



Centre for Sustainability  
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Governance Research  
INDIAN INSTITUTE OF MANAGEMENT AHMEDABAD

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SEMINAR SUMMARY REPORT

**The Lancet Citizens' Commission on  
Reimagining India's Health System:  
Governance Systems and Building Resilience**

March 18, 2025



by



**Prof. Tarun Khanna**

Jorge Paulo Lemann Professor at Harvard Business School and  
Director of the Lakshmi Mittal & Family South Asia Institute, Harvard University

Moderator:

**Prof. Anish Sugathan**

Faculty and Chairperson, Strategy Area  
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Seminar on

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Moderator: Prof. Anish Sugathan, Associate Professor of Strategy and Co-chair, CSCG, IIMA

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## About the Speaker



**Prof. Tarun Khanna**

Prof. Tarun Khanna is the Jorge Paulo Lemann Professor at Harvard Business School and the Director of the Lakshmi Mittal & Family South Asia Institute at Harvard University, where he has been a distinguished faculty member since 1993. His academic expertise lies at the intersection of strategy, innovation, and entrepreneurship, with a particular emphasis on emerging markets. Prof. Khanna's research extensively explores how entrepreneurs and companies navigate "institutional void" situations characterized by the absence of specialized intermediaries or regulatory frameworks and how they leverage opportunities within developing economies.

Beyond academia, Prof. Khanna actively contributes to practical initiatives that foster innovation ecosystems in emerging markets. His extensive experience and thought leadership have established him as a globally sought-after advisor and speaker, offering insights into building merit-based systems to enhance social well-being and economic development.

Prof. Khanna holds a Bachelor of Science in Engineering from Princeton University and a Ph.D. from Harvard University. His work has earned him recognition as a Young Global Leader by the World Economic Forum, along with appointments to various prestigious boards and advisory roles worldwide.

To know more about the speaker, [click here](#).

## About the Moderator



**Prof. Anish Sugathan**

Prof. Anish Sugathan is a faculty member and the Chairperson of the Strategy Area as well as the Chairperson of the Centre for Sustainability and Corporate Governance Research (CSCG) at the Indian Institute of Management, Ahmedabad. He pursued his PhD (FPM) from the Indian Institute of Management Bangalore (IIMB), a post-doctoral fellowship from the Harvard Kennedy School of Government, and is a visiting research fellow of the 2022 'Sustainable Futures' program at Princeton University. He serves as a member of the expert committee appointed by the Honorable National Green Tribunal of India for environmental impact assessment and evaluation. He is also a member of the Sectional Committee for Sustainable Finance of the Bureau of Indian Standards. He has served on the board of the state-owned electricity distribution utility UGVCL, Government of Gujarat, as an independent director. He advises several start-ups in the energy tech, impact investment, and innovative governance sectors.

Prof. Sugathan's research interests focus on the institutional and governance infrastructure of emerging economies, with a particular emphasis on sustainable development and corporate sustainability in India. His research has been published in reputable international journals as well as numerous national and international newspapers. His research has received several prestigious awards, including the SAP Labs India doctoral scholarship at IIMB, the Giorgio Ruffolo post-doctoral research fellowship at Harvard, and the Fung Global Fellowship at Princeton. His current research work is supported by BP UK through the PROSPER program, Evidence in Governance and Politics (EGAP) at the University of California, Berkeley, and Google through the Geo-for-Good research grant.

## Abstract

The Lancet Commission on Reimagining India's Health System was established in December 2020, amid the COVID-19 pandemic, to identify reforms needed to realize the goal of Universal Health Coverage (UHC) for the people of India. The Commission framed itself as a Citizens' Commission, with its analyses and reform options rooted in the lived experiences, expectations, and preferences of the Indian people, as expressed through participation in research and consultations. Furthermore, the commission was guided by the principle that all people in India have a universal, fundamental, and inalienable right to health and that the government must be held responsible and accountable for financing and operating the public sector, as well as stewarding and regulating both the public and private sectors. To this end, the commission engaged a diverse spectrum of expertise, including leaders of civil society organisations, and drew systematically upon extensive existing and new research to arrive at its observations and recommendations.

