

INDIA VISION 2047

HEALTHCARE REFORM POLICY BRIEF

THE CASE FOR A FOUR-TIER HEALTHCARE SYSTEM

Transforming India's Health Infrastructure Through Community Wellness Centers

Preferred Over the Current Three-Tier System

India Vision 2047 | Dharma Rajya Healthcare Framework
March 2026

EXECUTIVE SUMMARY

India's public health system has served its population through a **three-tier structure** — Primary Health Centers (PHCs), District Hospitals, and Specialty/Tertiary Hospitals — that was conceptualized and gradually improvised in the post-Independence era, especially in the past decade. While this framework laid essential groundwork, it is structurally ill-suited to the demographic, epidemiological, and aspirational realities of contemporary India.

This policy brief presents a rigorous, evidence-backed, and financially grounded argument for transitioning to a Four-Tier Healthcare Architecture — achieved by formally introducing Community Wellness Centers (CWCs), also called Preventive Wellness Centers (PWCs), as the foundational bottom tier. CWCs serve one community of 5,000 people each; at 2,80,000 centers, they cover the entire country.

Critically, **this expansion does not require building from scratch**. Over 1,75,000 Ayushman Bharat Health and Wellness Centres (AB-HWCs) already exist that can be converted to CWCs, and 20,000+ existing facilities are upgradable to PHC standard. The four-tier system is largely an architectural realization of infrastructure India has already invested in.

At a total annual outlay of ₹28,000 Crore — just ₹200 per person per year — and a one-time capital investment of ₹253 billion or less, the CWC tier represents one of the highest-return public health investments in India's history.

THE FOUR-TIER ARCHITECTURE

Tier 1: CWC / PWC — 5,000 population → **Tier 2:** PHC — 30,000 population → **Tier 3:** District Hospital (5 to 10 lakh population) → **Tier 4:** Specialty Hospital

Key findings: the four-tier system reduces burden on District Hospitals, shifts health expenditure toward prevention, leverages existing infrastructure, creates community ownership through public-private co-funding, integrates yoga and Ayurveda into mainstream public health, and directly advances India Vision 2047.

1. THE CURRENT THREE-TIER SYSTEM & ITS LIMITATIONS

1.1 Architecture of the Existing System

Tier	Facility	Population Served	Primary Function
Tier 1	Primary Health Centre (PHC)	Up to 30 thousand; sub-centers serve 3 to 5 thousand	Some preventive; mostly basic curative & maternal care
Tier 2	District Hospital	5–10 lakh	Inpatient, emergency, specialist OPD
Tier 3	Specialty / Tertiary Hospital	Regional / State level	Super-specialty, research, complex surgery

1.2 Critical Structural Inadequacy

1. The Absence of a Community-Level Wellness Tier. The structural deficiency of the three-tier system is what it lacks: a community-anchored, preventive wellness infrastructure. There is no formal tier serving communities at the 5,000-population level. Sub-Centers and ASHAs exist, but they are understaffed outreach extensions, not structured wellness institutions. Mass prevention-centric intervention has no home in the three-tier system.

2. The Non-Communicable Disease (NCD) Crisis. India's disease burden has undergone a seismic shift. NCDs — diabetes, hypertension, cardiovascular disease, cancer, and mental illness — now account for 63% of all deaths (WHO India, 2023). NCDs require continuous lifestyle management: physical activity, dietary discipline, stress reduction, and early detection. The three-tier curative system is architecturally incapable of delivering this.

3. Catastrophic Out-of-Pocket Expenditure (OOPE). At ~47% of total health expenditure (National Health Accounts 2021–22), India's OOPE is among the highest globally. Every year, ~5.0 crore households are pushed below the poverty line by medical costs (World Bank, 2023). The three-tier system provides no proactive layer to intercept illness before it becomes expensive hospitalization.

4. Overloaded District Hospitals. In 18 states, District Hospital bed occupancy exceeds 110% (CAG Report, 2022). These hospitals are flooded with patients — early-stage diabetes, hypertension, minor infections, stress disorders — that could have been prevented or managed at a community wellness level.

5. The Urban Health Vacuum. The three-tier model was designed for rural India. Urban populations — now 36% of India and rising to over 50% by 2036 — have no systematic public preventive health tier. Approximately 47% of urban slum residents have no public health facility within 2 km (NSSO).

6. Missed Potential of India's Cultural Assets. India possesses globally unmatched preventive health resources: yoga, Ayurveda, Siddha, Homeopathy, meditation, and a deep-rooted community walking culture. The three-tier system makes no institutional provision for integrating these into primary prevention — a structural failure to leverage a uniquely Indian competitive advantage in health.

2. THE COMMUNITY WELLNESS CENTER: INDIA'S MISSING FOURTH TIER

2.1 Vision and Definition

The Community Wellness Center (CWC), also called the Preventive Wellness Center (PWC), is a formally institutionalized community-anchored wellness facility serving a defined population of 5,000 people. It is the proposed Tier 1 of the four-tier healthcare system, and the institutional form through which India's preventive health vision becomes a daily reality for every citizen.

The CWC is not a hospital, a clinic, or a Sub-Centre upgrade. It is designed to prevent chronic illness, promote health via lifestyle choices, and build community resilience before disease emerges. It represents India's shift from treating sickness to building health.

