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EDITORIAL ANALYSIS

Reconnect Public Health With People, Why Wellness Slogans and Apps Cannot Deliver Universal Health Coverage

THE HINDU

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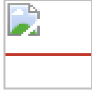

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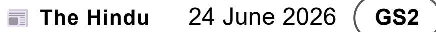
Reconnect Public Health With People, Why Wellness Slogans and Apps Cannot Deliver Universal Health Coverage



The Hindu 24 June 2026 **GS2**

Source: ujiyari.com — researched, fact-checked & UPSC-mapped

INTERVIEW ANGLE

"India has the world's largest publicly funded health assurance scheme, yet out-of-pocket spending stays high. Has Ayushman Bharat treated symptoms while ignoring the disease of weak primary care?"

Every fact web-verified against primary sources (https://ujiyari.com/how-we-verify/)

WHY THIS EDITORIAL MATTERS

India runs the world's largest publicly funded health assurance scheme and has issued hundreds of millions of digital health IDs. On paper, the story is one of historic expansion. The Hindu's argument is that this expansion has been measured in the wrong currency. Insurance enrolment, wellness centre rebranding and app downloads are visible and countable, so they dominate the narrative. The harder, slower fundamentals, can a poor woman in a village reach a functioning health centre, find a doctor and free medicines, and not be bankrupted by the visit, remain under-addressed. The editorial asks policymakers to reconnect public health with people's actual needs, which means rebuilding comprehensive primary care rather than layering schemes on a weak base.

THE CORE ARGUMENT

The central claim is a mismatch between what India has built and what Universal Health Coverage (UHC) actually requires. UHC, as the World Health Organization defines it, means everyone receiving the quality services they need without suffering financial hardship. India's three flagship pillars approach this only partially.

First, Pradhan Mantri Jan Arogya Yojana (https://ujiyari.com/schemes/pmjay/) (PM-JAY) provides 5 lakh rupees per family per year, but only for secondary and tertiary hospitalisation. It became truly national on June 8, 2026, when West Bengal signed on as the 36th State or Union Territory to implement it, completing nationwide coverage. Yet hospitalisation is the tip of the iceberg. Most illness, and most household health spending, is outpatient, on consultations, chronic disease medicines, and diagnostics that insurance does not cover.

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Second, Ayushman Arogya Mandirs (the renamed Health and Wellness Centres) were meant to deliver comprehensive primary care close to home. In practice the emphasis has often been on the wellness label, yoga sessions and signage, while the supply side of trained staff, assured drugs and working diagnostics lags.

Third, the Ayushman Bharat Digital Mission (https://ujiyari.com/schemes/ayushman-bharat-digital-mission/) (ABDM) creates the digital backbone, with the ABHA (Ayushman Bharat Health Account) ID as the citizen-facing identifier. Useful as infrastructure, but a health ID does not by itself produce a doctor, a drug or a diagnosis.

HOW TO THINK ABOUT THIS

Read this editorial through the distinction between **selective** and **comprehensive** primary health care, the central fault line in global health policy.

The Alma-Ata Declaration of 1978 envisioned comprehensive primary health care, health promotion, prevention, cure and rehabilitation (https://ujiyari.com/vocab/rehabilitation/), rooted in community participation and intersectoral action. It was idealistic and resource-hungry. In response, a **selective** primary health care model rose, targeting a few cost-effective interventions (immunisation, oral rehydration). The Astana Declaration of 2018 reaffirmed comprehensive primary care for the UHC era.

The exam-useful lens is this: a scheme can look like it advances health while quietly drifting toward the selective, easily-measured end. Insurance for hospitalisation, a wellness brand and a digital ID are each defensible, but together they can crowd out the unglamorous, comprehensive, recurring-cost work of primary care. The editorial's plea is a course-correction back toward Astana's comprehensive vision.

A second framing device is the **money-flow question**. Ask of any health reform, who pays at the point of care? If households still pay out of pocket for the bulk of routine care, coverage on paper has not become protection in practice.

