What We Value in Health

A Coalition Vision for Better Care in India

October 2025

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ACKNOWLEDGEMENTS

We would also like to acknoledge health system stakeholders who provided additional inputs.

- Krisha Mathur, Director, ACT Grants
- Nachiket Mor, Visiting Scientist, Banyan Academy of Leadership in Mental Health
- Dr Ramakrishna Prasad, Convener, Comprehensive Primary Healthcare Alliance
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- Shankar A G, Director, Programs, Swasti

This work was supported by Endless Network. We also thank Rubayat Khan, Director of Health Programs at Endless for his thoughtful feedback through the coalition formation and strategy development process.

We thank Condive for their valuable design support in developing this report.

Executive summary

This strategy paper is the product of a collective effort. It reflects the insights and perspectives of leaders across payers, providers, academia, civil society, and government who came together through the India VBC Coalition. Their willingness to engage openly and co-develop ideas underscores the spirit of collaboration that is essential to advancing value-based care. We are grateful for the many thoughtful contributions and reviews that shaped this document. At a moment when India's health system faces both opportunity and risk, this coalition's shared commitment to aligning care around outcomes, equity, and trust is what gives this strategy its power and promise.

Value-based care (VBC) offers a framework to realize this opportunity. It shifts the system from rewarding more services to rewarding what matters most—better outcomes at lower cost, grounded in dignity and patient experience. In practice, this means redesigning care delivery around longitudinal patient journeys, measuring outcomes and costs with consistency and transparency, and aligning financing to reward quality, safety, and equity.

This strategy paper is the product of six months of collective effort by the India Value-Based Care Coalition—a diverse group of leaders from payers, providers, academia, civil society, and government. Together, we identified the structural barriers that hold India back, the bright spots that signal change is possible, and the strategic initiatives most likely to catalyze transformation.

The coalition converged on four priorities for immediate action:

- **A People's commission for health improvement –** a trusted platform to make outcomes and costs transparent, enabling accountability and continuous improvement.
- **A comprehensive primary healthcare design laboratory –** an institutional home to co-create new models of financing and delivery that make primary care the trusted foundation of the system.
- **A business case for quality, safety, and patient experience –** equipping provider champions with analytic and financial tools to demonstrate that investing in better care is also good business.
- **Coordinated care bundles for NCDs and surgeries –** testing and scaling bundled approaches that improve outcomes and reduce fragmentation across high-burden conditions.

These initiatives build on enabling trends already underway digital and data infrastructure, payer-provider integration, cultural shifts in performance management, and growing patient voice. They also recognize that trust and dignity are as essential to reform as efficiency and cost savings.

India's path forward is clear. By aligning how we deliver, measure, and finance care, the country can transform health spending into real value for its people. This strategy offers a practical roadmap for collective action. The moment is urgent, but it is also full of possibilities. With shared commitment and collaboration, India can lead the world in demonstrating how value-based care makes health systems more human, more trusted, and more effective.

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1.INTRODUCTION

India's healthcare system stands at a critical juncture. As the country expands public and private coverage in pursuit of Universal Health Coverage, it risks spending more on healthcare without achieving better health. Without a deliberate shift toward value, this moment of expansion may entrench inefficiencies rather than deliver meaningful health outcomes.

Most health financing in India is oriented around a fee-for-service model, whether through out-of-pocket payments or insurance coverage. This approach incentivizes volume over value, with little accountability for outcomes or patient experience. Even though out-of-pocket spending has reduced recently (70% in 2004-05 to about 47% in 2021-22[1]), it remains the dominant source of health financing. Insurance—both public and private—still represents only a sliver of overall expenditure. Private insurance penetration is stagnant at ~8.75%[2], and public insurance schemes like AB-PMJAY, which is expected to cover 40% of the population, account for less than 2% of total health spending in some states . Although limited in scale today, the insurance sector may offer more immediate opportunities to reform payment incentives and align them with value. Meanwhile, public provision of care—offered almost free at the point of service—continues to serve a large share of the population, but often faces challenges around quality, standardization, coordination, and accountability. This fragmented, volume-driven system erodes trust between patients, providers, and payers. In India, healthcare often prioritizes delivery efficiency and monetization over a human-centered approach that emphasizes dignity, respect, communication, autonomy, and coordinated care.

We need to act now. India has a unique opportunity to shift towards human-centered and outcome-focused care. But lasting change cannot come from isolated fixes or single-point reforms. Instead, it demands a coherent, systemic approach that aligns how we **deliver** care, how we **measure** health system performance, and how we **pay** for services.

Only by integrating these three design elements can we shift incentives, improve accountability, and ensure that every rupee spent delivers real value to patients.

1 Front. Public Health, 2025 https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2025.1594542/full
2 IRDAI Annual Report 2023-24 https://irdai.gov.in/document-detail?documentId=6436847