2.2 Core Services and Activities

Each CWC is designed to offer a comprehensive preventive wellness experience tailored to its community:

Service Domain	Specific Offerings
Physical Wellness	Walking tracks, yoga sessions, breathing exercises (pranayama), community fitness programs
Traditional Medicine	Ayurveda and homeopathy consultations, Siddha medicine, herbal medicine, naturopathy guidance
Nutrition & Food Security	Organic food access and sales, nutrition counselling, diet management for NCDs, medicinal plant gardens
Mental Wellness	Meditation programs, stress management, peer support groups
Preventive Screening	Blood pressure, blood sugar, BMI, basic vision & hearing checks; AI-supported diagnostics
Health Education	Hygiene, maternal & child health, immunization awareness, first aid, holistic wellness literacy
Digital Health Integration	Telemedicine nodes, ABDM/ABHA health record creation, seamless referral facilitation to Tier 2 PHC

2.3 Staffing Model

Each CWC operates with a lean, community-embedded team of four trained professionals:

Role	Count per CWC	Primary Responsibilities
Yoga Instructor	2	Daily yoga, pranayama, meditation sessions; community fitness programs
Ayurvedic Practitioner	1	Ayurvedic consultations, chronic condition protocols, dietary counselling, Siddha/Homeopathy referrals
Community Health Worker	1	Health education, preventive screenings, health records, referral coordination, community outreach
Total Staff per CWC	4	Annual staff salary cost: ₹7,20,000 per CWC

Staff are sourced from existing community health worker pools, yoga and Ayurveda graduates, and retrained AB-HWC employees — minimizing new recruitment burden and leveraging India's existing wellness workforce.

2.4 Community Participation and Ownership Model

The CWC is designed from the ground up as a community institution — even though it uses government facilities and receives the bulk of its funding from the government. This distinction is critical to its success:

Non-Cash Activity Credits: Community members earn participation credits for attending yoga sessions, volunteering, or bringing family members — a gamification model proven in Swachh Bharat.

Family Participation Multiplier: Credits compound when entire families participate, making the CWC a social institution, not merely a health facility.

Walking as the Gateway Activity: Walking is already India's most popular exercise and social activity. Elegant walking infrastructure around the CWC draws people in organically for yoga, Ayurveda, and health consultations.

Local Ownership: With 25% of the operating budget sourced from local HNIs, foundations, NGOs, and CSR contributions, every CWC is co-owned by its community — creating pride and accountability that centrally delivered government services rarely achieve.

Local Health Champions: Respected community members trained as wellness advocates who drive participation, provide peer education, and serve as the human face of the CWC in their neighborhoods.

3. FINANCIAL FRAMEWORK: THE MOST AFFORDABLE HEALTH INVESTMENT IN INDIA'S HISTORY

3.1 Capital Expenditure: Building on What Already Exists

The most powerful financial argument for the four-tier system is that India has already partially built it. Over 1,75,000 Ayushman Bharat Health and Wellness Centres (AB-HWCs) are already operational and reconfigurable to CWC standard. An additional 20,000+ existing facilities are upgradable to PHC standard. The four-tier architecture does not require greenfield construction; it requires strategic renovation and repurposing. Greenfield construction is scarcely needed when there is no built-up healthcare infrastructure.

Capital Expenditure Component (Per CWC)	Cost (₹)	Justification
Infrastructure (renovation)	₹8,00,000	Renovating existing community buildings
Equipment	₹3,00,000	Yoga mats, basic medical tools
Technology	₹2,00,000	Digital health records, telemedicine setup
Ayurvedic Setup	₹1,50,000	Herbs storage, consultation tools, medicinal garden
Training Materials	₹1,00,000	Educational resources, staff development materials
Inventory	₹1,50,000	Medicines, wellness supplies, organic produce stocking
Contingency (10%)	₹1,70,000	Unexpected costs
Total CapEx per CWC	₹18,70,000	National total: ₹253 billion (₹25,300 Cr) for 135,000 additional centers; may not need as many

3.2 Annual Operating Expenditure Per CWC

Operating Expenditure Component (Annual, Per CWC)	Cost (₹)	Details
Staff Salaries	₹7,20,000	2 yoga instructors, 1 Ayurvedic practitioner, 1 health worker
Utilities	₹60,000	Electricity, water
Maintenance	₹50,000	Facility upkeep
Supplies	₹80,000	Meds, wellness materials
Staff Training	₹30,000	Ongoing staff development and certification
Community Programs	₹40,000	Health camps, wellness events, community outreach
Administration	₹20,000	Documentation, RTG reporting, records
Total OpEx per CWC (Annual)	₹10,00,000	National total: ₹280 billion (₹28,000 Cr/year)

3.3 National Financial Summary

Parameter	Total	Government (75%)	Private Sector (25%)
Total Annual Operating Budget	₹28,000 Cr	₹21,000 Cr	₹7,000 Cr
Number of Centers	2,80,000	—	—
Annual Cost per Center	₹10,00,000	₹7,50,000	₹2,50,000
Members per Center	5,000	—	—
Annual Cost per Person	₹200.00	₹150.00	₹50.00
Monthly Cost per Person	₹16.67	₹12.50	₹4.17
One-Time National Capital Investment	₹25,300 Cr	₹25,300 Cr	—