INSTITUTIONAL AND DATA CONTEXT

The financing picture is the clearest evidence for the editorial's thesis. India's public health expenditure remains close to 2 percent of GDP, well short of the 2.5 percent target set by the **National Health Policy 2017** (which aimed at that level by 2025). Crucially, the Union government's own share has not risen to meet its policy commitments, leaving States to carry more of the load.

METRIC	POSITION	SIGNIFICANCE
PM-JAY cover	5 lakh rupees per family per year	Hospitalisation only, not outpatient care
PM-JAY reach	All 36 States and UTs (West Bengal joined June 8, 2026)	Coverage now nationwide; depth still uneven
Public health spend	Around 2 percent of GDP	NHP 2017 target is 2.5 percent, unmet
Out-of-pocket expenditure	Persistently high	Drives households into poverty
Digital ID	ABHA under ABDM	Infrastructure, not a substitute for care

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Two structural gaps compound the financing shortfall. **Human resources**, sub-centres and Primary Health Centres (PHCs) frequently run short of doctors, ANMs and specialists, especially in rural and tribal districts. **Supply chain**, free essential drugs and diagnostics, the single biggest determinant of out-of-pocket spending, are inconsistently available, so patients buy them privately even at public facilities.

The demographic (https://ujiyari.com/vocab/demographic/) angle sharpens the stakes. India's working-age population is large now but ageing is approaching. The **demographic dividend (https://ujiyari.com/terms/demographic-dividend/)** can only be harvested if the workforce is healthy and productive; a frail primary care system squanders that window.

THE COUNTER-VIEW

A fair reading must engage the government's logic. In a country of India's scale and fiscal constraints, **breadth often has to precede depth**. Establishing financial protection through PM-JAY shields families from catastrophic hospitalisation costs, a real and large gain. The digital mission builds rails, interoperable records, portability (https://ujiyari.com/vocab/portability/), that future care delivery will depend on. Wellness centres, even imperfectly staffed, extend a public presence into areas that had none.

There is also a federalism (https://ujiyari.com/terms/federalism/) defence: health is a State subject, and rising State health spending (even as the Centre's share stalls) shows the system is not static. From this view, the editorial undervalues necessary sequencing and the genuine progress in financial-risk protection.

The rejoinder, and the editorial's stronger ground, is that sequencing cannot become a permanent excuse. Coverage that does not reach comprehensive primary care leaves the bulk of health needs unmet and out-of-pocket spending high. Means must not be mistaken for ends.

THE WAY FORWARD

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1. **Finance the fundamentals.** Move public health spending decisively toward 2.5 percent of GDP, with the Union restoring its committed share, and ring-fence funds for primary care recurring costs (staff, drugs, diagnostics), not just capital and insurance premiums.
2. **Comprehensive over selective.** Re-anchor Ayushman Arogya Mandirs to the full Alma-Ata to Astana package, prevention, promotion, chronic-disease management and mental health, not a thin wellness veneer.
3. **Fix outpatient and medicine costs.** Guarantee free essential drugs and diagnostics at public facilities to attack the largest source of out-of-pocket expenditure.
4. **Build human resources.** Use the demographic dividend years to train, deploy and retain doctors, nurses and community health workers in underserved districts.
5. **Digital as enabler, not end.** Treat ABHA and ABDM as tools that improve continuity of care and reduce duplication, measured by health outcomes, not ID counts.
6. **Measure what matters.** Shift dashboards from enrolment and downloads to access, financial protection and quality outcomes at the community level.

PYQ LINKAGE

This editorial maps cleanly onto recurring GS2 themes on health and governance.