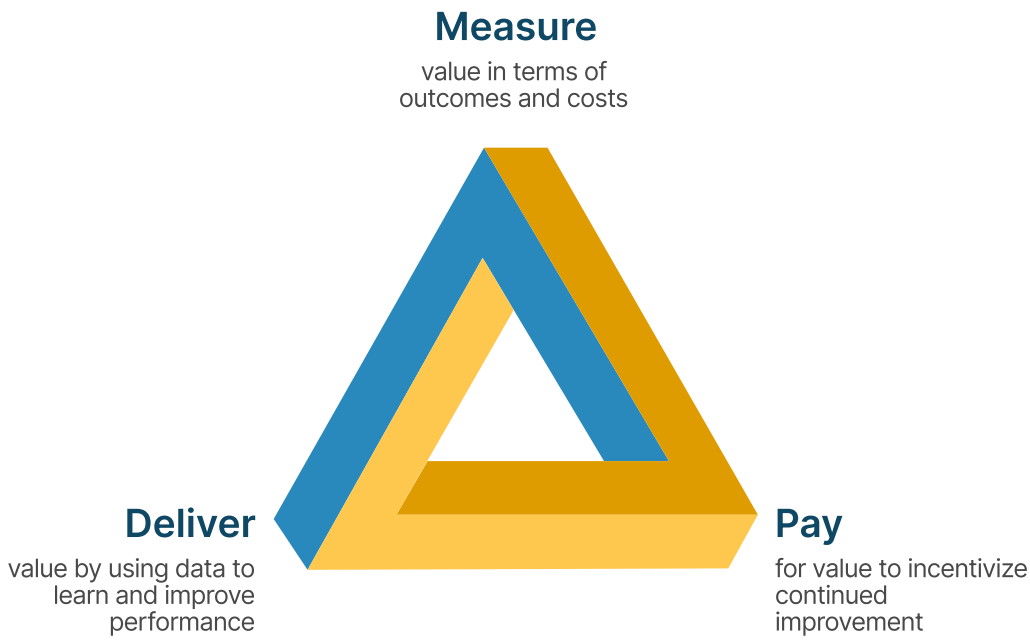

Figure 1: Leapfrog to Value's framework for implementing VBC principles in LMICs

Deliver: Value-based delivery is built around human-centered care pathways. For each pathway, providers design delivery pathways to match the patient journey to deliver the outcomes that matter to them, routinely review value-based data, and use those insights to continuously improve care. This focus leads the systems to emphasize preventive care in community and primary healthcare settings when possible, providing access to hospital-based treatment when necessary. The two settings have to be connected and integrated.

Measure: What a health system chooses to measure is its North Star. If the goal is to maximize value, measuring value is imperative. Value is measured as outcomes that matter most to patients divided by costs to achieve those outcomes. The numerator in the value equation is human-centered outcomes. For a mother and her newborn, this is not only a delivery at term without complications. It's also a fulfilling birth experience and success with feeding. The denominator is the costs required to achieve those outcomes, not only the cost of the individual drugs or procedures.

Pay: The flow of resources in a system shapes how and where care is delivered, how the health sector recruits talent, and which facilities and infrastructure attract investment. Given these far-reaching implications, payment design must reflect a health system's priorities. This means aligning budgets and payment schemes with the highest-value interventions.

Leapfrog to Value is a civic-spirited initiative advancing human-centered, outcome-focused models for measuring, delivering, and paying for care. As part of this effort, we facilitated the **India VBC Coalition** and supported the co-development of a localized strategy to shift India's health system toward value.

Over six months, we worked alongside a distinguished group of leaders (the Authors of this document) as co-owners of the thinking, identifying system drivers, barriers, bright spots, and shaping a shared path forward. This paper summarizes the insights and strategic priorities that emerged from that collective process.

2.VISION BEHIND THIS STRATEGY PAPER

The 2019 PwC report[3] estimates that, with appropriate implementation, value-based care (VBC) models could save ~900,000 lives and ₹4 lakh crores over five years across India, based on industry expert opinion and analysis. While these figures are directional, they align with broader evidence: the Lancet Global Health Commission on High Quality Health Systems[4] has shown that poor quality of care is responsible for 60% of deaths amenable to healthcare, suggesting that major mortality reductions are feasible through quality-focused reform. To realize this potential, India must overcome systemic barriers.

To ensure that the shift toward value-based care gains real momentum, we see a two-pronged approach. First, we aim to demonstrate effective models in segments with greater flexibility and opportunity for swifter change, i.e., privately insured populations and self-paying patients.These markets can serve as test-beds to develop payment models, IT-enabled data systems, and redesigned care pathways.

At the same time, we recognize the importance of embedding value-based care principles in public financing and provision. While public insurance schemes like PMJAY currently account for a small share of total spending, they are expected to become prominent source of health financing in the future.

Beyond public insurance, the public provision of care is the single largest opportunity to embed value and outcome orientation, and for creating palpable impact.

To sustain the long-term impact of this shift, we are also focusing on ecosystem enablers—such as IT and data infrastructure, a stronger cultural orientation toward quality and outcomes, outcome-linked payment mechanisms, and care delivery redesign—that can lay the foundation for broader adoption across both public and private sectors.

3 The 2019 PwC report https://www.pwc.in/assets/pdfs/healthcare/value-based-healthcare.pdf
4 the Lancet Global Health Commission https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(19)30485-1/fulltext

3.CHALLENGES IN THE ADOPTION OF VBC

India's transition to value-based care is constrained by deep-rooted structural and systemic gaps. Understanding these roadblocks is critical for designing interventions that are both realistic and have a meaningful impact. The challenges we describe here point to three priority areas where catalytic action could enable a shift from fragmented inputs to coordinated, outcome-focused care.

3.1. Redesign delivery around outcomes

Optimizing how care is delivered is essential for value-based models to take root. Yet today, no single entity is accountable for outcomes across the full care pathway—particularly in the out-of-pocket market, where patients often navigate fragmented and uncoordinated care on their own.

As a result, patients frequently receive treatment at the wrong level of care, moving unsystematically between primary, secondary, and tertiary services. This not only increases costs but also compromises outcomes.

In the public sector, overburdened and understaffed facilities are designed to maximize throughput, not deliver longitudinal improvements. The lack of continuity of information, relationship, and care is an important driver of poor quality of care.

Meanwhile, both public and private insurers—who could play a catalytic role in care redesign— have little market power. They remain at arm's length from the provision of care. They have to influence delivery through incentives, without direct levers to shape how care is delivered on the ground.

