners earn commercially from the CWC network?

Yes — and this is one of the most significant commercial opportunities the four-tier system creates. Private yoga instructors and Ayurvedic practitioners can hold sessions at CWCs on session-fee or retainer contracts. Organic food producers and Ayurvedic product suppliers can use the 2,80,000-center network as a certified distribution channel for subsidized organic produce sales. Health technology

companies can deploy telemedicine, AI diagnostics, and digital health platforms across the entire network. CWC partnerships represent a rare alignment of private commercial interest and public health benefit.

Q: What is the concierge membership model and why is it relevant for India?

Concierge medicine involves a monthly or annual retainer (₹500–2,000/month) giving members direct physician access, same-day appointments, extended consultations, and proactive care coordination across all four tiers. Revenue is entirely independent of government reimbursement cycles. It is particularly relevant because the CWC wellness tier creates a health-engaged population that has experienced the value of preventive care — a natural market for concierge primary care. As CWC members develop chronic conditions requiring personalized management, empaneled private GPs offering concierge services are the logical next step.

PREVENTING CONFUSION AND CONFLICT: REGULATORY DESIGN

Q: What are the five non-negotiable regulatory rules that prevent public-private conflict?

1. Statutory National Entitlement Package (NEP): Services covered at zero cost are defined by statute, not guideline — this boundary simultaneously defines the legal private market.

2. Balance Billing Prohibition: Charging PM-JAY beneficiaries extra for covered services at empaneled facilities is a cognizable offense, with enforcement modelled on Canada's federal transfer withholding from non-compliant provinces.

3. Fair and Timely Reimbursement: A National Claims Settlement Authority with a statutory 30-day payment guarantee for empaneled providers — the 609 PM-JAY hospital exits are a direct consequence of failing this rule.

4. Digital Referral Audit: ABDM digital referral trails audit all inter-tier referrals, preventing providers from routing patients to affiliated hospitals for financial gain.

5. Quality Parity Standards: NABH accreditation applies uniformly to all empaneled providers — public and private — as a binding condition of empanelment.

Q: Why is the National Entitlement Package boundary so important, and what does Canada teach us?

Canada's experience is the strongest available argument for boundary clarity. The Canada Health Act prohibits extra billing for publicly insured services — yet ambiguity in where the boundary fell produced two decades of constitutional litigation: Chaoulli v. Quebec (2005) and Cambie Surgeries Corp. v. BC (2022). The lesson: when the boundary between public entitlement and private market is unclear, conflict is inevitable. India must define the NEP with statutory precision — exactly what is covered, what is not, and what penalties apply when an empaneled provider charges for covered services. Clarity of the boundary is the structural condition for peaceful coexistence.

Q: Why have 609 private hospitals exited PM-JAY, and how does the four-tier system fix this?

The primary reasons are inadequate tariffs and chronic payment delays — making PM-JAY financially unviable for many private providers. The four-tier system addresses this structurally: a National Claims Settlement Authority with a statutory 30-day payment guarantee; tariff schedules that are regularly revised and fairly priced; and a prevention dividend mechanism that explicitly redirects CWC-generated savings (from reduced hospitalizations) to sustain fair Tier 2 and Tier 3 empanelment rates. Private providers exit public systems when financial terms are unfair — they stay when they are reliable.

Q: What is balance billing and why must it be prohibited?

Balance billing occurs when an empaneled provider charges a PM-JAY beneficiary an additional fee for a service already covered by the public entitlement. It is the most common form of public-private conflict globally and the most damaging to patient trust. Its prohibition — with legally enforceable penalties — is the single most important protection for entitlement integrity. It does not prevent private practitioners from charging market rates for services outside the NEP (premium rooms, faster scheduling, non-covered procedures); it only prevents charging twice for the same covered service.

INTERNATIONAL MODELS AND WHAT INDIA CAN ADOPT

Q: Which international model is most directly applicable to India's Tier 2 PHC challenge?