3.4 The ₹200 Per Person Argument

At **₹200 per person per year** — less than the cost of a single cup of coffee — every Indian citizen receives access to a community wellness facility offering yoga, Ayurveda, organic food access, preventive screenings, mental wellness programs, and health education:

- A single outpatient visit to a private doctor costs ₹300–₹800
- A single hospitalization under PM-JAY averages ₹15,000–₹25,000
- A few prevented hospitalizations per CWC per year pays back the entire annual cost of that CWC
- The ₹28,000 Crore annual CWC budget is a fraction of India's estimated annual ₹6.5 lakh crore OPE burden

"At ₹200/year per person, CWC is a great investment for a healthy India that slowly translates to a wealthy India." — CWC Financial Framework Document

3.5 The Public-Private Partnership Model

The 75:25 government-private funding model is a defining strength of the CWC framework:

Community Accountability: Local funders become local stakeholders. Government-only facilities suffer from neglect; co-funded community institutions do not by design.

CSR Mobilization at Scale: India's corporate CSR obligation under the Companies Act 2013 generates over ₹35,000 Crore annually. Channeling ₹4,000 Crore (approximately 11%) into CWC co-funding creates a sustainable, legally structured private contribution to public health infrastructure.

Scalability and Resilience: Diverse funding sources are more resilient than dependence on government budget cycles alone. Communities that co-fund are far more likely to maintain and expand their CWCs over time.

4. THE FOUR-TIER ARCHITECTURE: HOW IT WORKS

4.1 The Complete System

Tier	Facility	Population	Count	Core Functions & Benefits
1	CWC / PWC Community Wellness Center	5,000	2,80,000	Prevention, wellness, yoga, Ayurveda, , Homeopathy, Siddha, NCD screening, community health education Additional benefit: Organic produce sales to members at no markup rates, promoting nutrition while supporting local farmers
2	PHC Primary Health Centre	~30,000	~47,000	Basic curative care, infectious disease management, pediatric care, holistic remedies, AI-supported diagnostics, referral from Tier 1
3	District Hospital Secondary Care	5–10 lakh	~760	Advanced diagnostics, surgeries, specialized care, emergency, inpatient, ICU, blood bank
4	Specialty Hospital Tertiary / Apex	Regional / State	~400+	Advanced disease treatment, cutting-edge technology, organ transplant, cancer care, medical research, education

4.2 The Referral Cascade: How the Four Tiers Work Together

The power of the four-tier system lies not in any single tier but in their coordinated interaction:

Prevention at Tier 1 (CWC): A 45-year-old with borderline hypertension is detected at a CWC weekly screening. He joins the daily yoga program, receives Ayurvedic dietary counselling, and is monitored monthly. His hypertension doesn't progress to a stroke.

Primary Care at Tier 2 (PHC): A mother with a complicated pregnancy is referred from the CWC to the PHC for antenatal care. AI-supported diagnostics assist the PHC staff. The PHC handles what the CWC cannot — it does not refer upward unnecessarily.

Secondary Care at Tier 3 (District Hospital): Only cases genuinely requiring hospitalization, surgery, or specialist care reach the District Hospital. Bed occupancy normalizes. Quality of care improves. Waiting times reduce.

Tertiary Care at Tier 4 (Specialty Hospital): Complex, rare cases — cancers, cardiac surgeries, neurological disorders — receive focused attention at Specialty Hospitals, no longer crowded out by preventable admissions.

4.3 The CWC as the System's Immune Layer

In immunology, the body's most effective defense is not the hospital that treats sepsis — it is the immune system that prevents infection. The CWC is India's healthcare immune layer: the distributed, always-on, community-integrated system that prevents illness from escalating to a medical event.

International evidence demonstrates that every ₹1 invested in preventive community health infrastructure saves ₹3–₹8 in downstream curative expenditure (WHO, 2019). The CWC makes this principle structurally operational in India for the first time.

5. EVIDENCE-BASED RATIONALE

5.1 The Swachh Bharat Precedent

Perhaps the most compelling evidence that the CWC model can succeed in India is the Swachh Bharat Mission (SBM). Like the CWC, SBM required:

- Behavioral change at the individual and community level
- Mass participation across diverse geographies, cultures, and income groups
- A clear, tangible personal benefit alongside a social benefit
- Community ownership and social accountability mechanisms
- Government-led but community-executed implementation

SBM achieved over 100 million toilet constructions and measurably reduced open defecation — because it aligned with cultural values, offered direct personal benefit, and structured social incentives correctly. The CWC replicates this model precisely in preventive health.

5.2 Projected Health and Economic Outcomes

Based on the Dharma Rajya Healthcare Framework and comparative international evidence, the CWC tier is projected to deliver:

Health Outcomes	Economic Benefits
<ul style="list-style-type: none"> • 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 • Revival of traditional wellness practices • Strengthened community social bonds 	<ul style="list-style-type: none"> • ₹420 billion annual healthcare savings • ₹650 billion annual productivity gains • Reduced pharmaceutical waste and expenditure • Reduced OOPE burden on households • India positioned as global holistic healthcare leader • Enhanced cultural soft power globally

5.3 International Evidence for Four-Tier and Preventive Wellness Models

Thailand — Universal Coverage at Low Cost: Thailand's four-tier system achieves near-universal coverage at approximately 3.7% of GDP. The foundational village-level tier — analogous to the CWC — is credited with dramatic improvements in life expectancy and NCD mortality reduction over two decades.