India lacks prominent chronic care models that address behavioral and social determinants of health systematically. This gap is especially urgent in the context of non-communicable diseases (NCDs) and other chronic diseases, which now account for over 60% of total mortality.

Together, these challenges point to the need for a coordinated and longitudinal care model with accountability assigned to one single actor rather than the current care delivery, which is organized around episodic interventions.

3.2. Measure what matters

At the heart of value-based care lies the ability to measure what matters. Yet today, India's health system—both public and private—struggles with a fundamental gap: outcomes are not clearly defined nor routinely tracked. Utilization metrics dominate reporting, and there is no common vocabulary for clinical or patient-reported outcomes, making comparison or aggregation difficult. Fragmented data systems add another layer of complexity; frontline workers like ASHAs often toggle between multiple, non-integrated platforms.

Without consistent, transparent, and outcome-oriented measurement, there is limited accountability or feedback to improve care quality. There is a need for a common definition of quality in a way that matters to patients, bringing greater transparency, using the data for performance management. Completing this data-to-action loop can build momentum toward public and provider trust.

3.3. Finance care for better quality

India's current financing allocations and payment models offer few rewards for high-quality care. Perhaps the most deeply rooted barriers to value-based care lie in how healthcare is financed.

India's public health budgets remain modest, and private insurance covers just over 8% of the population. Most people still rely on out-of-pocket payments, which are often unstructured and detached from quality safeguards. The prevailing fee-for-service model rewards providing more services over appropriate care, driving inefficiencies, misuse. The prices of individual services have been increasing steadily, with medical inflation now hovering around 14–15% annually. Opaque pricing and weak accountability continue to erode trust between payers, providers, and patients. The payment and financing/allocation model is especially broken for primary healthcare.

While the government does not prioritize primary healthcare spending, the private insurers find it difficult to manage the volume of transactions and fear overuse of OPD covers. They hold back on creating true risk-pooling insurance for primary healthcare. However, encouraging the use of primary healthcare to the appropriate level is important to reducing longitudinal costs.

In this context, there is an urgent need to build new payment and financing models that account for quality, safety, and patient experience. The models must resonate with patients, families, providers, and purchasers. Such models have a hard balance to strike: grounding in the reality of today's markets and enabling a shift toward risk-sharing, accountability, and efficiency. Additionally, caring for vulnerable populations that do not fit typical profiles must allow for special attention and incentives.

4.INNOVATORS AND ECOSYSTEM ENABLERS THAT SIGNAL THE SHIFT.

India's shift toward value-based care is gaining quiet momentum—not through a single bold reform, but through a constellation of promising innovations and structural enablers. We outline five enabling trends—digital and data infrastructure, coordinated delivery models, financing and purchasing reform, shifts in culture and patient agency, , attention to health beyond healthcare, signaling early momentum on systemic reforms—that together are laying the groundwork for a scalable, outcome-focused transformation.

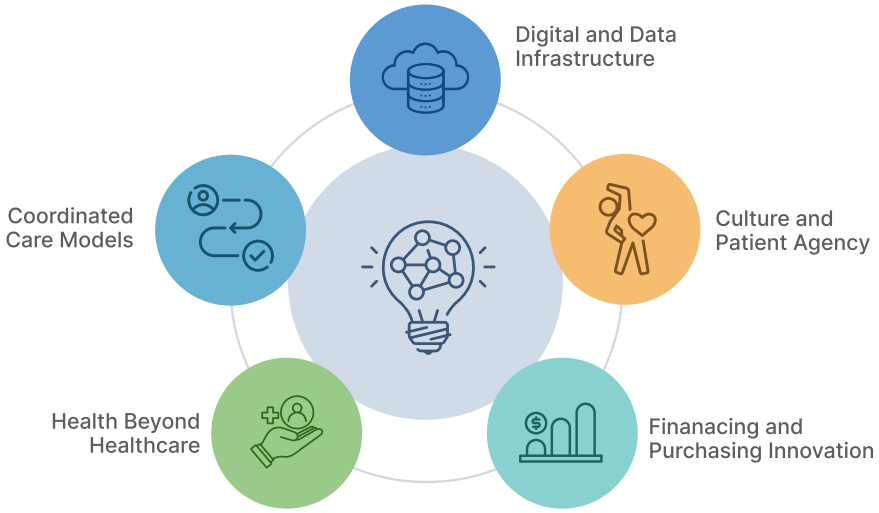

Figure 2: Innovators and ecosystem enablers that signal the shift.

4.1. Digital and data infrastructure

India is making significant investments in public digital health infrastructure, reflecting a recognition that better data and technology are essential for modernizing the health system. The major digital and data infrastructure investments that are supportive of value-based care are:

- **The Ayushman Bharat Digital Mission (ABDM)** is India's foundational leap toward a digital health infrastructure that is fit for building longitudinal patient records and interoperable data. Investing in this backbone is only the start. The platform does not determine or enforce standards on providers, which means outcomes and costs are often not present in the data. Even when such data were to be included, closing the data-to-action gap is critical.
- Emerging Health Technology Assessment mechanisms—HTAIn resource centers and HEFTA —are set to deliver richer, standardized cost data and cost-effectiveness analyses, though often limited to public settings and a narrow set of interventions.
- **The National Health Claims Exchange (NHCX)** can not only help in claims data analytics but also eventually enable financing models tied to performance and outcomes.
- **NABH's** evolving digital health quality standards are also a step in the right direction.
- Moreover, digital infrastructure is beginning to go beyond measurement and play a role in delivery and payment. For instance, teleconsultation infrastructure has boomed since COVID.