Two models are directly applicable. Canada: the vast majority of Canadian GPs run private businesses that bill the provincial public insurance plan — "publicly funded, privately delivered" primary care. Physicians own their clinics, hire staff, and operate for profit; what makes them appear 'public' is that their primary revenue comes from billing the government. This is precisely the Tier 2 model India should formalize. Finland: self-employed private GPs provide ~20% of general medical treatment, with patients receiving a partial National Health Insurance (KELA) reimbursement for private consultations — widening patient choice without full out-of-pocket burden.

Q: What does the Nordic experience add to the private sector coexistence model?

The Nordic countries — Sweden, Norway, Denmark, Finland — operate the world's most generous tax-funded universal health systems (85% public share of health spending), yet all four have growing private supplementary insurance markets: Sweden ~20%; Norway ~20%; Denmark ~42%; Finland ~25%. The Nordic lesson: even the most comprehensive public systems generate private market demand for speed, convenience, and non-core services — because the public system cannot efficiently deliver everything at premium quality simultaneously. India should design this supplementary private space deliberately, not wait for it to emerge ad hoc.

Q: What supplementary private health insurance framework should India develop?

A regulated market covering services outside or above the NEP: gap fees at Tier 3 and Tier 4; premium amenities (private rooms, faster elective scheduling); dental and vision care; outpatient drugs; Ayurvedic premium packages; physiotherapy; and mental health counselling. The framework should be modelled on France's mutuelle (top-up insurance held by 95% of the population), Australia's Extras (covering dental, physio, and faster elective surgery), and Nordic employer-funded supplementary plans. IRDAI should issue dedicated supplementary health insurance guidelines as a companion regulation to the NEP.

THE VIRTUOUS CIRCLE: HOW PUBLIC ENTITLEMENT GROWS THE PRIVATE MARKET

Q: How does the four-tier system create a larger and healthier private healthcare market?

Through three reinforcing mechanisms. First, CWC wellness programs create a healthier, workforce-engaged population — increasing private insurance enrollment and the addressable market for premium services. Second, CWC NCD prevention reduces catastrophic hospitalization — freeing household income from distress-driven out-of-pocket spending into voluntary premium health spending. Third, the four-tier referral cascade routes only complex, high-value cases to Tier 4 Specialty Hospitals — giving

private specialty practitioners a premium caseload with minimal public competition. In Australia, the introduction of universal Medicare actually increased private health insurance uptake over time.

Q: Isn't India's private sector revenue dependent on OOP spending that the four-tier system reduces?

This conflates two very different kinds of private spending. Distress-driven OOP spending — households paying for care they cannot otherwise access, often incurring debt — is not a sustainable market. It is a symptom of public system failure. Voluntary premium OOP spending — households choosing private care for superior experience, speed, or specialization — is a genuine private market. The four-tier system eliminates the first category and grows the second. A financially secure Indian household with access to the public four-tier entitlement is far more likely to voluntarily invest in premium yoga, Ayurvedic consultations, concierge medicine, dental implants, and private hospital rooms than a household currently depleting savings on preventable hospitalizations.

Q: What is the commercial case for private healthcare leaders to support the four-tier entitlement?

India's supplementary private health market — once a four-tier entitlement is established — will be structurally larger and more commercially attractive than the current distress-driven OOP market. Reference: France's mutuelle market is ~€30 billion annually on a population of 68 million. Canada's supplementary private spend is ~$108 billion CAD on a population of 40 million. India's population is 1.4 billion. Even at a fraction of developed-nation supplementary per capita spend, the voluntary private health market created by a successful four-tier entitlement will substantially exceed the distress-driven OOP market it replaces. Private healthcare leaders who support the entitlement are investing in the foundation of a far larger and more sustainable commercial market.

"The private sector is not the adversary of universal healthcare — it is its essential partner. The four-tier system restructures private practice: away from profiting from poverty and catastrophe, toward competing on excellence, speed, and choice."

— Section 10, India Vision 2047 Four-Tier Healthcare System Policy Brief