For more information, visit <http://www.citizenshealth.in/>

## Introduction

India's healthcare system, although has made significant strides over the decades, such as increased life expectancy, improved vaccination rates, and reduced child mortality, continues to face serious challenges. Despite improvements, the system often underperforms when benchmarked against countries with similar or lower GDP levels. In this context, Prof. Tarun Khanna's discussion offered a compelling lens through which to reimagine India's healthcare landscape. Drawing on his experience as one of the four co-chairs of a citizen-centered health commission, he emphasized the need to shift away from elite-driven, top-down approaches that have historically characterized health policy in India toward a more bottom-up approach.

The conversation emphasizes inclusivity and the importance of integrating diverse voices, especially those of patients, frontline workers, traditional healers, and marginalized communities, into decision-making processes. Prof. Khanna emphasizes the importance of grounding reforms in real-world experiences, promoting respectful collaboration among stakeholders with diverse perspectives, and fostering a trust-based dialogue rather than ideological confrontation. He also shares insights from the commission's work, including a nationwide citizen survey, participatory research initiatives, and cost-estimation models for delivering universal healthcare.

The talk also addresses systemic inefficiencies, including poorly allocated health expenditures and disparities in access between the public and private sectors. Prof. Khanna called for adaptive, context-sensitive policy implementation grounded in core principles, and explored how India's expanding digital infrastructure can be leveraged for last-mile service delivery. This discussion offered valuable lessons not just for healthcare practitioners and policymakers, but for anyone interested in co-creating equitable and sustainable systems of public service delivery.

## Seminar Summary

Prof. Khanna began his talk with a critical yet hopeful view of India's healthcare ecosystem. Drawing on extensive interdisciplinary research and collaborative field engagements, Prof. Khanna discussed the structural problems plaguing India's health sector and articulated a bold new vision for systemic reform. His address carried the weight of deep expertise and institutional experience. The talk centered on the multi-stakeholder health commission – The Lancet Commission on Reimagining India's Health System, which he helped convene. The commission aims to reimagine the delivery of universal healthcare (UHC) in India.

Questioning the utility and legacy of past healthcare commissions in India, Prof. Khanna argued that despite their long-standing existence, dating back to the Bhore Committee of 1946, these commissions have largely failed to produce actionable results. While they often included accomplished professionals such as senior doctors and bureaucrats, they were deeply exclusionary in design. The absence of frontline voices—for example, community health workers, patients, private sector actors, and local NGOs—resulted in reports that rarely reflected the practical needs or realities of India's diverse population.

As a result, even though some commissions produced technically sound documents, they lacked legitimacy and eventually had minimal implementation value. Prof. Khanna highlighted a critical institutional gap: policy design without stakeholder inclusion is likely to underperform or fail altogether.

### Structuring an Inclusive Commission

Responding to the failures of elitist policy formulation, Prof. Khanna co-chaired the Lancet Commission, which was built on the principles of inclusivity, deliberation, and pluralism. This Commission was co-chaired by four individuals representing four distinct sectors: public health, grassroots organizations, biology and research, and NGO leadership. Alongside them were over 25 additional commissioners representing a diverse

range of industries and professions, including surgeons, nurses, ASHA workers, AYUSH practitioners, patients, traditional medicine users, private insurers, and citizen representatives.

This design aimed to ensure that the Commission wasn't simply populated by experts, but by people who have firsthand experience with the health system, both as providers and recipients. According to Prof. Khanna, the guiding philosophy was that good governance demands representation from all corners of society. Members were also asked to adhere to explicit norms, which included mutual respect, non-exclusionary dialogue, and a willingness to engage across ideological lines. Notably, some individuals declined to participate due to differences in opinion and ideology, which further underlined the challenges of collaborative institution-building in a polarized environment.

Prof. Khanna went on to explain that the Commission's structure was divided into five key thematic work streams: citizen engagement, governance, human resources, financing, and technology. Each of these was led by around eight to ten commissioners. This segmentation ensured targeted focus on pressing healthcare issues. He also mentioned the development of a universal ranking system across districts, using a color-coded index (red, blue, and yellow) based on respect and responsiveness. This ranking was constructed using a simple geometric mean approach, avoiding complex debates over which metrics matter most and instead promoting consensus around common challenges.