However, these investments alone will not deliver value-based care unless they deliberately capture outcomes data and use such data to manage performance and strengthen patient experience.

Looking ahead, these digital investments also create fertile ground for a range of artificial intelligence (AI) applications. With interoperable health records, standardized cost data, and real-time claims information, India has the foundation to responsibly deploy AI for clinical decision support, predictive risk modeling, personalized care coaching, and fraud detection.

The ability to analyze outcomes and costs at scale could accelerate learning cycles, improve care coordination, and surface insights that strengthen both efficiency and patient experience. Realizing this potential will require not only technical capability but also careful governance to ensure transparency, equity, and patient trust.

Beyond the ecosystem enablers, there are interesting bright spots emerging. State-level pilots in Kerala and Uttar Pradesh are exploring tracking outcomes for a few tracer conditions. In the private sector, some insurers are experimenting with capturing patient experience data through claims systems, offering a glimpse into future payer-provider accountability mechanisms.

4.2. Coordinated delivery models

Efforts to reorganize care are gaining momentum across sectors—signaling a critical shift toward more coordinated models.

On the public side, the referral coordination pilot in Madhya Pradesh is helping patients navigate the system more effectively while reducing out-of-pocket spending. Another success on the public side has been verticalized public health programs. For instance, the tuberculosis and maternal health programs have demonstrated that with the right coordination, adherence and outcomes can be tracked and improved across the continuum of care. Technology platforms such as Nikshay for TB have played a significant role in enabling this coordination of care across different actors. Similarly, Tech-enabled community health worker (CHW) models for NCD management, such as one from Dvara, are demonstrating promising early outcomes. While these individual successes are worth learning from, the eventual goal is to have an integrated and comprehensive system that does not create vertical siloes.

On the private sector side, in parallel, we're seeing increasing movement of insurers into the prevention space. They are proactively managing NCDs and wellness to improve the health of the insured population. For instance, Aditya Birla Health Insurance has a health management model that looks at longitudinal care for NCDs like diabetes, etc., covering all costs, not just hospitalization ones.

The opportunity now is to consolidate and scale these experiments into delivery models that center both outcomes and user experience.

4.3. Financing and purchasing innovation

Financing is one of the most powerful levers to shift the system toward value. While India's payments have traditionally rewarded offering more services, early policy and market changes are starting to create space for more value-aligned approaches.

On the public side, the National Health Authority's value-based care (VBC) incentives policy[5] is an attempt to link payment to quality parameters, not just accreditations. In another example , while the NHA and the state schemes have struggled in empanelling private hospitals, the Central Government Health Scheme(CGHS) has been successful in empanelling and retaining high-quality private providers. CGHS initially offered additional incentives for accredited quality. Once such hospitals were empanelled and gained certain patient volumes with CGHS, it has also slowly phased out these incentives, creating a win-win-win. The patients receive higher-quality care, Providers gained sustained revenues, and CGHS was able to attract and retain higher-quality providers.

In India's fragmented health market, experiments in payer-provider integration are emerging as key vehicles for testing value-based care models at scale. For instance, Narayana's launch of closed-loop private insurance is an important experiment that both public health experts and businesses

5 the National Health Authority's value-based care (VBC) incentives policy
https://abdm.gov.in:8081/uploads/VBHC_Policy_Document_For_Upload_a20f871a55.pdf

are watching closely for indications of success. Managed care organizations such as Even, Loop, and Circle Health are also creating inherent incentives for longitudinal optimization of care. While the provider businesses as a whole may still be focused on profitability metrics, a movement around quality, safety, and patient experience is slowly gaining traction among health professionals in India.

4.4. Culture and patient agency

We are seeing a subtle and slow cultural shift from command and control to supportive performance management. Vertical national programs such as NTEP for TB are seeing this shift, where the district and state management are now supporting the TB units or PHCs in improving performance. The major reason cited for this shift is the availability of granular and irrefutable data on effort and performance.

Patient advocacy in India is gaining gradual momentum. Organizations such as Organization for Rare Diseases India (ORDI), Indian Alliance of Patient Groups (IAPG), and Hemophilia Federation India (HFI) are asserting patient voice in policymaking, demanding accountability, and shaping access to essential drugs.

This civic pressure is slowly shifting system power dynamics. These shifts, though gradual, suggest that performance data and patient voice are beginning to reshape the culture of accountability—creating the conditions for value-based care to take root more deeply and durably across India's health system.

4.5. Health beyond healthcare

India's major investments in the social determinants of health—such as Swachh Bharat for sanitation and Ujjwala Yojana for clean indoor fuel—are amplifying the impact of healthcare by improving the environments people live in. These contextual enablers don't always get the spotlight in health reform conversations, but are crucial in shifting social determinants of health—often the highest-value interventions to improve health outcomes.

India's shift to value-based care is gaining momentum through quiet innovations across data, delivery, financing, and culture. These early signals are promising, but fragmented. The real opportunity now is to connect and scale these efforts into a coherent system that rewards outcomes, improves patient experience, and builds lasting trust in the system. The next section outlines where and how this momentum can be accelerated.

5.INDIA VBC STRATEGY: FOUR STRATEGIC INITIATIVES

The coalition identified opportunities for value-based care transformation rooted in the challenges, enablers, and innovators described above. We agreed that concentrating efforts on a few strategic themes would yield the greatest leverage. Using four criteria—potential for impact, evidence and precedents, return on investment, and support from health system actors—we prioritized and consolidated our options into four strategic initiatives. Each initiative requires different levels of convening, co-design, and execution support, but all represent catalytic opportunities for action now.