Japan — Community Health Centers: Japan's 469 Hokenjo (Public Health Centers) deliver preventive health services to defined community populations. Japan has among the highest life expectancy globally at moderate healthcare spend — a direct product of its preventive community health architecture.

Cuba — Polyclinic Model: Cuba's community-based polyclinics have produced health outcomes comparable to developed nations at a fraction of the expenditure. Prevention and community engagement are the model's defining features.

Brazil — NASF and Community Health Teams: Brazil's community health worker teams, operating as a formal tier below primary care, reduced hospitalization rates by 28% in their first five years and significantly improved NCD management indicators.

5.4 India-Specific Data Supporting the CWC Tier

Indicator	Current Status	CWC Impact
NCD share of total deaths	63% (WHO 2023)	Reduces through lifestyle intervention
OOPE as % of Total Health Expenditure	~47% (NHAs 2021–22)	Reduces through upstream prevention
Households pushed to poverty by healthcare	~5 cr/year	Reduces through prevented hospitalizations
District Hospital bed occupancy (18 states)	>110%	Reduces through upstream absorption
AB-HWCs already operational and upgradable	1,75,000+	Direct conversion to CWC — minimal new capital
Existing facilities upgradable to PHC	20,000+	Strengthens Tier 2 with minimal greenfield cost
India's annual CSR funding pool	>₹35,000 Cr	Covers up to 20% of CWC private match requirement

It is notable that children under 14 and adults over 65 — approximately 31% of India's population — while not the primary CWC activity participants, benefit directly from Ayurveda, organic produce, and healthier community members. The aggregate wellness effect of a CWC extends well beyond its active participant base.

6. ALIGNMENT WITH NATIONAL POLICY FRAMEWORKS

6.1 India Vision 2047

India Vision 2047 — anchored in the Dharma Rajya framework — envisions India at its centenary as a developed, prosperous, and equitable nation. A healthy population is not merely a development goal; it is a precondition for achieving it.

The CWC-led four-tier system directly operationalizes Vision 2047's healthcare aspirations:

- Universal health access, reaching every community of 5,000 people across India
- Prevention-first philosophy, reducing catastrophic health expenditure
- Community empowerment, creating locally owned and locally accountable institutions
- Integration of India's traditional wellness wisdom (yoga, Ayurveda, Siddha) into mainstream public health
- Digital health infrastructure, through telemedicine nodes and ABDM integration at CWC
- Environmental sustainability through eco-friendly facilities, medicinal plant gardens, and reduced chemical use

6.2 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. The CWC tier is the institutional vehicle through which these goals become operational reality.

NHP 2017 also explicitly recognizes the importance of Yoga and traditional medicine in preventive health — precisely what CWCs deliver at scale.

6.3 Ayushman Bharat Architecture

The CWC framework is directly complementary to Ayushman Bharat. The 1,75,000+ existing AB-HWCs are not being sidelined — they are being repurposed and formally classified as Tier 1 CWCs within the four-tier framework. This is not a competing program; it is the logical maturation of the AB investment.

The CWC fills the critical gap that Ayushman Bharat leaves open: the pre-PHC, community-level wellness layer. A citizen who is healthy does not need health insurance in regular life but for assurance that it is there; the CWC keeps citizens healthy.

6.4 Real-Time Governance (RTG) Integration

The CWC framework incorporates Real-Time Governance (RTG) as a cornerstone of operational excellence. An independent governing body — comprising healthcare professionals, government officials, business leaders, and NGOs — will oversee the network. RTG enables:

- Continuous monitoring of CWC utilization, participation rates, and health outcomes
- Peer learning between CWC administrators across districts and states
- Rapid identification and correction of underperforming centers
- Public dashboards that create accountability and generate community pride
- Data-driven policy refinement at the national level
- RTG transforms the CWC network into a learning, adaptive system — one that improves in quality over time rather than degrading, as government facilities so often do.

7. IMPLEMENTATION ROADMAP

The implementation strategy is built on a core principle: use what India already has. Existing AB-HWCs, Panchayat buildings, community centres, and schools form the physical backbone of the CWC network. Existing community health workers, yoga graduates, and Ayurveda practitioners form its human backbone. The four-tier system is largely a structural realization of investments already made.

Phase 1 — Pilot and Foundation (Year 1–2)

Target: 1,000 pilot CWCs across representative urban, peri-urban, and rural settings in 10 states.

1. Issue National Policy Notification formally defining the four-tier healthcare classification under the National Health Mission
2. Develop dedicated Indian Public Health Standards (IPHS) norms for CWCs: infrastructure, staffing, services, governance
3. Select 1,000 pilot sites from existing AB-HWCs and upgradable community buildings
4. Renovate and equip pilot CWCs — yoga spaces, Ayurvedic setup, digital health infrastructure
5. Train staff: certified yoga instructors, Ayurvedic practitioners, and community health workers
6. Deploy RTG digital platform for real-time monitoring and governance
7. Mobilize initial HNI, CSR, and Foundation funding (target: ₹350 Crore for 25% pilot match)
8. Launch pilot Non-Cash Activity Credit system with a unified digital platform

Phase 2 — Scale-Up (Year 2–3)

Target: 50,000 CWCs, integrating with existing infrastructure at scale.