### What the Commission has Accomplished

The core work of the Commission involved research by a network of 20 to 25 major institutions and approximately 25 PhD students, postdoctoral fellows, and faculty members, who met monthly to conduct broad-based studies. One of the most remarkable aspects of this initiative was the execution of a comprehensive, statistically representative citizen health survey, being the first of its kind in India. This survey was groundbreaking

because it asked ordinary citizens what they wanted from the healthcare system—something that had never been done at this scale. Conducted across 121 districts and over 50,000 households, the survey asked citizens what they desired from their healthcare system. Respondents included not only patients but also ASHA workers, general practitioners, pharmacists, and specialists. The survey questions were made publicly available online to ensure transparency and verifiability. The results are supported by additional research and in-depth case studies across high, mid, and low-performing districts, providing a nuanced understanding of healthcare system functionality in India.

One major project involved a hypothetical costing exercise to estimate the cost of delivering universal healthcare in India. The results suggested that although India spends significant sums on healthcare, the allocation of funds is inefficient. Some states spend far more than necessary without achieving commensurate outcomes, indicating issues in resource utilization rather than just underfunding. These findings led the Commission to define the concept of universal healthcare for the first time. As a result, UHC was described as a "basket of services" that should be universally available, encompassing preventive care, primary care, and tertiary services. Despite the existence of multiple benchmarks and studies, there was no consensus on how to translate these into action. The group's goal was to provide evidence-based yet adaptable guidelines, rather than rigid blueprints.

A key finding of the Commission is the general preference among people for treatment in public sector facilities, both for current and future care—likely a result of the improved trust that developed during the COVID-19 pandemic, when public systems played a leading role in vaccine delivery and emergency care. The speaker views this renewed trust as an opportunity to strengthen the public sector, which, he argues, should remain the primary vehicle for delivering universal health care. The private sector, meanwhile, should play a complementary and regulated role in driving innovation, filling gaps, and helping instill discipline in the public system through competition.

Analytically, Prof. Khanna leveraged his background as an economist to conceptualize healthcare as a production function of labor, capital, and technology. He argued that supply-side limitations are only half the problem; demand-side issues, such as citizens not knowing what to ask for, are equally significant. To overcome this limitation to an extent, he advocated for benchmarking and measuring performance to drive improvement and accountability.

### India's Healthcare System: A Tempered Critique

Prof. Khanna provided a trenchant critique of India's highly fragmented healthcare system, emphasizing that the existing public-private mix lacks integration. Private sector involvement is sizable but often inaccessible, and the continuum of care is severely compromised. Patients are frequently bounced between unconnected primary and secondary care providers, lacking shared medical histories and coordinated follow-ups. Pharmacists have had to increasingly fill the gap left by primary care providers, although they are not medical doctors. In many cases, pharmacists prescribe ineffective or even harmful medications, a reality captured through diagnostic experiments by the professor's colleagues.

A crucial part of the Commission's analysis focused on Non-Communicable Diseases (NCDs), with India identified as a global hotspot, especially for metabolic diseases in men. The public health system, which is largely still focused on communicable diseases, is out of sync with this growing NCD burden. Furthermore, access and affordability continue to be key challenges. Catastrophic health expenditures continue to be a leading cause of financial hardship and bankruptcy in India. Although insurance schemes exist, their coverage is minimal, with only about 2% of inpatient cases in private hospitals and 7% in public hospitals being partially covered. Most people remain exposed to financial risk, and insurance benefits often don't align with patient needs.

Delving deeper into the topic, Prof. Khanna addressed the structural and institutional barriers in the insurance sector. The insurance regulator, for example, mandates a high capital requirement (around 1 billion) to start a new insurance firm. While this is intended to prevent fraudulent or unsustainable models, it inadvertently concentrates market power among a few large insurers, limiting innovation and accessibility. Trust deficits between patients and providers, as well as between regulators and insurers, further complicate efforts to reform the sector.