Initiative 1	Initiative 2	Initiative 3	Initiative 4
People's commission for Health Improvement (जन आरोग्य सुधार आयोग)	Comprehensive Primary Health Care Design Laboratory	Business Case for Quality, Safety & Patient Experience	Coordinated Care Bundles for NCDs and Surgeries

Figure 3: The Four Strategic Initiatives

India's transition to value-based care hinges on these four strategic initiatives. These include systemic efforts to (1) institutionalize quality and transparency through the "People's commission for health improvement", (2) reorganize primary healthcare through a "comprehensive primary healthcare design laboratory", (3) build the "business case for quality, safety, and patient experience", and (4) redesign delivery through coordinated care bundles. Together, they form a practical roadmap for collective action.

Initiative 1

People's commission for Health Improvement (जन आरोग्य सुधार आयोग)

India's health system lacks a nationally trusted platform to make healthcare outcomes and quality visible—and actionable. We propose to fill this gap with The People's Commission for Health Improvement (working title), by creating an independent institution that enables transparency, benchmarking, and continuous improvement across the health system. Anchored in outcome data, the Commission would serve as a shared backbone for patients and families, payers, providers, and policymakers committed to advancing value-based care.

The problem and opportunity

India's healthcare system faces persistent challenges around quality, equity, and accountability. According to the Lancet Commission on Reimagining India's Health System, 64.4% of deaths in South Asia that are amenable to healthcare are attributed to poor quality care rather than lack of access[6]. Many Indians receive substandard care, with considerable gaps in safety, effectiveness, and patient experience. This also leads to wasteful expenditure. For instance, it has been estimated that 50% of family spending on healthcare is on unnecessary medications or investigations[7].

While NABH, NQAS, and SaQshal quality accreditation exist, and there are pathway-specific programs such as LaQshya and MusQan, they are often focused on input-linked definition of quality. They often enable providers to attract a higher reimbursement rate from payers. But patients still do not perceive these accreditations as a sign of trustworthiness. Overall, India lacks a trusted, transparent, outcome-focused platform that can anchor system-wide quality improvement. India has the opportunity to establish its institutional platform —anchored in transparency, continuous learning, and aligned incentives—that positions the country as a global leader in outcome-driven care.

The investments in digital infrastructure, such as Ayushman Bharat Digital Mission (ABDM), National Health Claims Exchange (NHCX), Health Technology Assessment India (HTAIn), and regulatory updates by the IRDA are paving the way for transparency. State-level quality management efforts are starting in Kerala and Uttar Pradesh. These bright spots create a unique window to establish an institutional platform that anchors transparency and performance improvement as pillars of India's healthcare system.

Purpose

We propose the creation of a nationally trusted institutional platform that enables public and private payers and providers to make outcomes visible, benchmark performance on outcomes and costs, and drive sustained improvements in quality.

To ensure relevance for patients, the outcomes tracked must include patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs), in addition to clinical outcomes.

Role of the initiative

The neutral body can be structured either as a statutory institution or a non-profit with formal government partnerships (e.g., through MoUs with entities like QCI, etc.).
This body will:

- **Create transparency:** Develop a National Health Transparency Registry that reports on outcomes (including patient-centered ones) and costs for high-burden conditions.
- **Enable improvement:** Provide advisory services and training to hospitals through evidence-based knowledge products and practical improvement tools.
- **Shape culture:** Use storytelling and strategic advocacy to foster a broader culture of performance and continuous improvement.

6. *The Lancet, 2018* https://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2818%2931668-4/fulltext
7. *J Public Health, 2016* https://academic.oup.com/jpubhealth/article-abstract/38/2/e150/2241161?redirectedFrom=fulltext

Precedents

Globally, institutions like the Institute for Healthcare Improvement (IHI) and the International Consortium for Health Outcomes Measurement (ICHOM) illustrate what it takes to embed quality and accountability into national health systems. IHI helps health systems and providers design and implement large-scale performance improvement programs. Besides standards and methods, it also guides the providers through the quality improvement journey across the US, UK, Australia, and many other countries. ICHOM develops standardized outcome measurement sets that allow providers, payers, and patients to track what truly matters across clinical and patient-reported outcomes. Together, these examples demonstrate that building trusted institutions for transparency and continuous improvement is not only possible but foundational to scaling value-based care—India now has the chance to create its own model tailored to local needs.

High-level roadmap

The initiative will proceed through a phased approach:

Design and pilot phase (2025–2026):

- Develop the concept and governance model.
- Mobilize anchor partners and secure seed funding.
- Design the quality and cost registry architecture around 1–2 tracer conditions in alignment with national digital infrastructure efforts like ABDM and HTAIn. The outcomes selection can draw upon Leapfrog to Value's work in TB, HIV, and Maternity, while the costing framework can draw on ISB and L2V's costing work with the Fernandez Foundation.
- Develop a longer-term, sustainable business model to reduce the dependence on philanthropy
- Pilot in one district and one private healthcare institution.
- Publish knowledge products around quality improvement

Scale-up Phase (2027–2030):

- Expand the initiative to one state and pilot it in 2-3 districts in other states.
- Refine tools and governance based on pilot learnings.
- Build momentum toward national adoption.

Call to action for potential leaders and collaborators

To realize this vision, we invite partners to collaboratively develop the concept further. Potentially, the platform can be convened by credible civil society actors such as Swasth or Global Development Incubator, which houses Leapfrog to Value, with technical support from global quality improvement organizations (IHI) and academic institutions (e.g., ISB). Partnerships with national and state-level government bodies—including NHA/PMJAY, HTAIn, ABDM, and IRDA—will be critical. Stakeholders may include patient organizations, public and private payers and providers, civil society organizations, donor agencies, and multilateral institutions.