9. Expand to 50,000 CWCs prioritizing communities with highest NCD burden, lowest PHC utilization, and greatest urban health gaps
10. Fast-track conversion of 1,75,000 AB-HWCs to CWC standard — the largest single source of ready infrastructure
11. Integrate all CWCs with the ABDM (Ayushman Bharat Digital Mission) digital health stack ABHA (Ayushman Bharat Health Account) for health record creation and referral tracking
12. Mandate all state health departments to include CWC budgets in annual health plans
13. Launch National CWC Wellness Challenge — a public mobilization campaign modelled on Swachh Bharat
14. Establish quality monitoring mechanisms with independent evaluation teams

Phase 3 — Full Rollout and Consolidation (Year 3–4 and beyond)

Target: Complete national coverage of 2,80,000 CWCs — one per 5,000 population.

15. Achieve full national CWC coverage, integrating into a complete digital health ecosystem
16. Full NCD primary prevention at Tier 1 (CWC) and management at Tier 2 (PHC), with District Hospitals reserved for genuine secondary care
17. Conduct first national outcome evaluation: NCD mortality reduction, OOPE savings, hospital occupancy, community participation rates
18. Leverage the 2025–26 Union Budget ₹1 lakh crore healthcare allocation as primary capital funding source
19. Position India as a global South-South cooperation model for holistic community preventive health

Phase	Timeline	CWC Target	Key Milestone
Phase 1	Year 1–2	1,000 pilots	Policy notification; staff certification; RTG launch
Phase 2	Year 2–3	50,000 CWCs	AB-HWC conversion; ABDM integration; Swachh Bharat-style campaign
Phase 3	Year 3–4+	2,80,000 CWCs	Full national coverage; outcome evaluation; global model

8. ADDRESSING COUNTERARGUMENTS

"Sub-Centers and ASHAs already exist at the community level." Sub-Centers 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.

"₹28,000 Crore is too large a budget commitment." India's total public health expenditure is approximately ₹4.7 lakh crore annually. The CWC budget represents approximately 6% of this — for a tier that serves 100% of the population. The ₹28,000 Crore annual outlay 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.

"People won't use wellness centers — they only come when sick." The Swachh Bharat precedent directly refutes this. When activity is culturally resonant (walking, yoga), the benefit is personally tangible, the design is attractive, and social incentives are structured correctly, mass participation follows. The CWC framework has been designed precisely around these behavioral insights.

"This is just another government scheme that will be under-utilized." The CWC is explicitly designed to avoid government facility pathologies: 75% government funding ensures commitment; 25% local co-funding ensures ownership; RTG ensures real-time accountability; activity credits ensure participation; community walking infrastructure ensures daily organic usage. These are structural safeguards, not aspirations.

"India should fix the existing three tiers before adding a fourth." This is a false choice. Strengthening existing tiers is ongoing under NHM and Ayushman Bharat. But fixing curative tiers alone cannot solve a problem rooted in insufficient prevention. The three-tier system will always be overwhelmed if no upstream community wellness layer intercepts preventable illness. The CWC makes fixing the three tiers more achievable by reducing the demand they face.

"We don't have the human resources to staff 2,80,000 new facilities." This concern is addressed directly by the implementation strategy. The CWC draws from India's existing pool of yoga graduates (India trains over 3 lakh yoga professionals annually), Ayurveda practitioners, and retrained AB-HWC community health workers. The staff requirement of 4 persons per CWC — 11.2 lakh people nationally — is achievable within India's existing and pipeline wellness workforce.

9. CONCLUSION AND RECOMMENDATIONS

9.1 Conclusion

India stands at a historic inflection point — the world's most populous nation, with a young workforce, accelerating economic growth, and the ambition of becoming a Developed Nation by 2047. Whether this ambition is realized depends, in no small part, on whether India's citizens are healthy enough to build it.

The current three-tier healthcare system cannot deliver the health outcomes that Vision 2047 demands. It is a curative system in an era that demands prevention. It is a hospital-centric system that responds to disease rather than building health.

The four-tier system — with Community Wellness Centers as its foundational layer — is the structural answer. It is affordable (₹200 per person per year). It is financially sustainable (75:25 public-private model). It is culturally resonant (yoga, Ayurveda, walking culture). It is operationally feasible (built on 1,75,000+ existing AB-HWCs). It is governable (RTG and activity credits). And it is systemically transformative.

A healthy India is a wealthy India. The CWC makes that transformation structurally possible — and India has already laid the foundations to make it real.