Prof. Khanna continued by emphasizing the deep systemic frustrations experienced by both patients and providers in India's healthcare system. On the provider side, physicians often lack access to a patient's medical history, which undermines the continuity and quality of care. Doctors are not only demotivated by financial constraints but also suffer from a lack of professional satisfaction when they are unable to follow up on patient outcomes. Care is often fragmented, with no structured forward or backward linkage across the system, resulting in inefficiencies and mistrust throughout the system. The public healthcare system operates under a regime of mistrust, where fraud prevention is enforced through excessive controls and oversight. For instance, rather than empowering local units with a fixed budget and the autonomy to use it efficiently, the system micromanages line items, adding stress and inefficiency. There is a stark absence of a more empowering model, such as allocating a fixed amount per person and allowing local actors to retain savings for better performance. Instead, the system's overregulation reflects a fundamental mistrust in service providers, leading to significant inefficiencies.

A key indicator of this dysfunction is the persistently high level of out-of-pocket expenditure. Although this figure has decreased from 65% to 48%, it remains among the highest in the world. This situation disincentivizes patients from seeking timely care, particularly preventive care, leading to higher rates of medical complications. The existing system spends significant funds inefficiently, often at the wrong time, on the wrong interventions, and for the wrong groups of people. Beneficiaries of the

current setup resist reform, making change politically challenging. The speaker frames this as a strategic "game of chess" for policymakers, where creativity and persistence are needed to outmaneuver entrenched interests.

Pressing on this point, Prof. Khanna emphasized the need for a "production approach" to healthcare, focusing not only on delivery and outcomes but also on creating informed patients, more innovative health systems, and effective governance mechanisms. A well-functioning healthcare system must include effective marketing of health interventions, mobilization of talent, and coordinated infrastructure. Drawing a comparison with the U.S., Prof. Khanna noted that while healthcare is a dominant public issue there, it has historically not been a political priority in India. Until recently, no major Indian political party had included healthcare prominently in its manifestos. This began to change in the last election cycle, and more citizens are now listing healthcare as one of their top priorities, as evidenced by large-scale surveys of citizens.

### Cautious Optimism

On a positive note, there are promising developments in technology. Innovations are emerging not only in drug discovery but also in telemedicine, remote diagnostics, genome sequencing, and the use of AI for real-time health surveillance. These technological shifts are improving access and infrastructure, offering hope for more efficient service delivery. There has also been a discussion on the growing role of digital infrastructure in healthcare delivery. Prof. Khanna believed that India's digital backbone offers potential for last-mile connectivity, which can help improve healthcare access in even the most remote areas. Yet, access still varies widely across regions and between public and private sectors, with many preferring the latter due to perceived quality differences.

However, on the governance and financing side, the picture remains grim. There is already enough money in the system to achieve significantly better outcomes, but poor fund management and lack of

political will hinder progress. For example, Prof. Khanna cited the Rashtriya Swasthya Bima Yojana (RSBY) and related health funds that were intended to benefit millions. Yet, the funds are often underutilized or mismanaged due to weak oversight. Furthermore, the absence of regulation and accountability mechanisms is a significant bottleneck, which means that the system lacks transparency in how public funds are allocated, spent, and audited. People do not demand better services or accountability because they are unaware of their entitlements or distrustful of the system. However, Prof. Khanna stated that significant improvements are possible, such as moving India's healthcare quality index from 44 to 55, even without additional funding, simply through more innovative governance and political courage. However, there are six to seven politically sensitive reforms that must be addressed directly to achieve this transformation.

Prof. Khanna also identified a fundamental structural issue in India's healthcare system: the absence of continuous, long-term visibility into patient care. Chronic patients—such as those with cardiac or diabetic conditions—require ongoing care and monitoring. Still, no single person or institution is currently responsible for maintaining a consistent view of patient history. This fragmentation creates significant gaps in treatment and care outcomes, particularly for individuals without adequate representation or support within the system.

Reflecting on his own journey, Prof. Khanna shared a personal narrative of how his interest in health systems evolved. Initially engaged in academic research, his focus shifted towards understanding the intersection of health and finance. Rather than relying solely on theory, Prof. Khanna immersed himself in civil society work to gain a deeper understanding of the real-world dynamics of healthcare delivery. This practical engagement helped him develop a nuanced expertise in the interplay between public health systems and financial structures. He also emphasized that this kind of hybrid knowledge is essential in India, where health intersects with corporate, social, and political interests. With foundational skills in economics and public policy, Prof. Khanna then began addressing

specific healthcare problems, building tools, insights, and networks over time. He credited his mentors and the broader intellectual community with teaching him how to engage meaningfully with complex policy issues. Ultimately, he decided to pivot from critique to construction—to stop merely analyzing problems and begin working on solutions. This shift was driven by the belief that change is possible and necessary, particularly in the healthcare space, which affects millions of lives.