Initiative 2

Comprehensive Primary Health Care Design Laboratory

India's fragmented primary healthcare system cannot be fixed through isolated pilots or policy tweaks alone. The Comprehensive Primary Health Care Design Laboratory proposes a new institutional platform to co-create integrated, value-based models of financing and delivery—bringing together insurers, financial institutions, providers, state actors, and philanthropic actors to reimagine primary healthcare as the trusted foundation of the health system.

The problem and opportunity

India's primary healthcare remains fragmented and underfinanced, despite decades of policy attention. Most primary healthcare—where health needs begin and can often be resolved—is delivered in largely out-of-pocket settings. This leaves families and insurers with little visibility or incentive to intervene early. When delivered effectively, primary healthcare reduces costs, improves patient experience, and mitigates future risk, making it central to any value-based transformation.

Primary healthcare can become low-value when underutilized or overutilized. For NCDs and preventive care, primary healthcare is often underutilized, leading to poor outcomes, which prove to be expensive for patients and payers. The underutilization in many cases is a result of poor design of services, focused mainly on drug dispensing for hypertension and diabetes. Insurance for primary healthcare can be overutilized, leading to high cost and low value. Overall, poorly organized primary healthcare is also trust-eroding for all actors.

Additionally, for private insurers, financing OPD care has proven commercially challenging due to the large volume of small ticket size transactions, fraud risks, and limited actuarial data. As a result, in private insurance, primary care is often excluded. When they do include it, it is not viewed as an insurable claim, but rather as an add-on benefit.

But a new opportunity is emerging. Policy reforms like Health and Wellness Centers, ABDM, digital payments infrastructure, and a growing interest among insurers and employers in preventive health create the conditions conducive to reimagining primary healthcare as the organizing backbone of India's health system—not a cost center, but a platform for integration, continuity, and value.

While the Ayushman Aarogya Mandirs are crucial in strengthening public primary healthcare, they may be limited in quality and integration. They may also lack the flexibility required for experimentation. A dedicated primary healthcare lab will complement the government's efforts by generating evidence and developing scalable care delivery models that can inform and strengthen Ayushman Aarogya Mandirs.

Lastly, with recent developments in AI, it is now seeming feasible to have a personalized AI health coach for patients and a clinical decision support system for health care workers, at a low cost. AI can act as a cost efficiency lever.

Purpose

This initiative aims to strengthen the architecture for a trusted, team-based, and accountable primary healthcare system in India, where financing, technology, and care delivery are designed together to center on prevention, reduce fragmentation, and improve outcomes.

The vision is to shift from today's episodic, transactional OPD encounters to longitudinal care relationships supported by interoperable tech, risk-aligned financing, and a coordinated provider network.

Role of the initiative

Today, no single actor can fix primary healthcare alone. Market players lack the incentives and platforms to co-design new models; public programs remain siloed and under-resourced. What's missing is a space where insurers, financial institutions, providers, and government actors can jointly design, test, and scale integrated solutions.

We propose a Comprehensive Primary Health Care Design Laboratory, housed at the Indian School of Business (ISB). The co-design will bring together insurers, fintech platforms, providers, and state actors.

The Lab will prototype end-to-end models—combining new financing mechanisms, delivery models, and accountability—to make primary healthcare feasible to finance, attractive to insurers, and trusted by patients.

Unlike existing pilots, this Lab brings:

- A design-first lens grounded in value-based care principles
- Cross-sector anchoring at ISB to convene unlikely allies
- Entry points for both commercial and public pathways
- Capacity for iterative, real-world testing tied to cost and outcome metrics
- Prioritized equity and inclusion agenda to ensure the needs of underserved groups, such as workers, migrants, and the urban poor, are addressed
- Convergence of private, civil society, and philanthropic actors to co-create the solutions

The Lab will anchor three interlocking innovation tracks, reinforcing the goal of accountable, equitable, and outcome-focused care:

- **Financing models** – that aligns risk and responsibility across payers and patients. Explore savings-linked accounts, prepaid subscription models, and cost-sharing structures.
- **Tech- and AI-Enabled delivery** – enable CHWs and other providers, and embed nudges, referrals, and outcomes tracking for longitudinal care.
- **Wrap delivery and payment into inclusive pilots** – with employers, state systems, and low-income groups to test uptake, cost-effectiveness, and patient experience—generating real-world evidence to inform scale-up.

Precedents

Global and domestic examples show that structured, pre-paid, and community-rooted models can make OPD care both impactful and financially viable. For example:

- WHO Innovation Hub is a Global accelerator for digital health innovations. It has engaged 17 countries, scaled 6+ innovations in mental health, maternal & child health, and primary healthcare.
- Weill Cornell Medicine established a primary care innovation lab for innovation in clinical care, training, and mentorship for the next generation
- In 2021, Swasti created case studies on 10 exemplars in primary healthcare in India, with different models and reasons for success. They also host the Comprehensive Primary Health Care (CPHC) Alliance for collective action around primary healthcare

High-level roadmap

The initiative will unfold in three phases:

- **2025 Design & Alignment:** Co-create prototypes with community, insurers, fintechs, and providers; simulate care journeys; develop fraud mitigation and user engagement strategies.
- **2026–27 Pilot & Learn:** Launch primary healthcare offerings for defined segments of the community; embed monitoring for costs, health outcomes, and patient experience; test government buy-in.
- **2028+ Institutionalize & Scale:** Codify learnings into replicable models; integrate into Ayushman Bharat, IRDAI-regulated products, or employer schemes; support states to adapt delivery infrastructure using HWC/ABDM linkages.