9.2 Key Recommendations

1. Formally notify the Four-Tier Healthcare Classification under the National Health Mission framework — recognizing CWCs as the foundational Tier 1
2. Develop dedicated IPHS norms for CWCs: infrastructure, staffing, services, governance, and RTG integration
3. Allocate ₹3,500 Crore (could be less) in the Union Budget for pilot launch of 1,000 CWCs across 10 states in Year 1
4. Immediately begin conversion of existing AB-HWCs to CWC standard — the fastest and most cost-effective path to scale
5. Establish a National CWC Mission under Ministry of Health and Family Welfare (MoHFW) with a dedicated Secretariat, State Nodal Officers, and independent governing board
6. Issue CSR guidelines recognizing CWC co-funding as a qualifying activity under Schedule VII of the Companies Act 2013
7. Launch the National CWC Wellness Campaign — a public mobilization initiative modelled on Swachh Bharat
8. Commission an independent evaluation framework to measure outcomes: NCD mortality, OOPE reduction, hospital occupancy, PHC referral rates, and community participation

"At ₹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 Healthcare

10. INTEGRATING PRIVATE HEALTHCARE INTO THE FOUR-TIER PUBLIC ENTITLEMENT SYSTEM

The four-tier healthcare system, as a public entitlement, raises a natural and important question: **where do private practitioners fit, and how do they survive and thrive without conflict?** India's private sector currently delivers 70% of the nation's total healthcare infrastructure and 62% of outpatient care. Any reform that ignores or antagonizes this sector will fail. Any that integrates it intelligently will accelerate success.

The global evidence across ten developed nations — including the Nordic countries, provide the world's most extensive public health coverage — is unambiguous: public entitlement systems do not eliminate private practice. They redefine its value proposition. **Private practitioners shift from competing on access to competing on experience, speed, specialization, and personalization.**

10.1 The Global Precedent: Ten Countries, One Pattern

The table below spans the full spectrum of public health entitlement models — from the Nordic countries at one end (the world's most comprehensive tax-funded universal coverage) to regulated multi-payer models in continental Europe and the hybrid models of Australia and Canada. In every case, a structured private sector coexists and thrives.

Country	Model	How Private Practitioners Coexist with the Public Entitlement
NORDIC COUNTRIES — Tax-Funded Universal Coverage (Beveridge Model)		
Sweden	Tax-funded universal	Publicly funded, largely publicly delivered. Private practitioners operate primarily in primary care — GPs may run private clinics contracted to regional health authorities. Private insurance covers ~20% of the population (predominantly employer-funded supplementary plans offering faster specialist access and elective care to circumvent long public waiting times, which can exceed 90 days for some procedures). Private equity-backed hospital groups like Aleris are an expanding force.
Norway	Tax-funded universal	Private healthcare plays a minor role due to the high standards of the state system — Norway's per-capita health spend is among the world's highest. However, supplementary private insurance is growing (up 7% in population coverage 2006–2016), primarily for faster access to specialists and elective procedures. Self-employed GPs contracted to municipalities are effectively private businesses billing public funds.
Denmark	Tax-funded universal	Denmark has the most developed private supplementary market of the Nordic group. ~42% of Danes have some private coverage (14% solely through the Sygeforsikring Danmark mutual). Private insurance is predominantly employer-based — used to minimize employee sick days through faster treatment

		access. Self-employed GPs are fully contracted to the single-payer public system.
Finland	Tax-funded universal	Finland operates a distinctive dual-channel primary care system: public health centres (salaried GPs) alongside a private sector reimbursed by the National Health Insurance (KELA). Self-employed private GPs provide ~20% of general medical treatment , with patients receiving a partial NHI reimbursement for private consultations. Complementary private insurance covers dental and specialist access gaps.
<p>Nordic Lesson for India: Even in the world's most generous universal health systems, a private sector thrives by targeting the gaps the public system cannot efficiently fill — primarily waiting times and non-covered services. The mechanism is supplementary private insurance, not competition with public entitlement. India should design this space deliberately rather than allow it to emerge ad hoc. Finland's partial NHI reimbursement for private GP visits is particularly applicable to India's Tier 2 challenge.</p>		
OTHER DEVELOPED NATIONS WITH PUBLIC HEALTH ENTITLEMENTS		
Germany	Sickness Funds (Bismarck)	86% in statutory health insurance (SHI). Most physicians operate as SHI-contracted private businesses — billing the sickness funds while running independent practices. Higher earners opt for private insurance (PHI). Public-private split is in the payer, not the provider.
France	Social Insurance + Sector System	Physicians choose one of three sectors: regulated fees (Sector 1), free-to-set fees with patient top-up (Sector 2), or fully private (Sector 3). Private <i>mutuelle</i> top-up insurance — held by ~95% of the population — sustains a robust tiered private sector.
Netherlands	Regulated Private Insurance	All insurance is private but heavily regulated. Insurers must accept all applicants at the same premium. Providers are largely private, yet universal access is guaranteed by regulation. Demonstrates that private delivery and universal access are not contradictions .
Australia	Medicare + Gap Fee	Universal Medicare covers all medically necessary care. Private practitioners accept Medicare rebates and charge a regulated gap fee for premium service. Private insurance covers the gap and non-insured extras. Same physician may treat public and private patients.
UK (NHS)	National Health Service	NHS provides free care to all. Private practitioners serve those who value speed and choice. NHS contracts out elective procedures to private hospitals when capacity is exceeded. Private medical insurance (~10% of population) sustains a parallel premium tier.
Canada ★ Key lesson	Canada Health Act (Beveridge + Provincial)	World's strictest prohibition on extra billing for insured services — yet 29% of healthcare is private, entirely in the uncovered services space. 67% of Canadians hold supplementary private insurance. Most Canadian physicians are private businesses

		<p>that bill the public fund — the precise Tier 2 model India needs.</p> <p>Cautionary lesson: Ambiguous public-private boundaries produce constitutional conflict. Canada spent two decades in court (<i>Chaoulli v. Quebec</i>, 2005; <i>Cambie Surgeries v. BC</i>, 2022). Statutory boundary clarity is the structural condition for peaceful coexistence.</p>
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The universal lesson across all ten countries: public entitlement systems do not eliminate private practice — they restructure it. The Nordic experience adds a critical nuance: even the world's most generous universal systems generate a growing private supplementary market, because the public system cannot efficiently deliver speed, convenience, and non-core services at scale.