- **GS2, Governance and Welfare:** "Public health system has limitations in providing universal health coverage. Do you think that the private sector could help in bridging the gap? What other viable alternatives do you suggest?" (UPSC Mains 2015). This editorial supplies fresh, dated evidence (PM-JAY's 2026 nationwide reach, the 2.5 percent GDP shortfall) and the comprehensive-versus-selective framework to answer it.
- **GS2, Issues relating to development and management of Social Sector:** questions on schemes for vulnerable sections and on the comparative development of social sectors map to the access-affordability-quality lens here.
- **Prelims hooks:** Ayushman Bharat pillars (PM-JAY, Ayushman Arogya Mandirs, ABDM), the ABHA ID, the NHP 2017 spending target, and the Alma-Ata 1978 and Astana 2018 declarations are all high-probability factual anchors.

Lift line for answers: *Coverage and digital identity are the means; comprehensive primary care that people can actually reach, afford and trust is the end of Universal Health Coverage.*

Source: Reconnect Public Health With People, Why Wellness Slogans and Apps Cannot Deliver Universal Health Coverage — Ujiyari.com | Free UPSC & State PCS Editorial Analysis

KEY ARGUMENTS AT A GLANCE

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India's health architecture has expanded insurance coverage and digital rails while under-investing in the comprehensive primary care that alone can deliver real Universal Health Coverage.

✓ SUPPORTING

- PM-JAY now covers all 36 States and UTs after West Bengal joined on June 8, 2026, yet it is hospitalisation insurance that does little for outpatient, preventive and chronic care where most illness and most spending sit.
- Public health expenditure remains stuck near 2 percent of GDP against the National Health Policy 2017 target of 2.5 percent, keeping out-of-pocket expenditure high and pushing households into poverty.
- Ayushman Arogya Mandirs and the Ayushman Bharat Digital Mission have foregrounded wellness messaging and ABHA IDs, while sub-centre and primary health centre gaps in staff, drugs and diagnostics persist.

⚠ COUNTER

Defenders argue that financial protection through insurance and a digital backbone are necessary first steps, and that coverage breadth had to precede depth in a country of India's scale and fiscal limits.

→ WAY FORWARD

Raise public health spending toward 2.5 percent of GDP, fund comprehensive rather than selective primary care in the spirit of Alma-Ata and Astana, fully staff and supply sub-centres and PHCs, and treat digital tools as enablers of care, not substitutes for it.

MAINS ANSWER FRAMEWORK

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QUESTION

'India''s flagship health programmes have prioritised insurance coverage, wellness branding and digital infrastructure, but the fundamentals of access, affordability and quality of primary care remain weak. Critically examine why these design choices have not translated into genuine Universal Health Coverage, and suggest a roadmap to re-anchor public health policy to community-level needs. (250 words)'

INTRODUCTION

Universal Health Coverage means all people accessing quality health services without financial hardship. India's recent reforms have advanced coverage and digitisation, but the evidence on access, affordability and quality remains uneven.

BODY

The Ayushman Bharat package rests on three pillars, PM-JAY insurance, Ayushman Arogya Mandirs and the Ayushman Bharat Digital Mission. PM-JAY achieved nationwide reach when West Bengal became the 36th State or UT to implement it on June 8, 2026, offering 5 lakh rupees per family for hospitalisation.

Yet most health spending is on outpatient care, medicines and diagnostics, which insurance barely touches, so out-of-pocket expenditure stays high even as coverage widens. Public health spending hovers near 2 percent of GDP against the 2.5 percent target of the National Health Policy 2017, and the Union share has if anything fallen.

The wellness branding of Ayushman Arogya Mandirs and the ABHA-led digital push have outpaced the unglamorous work of staffing sub-centres, ensuring free drugs and diagnostics, and retaining doctors in rural areas. The conceptual drift is from the comprehensive primary care of Alma-Ata 1978, reaffirmed at Astana 2018, toward a selective, technology-fronted model that addresses visibility more than need.

CONCLUSION

Coverage and digital IDs are means, not ends. Re-anchoring policy to community-level needs, financing comprehensive primary care and using demographic dividend years to build human resources can convert paper coverage into lived health security.

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