Call to action for potential leaders and collaborators

This is a rare moment of alignment. The health system is converging around digital infrastructure, financing reform, and growing interest in prevention. Yet without a shared platform to design OPD care that works for patients, providers, and payers, India risks another decade of fragmentation.

We call on insurers, regulators, fintechs, employers, state actors, and delivery innovators to join us in shaping the backbone of a new health system. This is a chance to solve a wicked problem by solving it together.

Core collaborators may include insurers, banks, the CPHC alliance and its members, primary healthcare providers, including the primary health centers, private clinics, and diagnostic chains, Swasth Alliance, Dvara, and health tech platforms. We especially invite partners committed to inclusion—those working with women, informal workers, or rural populations—to help shape primary healthcare that delivers on dignity and value.

Initiative 3

Business Case for Quality, Safety & Patient Experience

The problem and opportunity

India's healthcare system is—and will remain—dominated by private provision. This reality makes it essential to align business value with social value; unless quality, safety, and patient experience are part of a provider's competitive and financial advantage, they will remain underprioritized. Despite strong advocacy from clinicians and quality leaders, most healthcare organizations in India still treat such investments as cost centers rather than strategic drivers. A key barrier is the absence of robust analytic tools and business frameworks that clearly demonstrate financial and reputational returns.

At the same time, several shifts create a timely opening. The adoption of NABH accreditation standards has improved processes, though adoption remains limited outside major hospital chains. Patients are increasingly informed and digitally active, with experience ratings influencing trust and choice of hospital. International research shows that hospitals with stronger safety and experience scores not only improve outcomes but also reduce costly readmissions and retain patient share. In India, preventable medical errors, hospital-acquired infections, and lack of transparency continue to generate wasteful spending and reputational risk—eroding trust in both individual institutions and the sector as a whole. Yet a growing movement of medical professionals is championing quality and patient experience. The opportunity now is to equip these champions with tools that demonstrate how better care is not just ethically imperative, but also central to business sustainability and sector credibility.

Purpose

This initiative aims to equip provider champions with robust, context-specific frameworks and advocacy tools to credibly demonstrate the business, financial, and strategic benefits of quality, safety, and patient experience investments.

It seeks to shift board-level and C-suite thinking—establishing quality as a means to drive financial sustainability, differentiation, and resilience in a changing policy and patient landscape.

Role of the initiative

- **Quantify returns:** Develop and adapt tools for Indian hospitals to track and report the impact of quality and safety measures on costs, readmissions, length of stay, litigation risk, and patient loyalty—leveraging global models such as the IHI's business case for safety framework.
- **Equip professionals:** Create evidence-backed advocacy materials and analytic guides, drawing from case studies where patient experience improvement correlated with revenue growth, reduced costs, or enhanced insurer negotiations.
- **Peer learning and exemplars:** Convene a peer network for quality champions to share practical wins, failures, and learnings, and publish public case examples—amplifying early adopters and encouraging emulation.

Precedents

Globally, several models demonstrate the value and feasibility of making the business case for quality and patient experience.

The Institute for Healthcare Improvement (IHI) has developed the Optimizing a Business Case for Safe Health Care, which offers hospitals a stepwise method to calculate the direct economic impact of safety initiatives. In the UK, the National Health Service (NHS) introduced the Patient Experience CQUIN—an incentive mechanism tying a portion of provider payments to improvements in patient experience scores. While this is different from inherent ROI from safety, experience, and quality, this approach resulted in measurable gains both in patient satisfaction and in provider adoption of evidence-based improvements.

High-level roadmap

- **Toolkit co-creation (2025):** Partner with 3–5 early adopter hospitals to co-create a business case toolkit, involving finance, quality, and clinical teams. This can be convened and authored by neutral bodies that can consider both the healthcare, quality, and business sides of this problem.
- **Support for quality champions (2025–2026):** Identify and support a cross-sector cohort of quality champions; provide them with coaching and training on the analytic tools. Support them in adapting the tool for internal use.
- **Policy and accreditation integration (2027):** Integrate business-case resources into position papers and standards from quality bodies such as NABH and IRDA's quality-related engagements.
- **Learning and evidence publishing (2028):** Run learning events and systematically publish case studies highlighting financial and strategic returns.

Call to action for potential leaders and collaborators

This initiative invites national and sub-national hospital chains, quality bodies such as NABH, professional medical associations, patient safety advocates, quality champions, and academic health management centers to join as co-creators. By building a credible business case for quality, providers not only strengthen patient trust and team morale but also future-proof their organization against shifting patient and payer expectations. Contributors will help shape tools and playbooks that support providers across ownership models, while rapidly increasing the standing of quality in India's healthcare sector.

Initiative 4

Coordinated Care Bundles for NCDs and Surgeries

The problem and opportunity

Like many LMICs, in India too, care is typically organized around individual visits instead of coordinated episodes of care, especially for chronic non-communicable diseases (NCDs) and surgeries. This results in avoidable complications, inconsistent outcomes, patient frustration, and elevated costs. Studies show that fragmented care particularly affects patients with multimorbid conditions, as they navigate multiple touchpoints and uncoordinated providers, often leading to drop-offs and higher rates of readmissions. Furthermore, over 61% of deaths in India in 2016 were attributed to NCDs, underscoring the urgency for more coherent delivery models.

There is a growing body of operational evidence. PMJAY's Health Benefit Packages (HBPs) already apply bundled payments for defined procedures, incentivizing providers to manage a whole episode (pre-op, surgery, post-op). Vertical health programs have succeeded in providing coordinated care for TB and maternity care. But such comprehensive, integrated pathways are limited for high-burden NCDs and complex surgeries in mainstream providers.

There is a massive opportunity for coordinated care that is bundled under a single financial package, either for a whole episode of care for surgeries or an annual capitation fee for chronic care. This is likely to create the incentives for providers to provide the most appropriate care.