10.2 India's Private Sector: Strength and Structural Tension

India's private healthcare sector accounts for **70% of total healthcare infrastructure** and delivers **62% of outpatient care**. Under PM-JAY, 40% of empaneled hospitals are already private. This is not a sector to be displaced — it is a sector to be strategically integrated. However, **609 private hospitals have exited PM-JAY**, citing low reimbursement tariffs and delayed payments. The four-tier system must resolve this by design.

10.3 The Four-Tier Private Integration Framework

The following framework defines where private practitioners fit at each tier, without confusion or conflict:

Tier 1: CWC — Private Wellness Practitioners as Platform Partners

The model: CWCs are community platforms, not exclusive government facilities. Private yoga studios, Ayurveda clinics, naturopathy practitioners, homeopathy consultants, organic food producers, and health technology firms can be empaneled as CWC service providers — contracted to deliver sessions at CWC facilities and billing the community wellness fund.

- Private yoga and Ayurvedic practitioners hold CWC sessions on session-fee or retainer contracts — maintaining independent practice while contributing to the public wellness mission
- Organic food producers use the CWC as a certified distribution channel for subsidized organic produce sales — commercial opportunity that advances the CWC nutrition mandate simultaneously
- Private health technology firms deploy digital health tracking, telemedicine, and AI diagnostic tools across 2,80,000 CWC nodes — an unprecedented distribution opportunity

Nordic parallel: Finland's model of partial NHI reimbursement for private consultations at Tier 1 equivalent applies here — the public wellness fund can partially reimburse citizens for using empaneled private Ayurvedic or yoga practitioners, widening choice without expanding public delivery cost.

Tier 2: PHC — Private GPs as Publicly Funded, Privately Delivered Primary Care

The Canada-Nordic model applied directly: most PHC physicians should be private practitioners running independent businesses that bill the public fund. This is the dominant model in Canada, Denmark, Norway, and Finland — publicly financed private delivery, the most effective primary care architecture in the world.

- Private GPs are empaneled as Tier 2 providers, billing the National Health Authority at standardized tariffs for consultations, diagnostics, and referrals for PM-JAY beneficiaries
- Clinics registering as Tier 2 nodes receive official designation, ABDM integration, and referral traffic from catchment CWCs — a material business advantage

Critical requirement (Canada's lesson): reimbursement tariffs must be fair and paid within 30 days. The prevention dividend from the CWC tier must be explicitly earmarked to sustain this.

Tier 3: District Hospital — Private Hospitals as Contracted Secondary Providers

- Private secondary hospitals receive PM-JAY referrals from Tier 2 for hospitalization, surgery, or specialist OPD care at standardized tariffs
- Where public District Hospitals are overloaded, private hospitals serve as effective Tier 3 under government contract — mirroring the Nordic and NHS model of outsourcing elective procedures to private facilities during demand peaks

The dual-track rule (Australia's gap model): PM-JAY beneficiaries receive identical clinical care at zero cost. Premium amenities — private rooms, faster scheduling — are available in a designated private wing at transparently disclosed additional cost. Covert upselling is prohibited.

Tier 4: Specialty Hospital — Private Apex Providers as Essential Delivery Partners

- Private Specialty Hospitals serve as contracted PM-JAY providers for super-specialty packages — cardiac surgery, cancer care, and organ transplants — where their expertise leads the public sector
- Simultaneously, they serve privately insured and out-of-pocket patients at market rates — the dual-market model that sustains Nordic private hospital groups like Aleris and Australian private hospitals alike

The Tier 4 principle: public volume provides a stable revenue floor; premium patients deliver margin. This is financially viable and ethically sound precisely because the four-tier entitlement eliminates distress-driven demand, leaving only voluntary premium demand.

10.4 Six Strategies for Private Practitioners to Thrive

#	Strategy	How It Works in the Four-Tier Context
1	Empanelment & Dual Practice	Register as contracted Tier 2, 3, or 4 providers. Treat PM-JAY beneficiaries at public tariffs; treat private patients at market rates. Income is diversified and stabilized. Mirrors Germany's SHI-contracted physician model and Canada's publicly billed private practices.
2	Supplementary Insurance & Gap Fees	For patients wanting faster access or premium amenities, charge a regulated gap fee above the public package. A supplementary private insurance market — modelled on Nordic employer-funded plans, French mutuelle, and Australian Extras — covers this gap, creating a premium private tier that coexists without conflict.
3	Specialization & Niche Excellence	The public four-tier system covers breadth. Private practitioners' own depth. Orthopedics, ophthalmology, cosmetic procedures, sports medicine, fertility, dental, advanced imaging — areas where private practitioners build distinctive premium practices the public system neither replicates nor intends to.
4	Concierge & Membership Models	Annual memberships (₹500–₹2,000/month) providing direct physician access, same-day appointments, extended consultations, and four-tier care coordination. Revenue entirely independent of government reimbursement. CWC members needing chronic disease management are the natural market.
5	CWC Ecosystem Partnerships	Private Ayurvedic clinics, yoga studios, organic food brands, health technology firms, and diagnostic labs partner with CWCs as contracted providers. 2,80,000 CWC nodes represent an unprecedented distribution platform — commercial opportunity that simultaneously advances public health outcomes.
6	IPA/CIN Collective Contracting	Small and medium private practices form Independent Practice Associations (IPAs) or Clinical Integration Networks (CINs) to collectively negotiate tariffs with the National Health Authority — pooling the bargaining power of large chains without sacrificing independence. Proven in Belgium, Netherlands, and the US.

10.5 The Regulatory Architecture: Five Non-Negotiable Rules

Peaceful coexistence is achieved by clear rules, not goodwill. Canada's two decades of constitutional litigation over public-private boundaries is the strongest possible argument for statutory precision. The following five rules prevent confusion and conflict:

Rule	Operational Requirement
1. Define the National Entitlement Package with statutory precision	Specify by statute — not guideline — the exact services covered at zero patient cost across all four tiers, updated annually. This boundary simultaneously defines the private market above it. Canada and the Nordic countries succeed precisely because this boundary is unambiguous.
2. Prohibit balance billing on entitled services	Any service within the entitlement package must be delivered at zero cost to PM-JAY beneficiaries at empaneled facilities. Charging patients extra for covered services is a cognizable offense — with enforcement modelled on Canada's withholding of federal transfers from non-compliant provinces.
3. Guarantee fair and timely reimbursement	Empaneled providers must be paid at fair, regularly revised tariffs within 30 days of claim. A National Claims Settlement Authority with statutory time limits must be established. The 609 PM-JAY hospital exits are a direct consequence of failing this rule.
4. Enforce referral protocol integrity via digital audit	Private practitioners at Tier 2 must follow four-tier referral protocols. The ABDM digital referral trail creates auditability. Random audits and de-empanelment for protocol violations are the enforcement mechanism.
5. Apply quality parity standards uniformly	PM-JAY beneficiaries at private empaneled facilities receive the same clinical standard as at public ones — same consumables, same protocols. NABH accreditation applies uniformly to all empaneled providers. Quality is a condition of empanelment, not an aspiration.

10.6 The Virtuous Circle: Why the Four-Tier System Grows the Private Market

A well-documented finding across all ten countries is that **strong public health entitlements expand the private healthcare market, not contract it**. Australia's introduction of universal Medicare increased private insurance uptake over time. Nordic countries have seen consistent growth in supplementary private insurance even as their public systems strengthen. The mechanism is the same everywhere:

THE VIRTUOUS CIRCLE

CWC wellness programs → Healthier population → More workforce participation → More private insurance enrollment → Larger addressable market for private practitioners

CWC NCD prevention → Fewer catastrophic hospitalizations → Less household financial ruin → More discretionary income for health top-ups → Sustainable voluntary private wellness market

Four-tier referral cascade → Complex, high-value cases reach Tier 4 → Private specialty practitioners operate in the highest-margin segment with minimal public competition

India's ₹6.5 lakh crore annual OOPE burden is not a private market — it is a public health disaster. Eliminating catastrophic expenditure through the four-tier entitlement replaces compelled, distress-driven spending with **voluntary, value-driven private health consumption** — a far more commercially sustainable and ethically sound foundation for private practice in a developed India.

10.7 Recommendations for Private-Sector Integration

1. Establish a National Four-Tier Empanelment Framework with clear eligibility, tariff schedules, quality standards, and billing rules for private practitioners at each tier — modelled on Germany's Federal Joint Committee structure
2. Enact a National Entitlement Package (NEP) by statute — defining with legal precision what is covered at zero cost, and explicitly bounding the supplementary private market above it, drawing on Canada's balance billing prohibition and France's sector system
3. Create a National Claims Settlement Authority with a statutory 30-day payment guarantee for all empaneled providers — eliminating the reimbursement delays that have driven 609 private hospitals to exit PM-JAY
4. Develop a regulated Supplementary Private Health Insurance framework — modelled on Nordic employer-funded supplementary plans and French mutuelle — covering gap fees, premium amenities, dental, vision, and faster elective access
5. Adopt Finland's partial public reimbursement model for private primary care consultations at Tier 2, enabling patient choice between public PHCs and empaneled private GPs without full out-of-pocket burden
6. Formally recognize and incentivize IPA/CIN formation among small and medium private practitioners for collective contracting with the National Health Authority
7. Deploy ABDM digital audit trails for all inter-tier referrals to prevent fraudulent self-referral and covert patient-routing

8. Mandate NABH quality standards uniformly across all empaneled providers — quality parity as a binding condition of empanelment

The private sector is not the adversary of universal healthcare — it is its essential partner.

From Sweden to Australia, Canada to Germany, the pattern is identical: public entitlements restructure private practice — away from profiting from poverty and catastrophe, toward competing on excellence, speed, and choice.

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