Purpose

This initiative aims to introduce and scale bundled coordinated care models for select NCDs and surgeries—aligning provider and payer incentives around whole-episode outcomes, not just service volume. The objective is to enable transparent, efficient, and accountable care journeys for patients, while providing cost predictability and quality improvements for insurers and purchasers.

Role of the initiative

The initiative will collaborate with healthcare providers, public and private insurers to define clinical bundles for high-burden NCDs and surgical procedures, specifying included services and expected outcomes, including payer-provider negotiation on the value-based contract that links outcomes to payments. Once designed, it will work with payers (including insurers) and providers to launch bundle pilots in diverse settings (urban/rural/insured/self-pay) to test and refine bundled payment mechanisms and multidisciplinary care protocols. It will ensure that a good experimental design and evidence plan accompany the pilot. Finally, it will track patient outcomes and resource use, enabling continuous adjustment of both payment and care pathways.

Precedents

- A multi-country review identified 23 bundled payment initiatives. The bundles range from maternity, knee replacement, oncology to diabetes and many more. The same paper suggests that of the 32 studies, 18 studies showed improvements in quality of care while 20 reported modest savings or a reduction in spending growth. One of the strongest saving examples was Sweden's bundled-payment model for hip and knee replacements that resulted in a 34% decrease in total average medical spending.
- A care coordination program for heart failure in Taiwan showed a statistically significant association with reduced 30-day hospital readmission and mortality rates among heart failure patients and others with chronic conditions. Other studies have shown improvement in clinical and patient-reported outcomes as well as a reduction in costs.
- The PMJAY program reimburses providers using case-based bundled payments for over 1,300 hospital-based health benefit packages, covering partial or full episodes for surgical and select diseases.

High-level roadmap

- **Prepare (2026)**
  - Identify tracer NCDs and surgical procedures based on burden, variation in outcomes, and feasibility for bundling
  - Work with insurers, new-age managed care organizations in India to understand the claim patterns.
  - Collaborate with pilot sites to map existing care pathways and costs, including primary healthcare use.
- **Develop prototype (2027):** Design bundled payment and care delivery protocols with willing insurers, managed care organizations, and providers. Publish the prototype as a knowledge asset for anyone interested in joining the program.
- **Pilot and monitor (2027+):** Implement pilots with embedded digital monitoring and feedback loops; adjust models based on real-world insights. Document learnings for replication and policy integration; scale toward broader population coverage.

Call to action for potential leaders and collaborators

We call on insurers to contribute by co-developing and piloting bundled products, as well as by investing in robust outcome measurement and care management capabilities. Providers are invited to join as pilot sites and to play an active role in designing, delivering, and iterating clinical and operational workflows for bundled care episodes. Philanthropic organizations and donors can accelerate adoption by supporting technical assistance, convening collaboration, and facilitating knowledge-sharing mechanisms. Finally, academic and technical partners can add significant value by contributing analytic expertise, conducting rigorous evaluations, and building capacity to strengthen implementation and enable scale-up. By creating coordinated and bundled care, India can move from visit-based, fragmented care to episode-based, value-driven systems that deliver for patients, payers, and providers alike.

6.FIVE STRATEGIC MOVEMENTS TO WATCH

Alongside the four flagship initiatives, a set of important movements is rapidly unfolding across India's health ecosystem, signaling the growing momentum toward value-based care (VBC) at scale. These efforts—although nascent—offer a window into systemwide readiness and innovation. Their evolution should be monitored closely, as each holds the potential to become a national exemplar or reveal invaluable insights for future reform.

- The General Insurance Council, which brings all private health insurers together, is focusing on developing shared resources such as common empanelment, Standard Treatment Guidelines (STGs), and provider rating systems. This approach aims to minimize duplication, lower administrative burdens, and systematically elevate the quality baseline across the private sector. For new insurers, this will also reduce the entry barriers.
- Tech-enabled community health worker (CHW) models, exemplified by Dvara's non-communicable disease (NCD) program, areharnessing digital tools to strengthen frontline care, improve early disease management, and expand access—particularly in underserved populations.
- Integrated payer-provider models—including Narayana's One Health initiative—are demonstrating how vertically aligned care delivery and inherent financial incentives can streamline patient journeys, improve accountability, and drive measurable outcomes
- Customer engagement models from private insurers, such as Aditya Birla's One VYTL product, are opening new pathways for risk protection and proactive health management.
- Finally, insurers are starting to make efforts to systematically capture data on patient care experience, setting the stage for more transparent, responsive, and patient-centric systems.

These movements, collectively, can offer proof points and critical lessons as India charts its path toward robust value-based healthcare.

7.CONCLUSION AND WAY FORWARD

India's transition toward value-based care is no longer a distant ideal—it is an emerging imperative shaped by pragmatic experiments, collaborative platforms, ecosystem enablers, and the readiness of system leaders to look beyond incremental improvements. The four flagship initiatives outlined here spotlight the potential for structural change: from a national quality improvement effort, nurturing a primary healthcare design lab, building a business case for quality, to launching bundled payment pilots. Early signals—including insurer collaborations, integrated care models, and efforts to capture real outcomes—offer both optimism and a testing ground for continuous learning.

Next steps require disciplined and purposefully designed execution along with active partnerships across stakeholders. Each initiative should focus on robust piloting, transparent measurement, and rapid adaptation based on feedback. Leaders in government, insurance, providers, and philanthropy must channel resources toward aligned incentives and shared learning. By moving deliberately and learning rapidly, India can create a new standard where quality, experience, and value are not exceptions—but the norm for every patient.

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