Prof. Khanna then transitioned into a broader reflection on markets and institutions. He argued that markets are essentially rule-based systems that facilitate people finding each other to engage in mutually beneficial exchanges. Whether it's a market for chemicals, services, or ideas, the key is setting the proper rules and ensuring that participants can connect and transact effectively. However, markets don't always work automatically. In many cases, the problem is the absence of what Prof. Khanna calls "missing institutions"—the frameworks that enable trust, facilitate information exchange, and enforce compliance.

The conversation then turned to the evolution of new technologies and the social challenges they present. Drawing a comparison to the early days of the internet or genomics, Prof. Khanna noted that every transformative technology initially exists in a policy vacuum. There is little clarity on rules, risks, or governance structures. In such periods of flux, societies undergo political and institutional struggles to define norms. This creates both opportunity and confusion. He suggested that this uncertainty is not a failure but a natural part of social adaptation. Prof. Khanna further underscored that with every technological change comes a period of contestation—where society debates the implications of such a change and establishes new rules accordingly. This process takes time but is essential for embedding innovations in a just and sustainable manner. He implied that the emergence of technologies like AI and genomic sequencing in healthcare will follow a similar trajectory, marked by regulatory ambiguity and potential misuse, but also offering transformative possibilities.

Towards the end, Prof. Khanna addressed a question about current health insurance experiments, specifically the Ayushman Bharat program. He acknowledged the promise of such initiatives but also pointed out the serious implementation gaps. Issues such as poor data systems, bugs, and distrust, particularly in areas like dental insurance, continue to hinder these efforts. Dentists, for instance, often lack confidence in the reimbursement process, resulting in poor participation.

In closing, Prof. Khanna reiterated that India's healthcare system is plagued by fragmentation and inefficiencies, especially in continuity of care. Richer patients can bypass these issues by curating their own networks of care, but most Indians remain at the mercy of disconnected services and underqualified intermediaries. He stressed the need for systemic reform that strengthens public healthcare delivery, creates effective insurance models, and ensures patients are treated holistically rather than in a fragmented and piecemeal manner. However, despite these challenges, Prof. Khanna remains optimistic. He asserted that such experiments are necessary and must be continued and improved upon because the cost of inaction is far greater. The healthcare system is broken and needs extensive reform; however, imperfect as it may be, it must continue.



## Key Takeaways & Conclusion

- **India's Healthcare Paradox:** Despite notable improvements in metrics like mortality rates and immunization coverage, India continues to underperform relative to its GDP and peers, signaling systemic inefficiencies rather than mere underfunding.

- **Inclusivity in Health Governance:** The new health commission took a deliberate, unprecedented approach by ensuring representation from diverse stakeholders—doctors, nurses, frontline workers, traditional healers, insurers, and citizens—challenging the long-standing norm of elite-dominated policymaking.

- **Listening to Citizens:** For the first time, a nationally representative citizen survey was conducted to understand what people want from their healthcare system, shifting the narrative from top-down reforms to demand-driven policy design.

- **Cost Is Not the Primary Barrier:** Economic modeling has shown that delivering essential, universal healthcare is feasible within existing budgets, especially in many states that already spend above the required threshold, pointing instead to poor allocation, inefficiency, and a lack of prioritization.

- **From Rigid Solutions to Guiding Principles:** The report avoids one-size-fits-all prescriptions, instead offering adaptable principles that can be tailored to diverse local contexts, encouraging negotiation and implementation at state and district levels.

- **Digital Infrastructure as an Enabler:** India's digital backbone presents a unique opportunity to bridge access gaps, particularly for underserved and remote communities, underscoring the role of technology in last-mile service delivery.

- **Collaboration Over Consensus:** The Commission's work was grounded in respectful disagreement and co-creation, reinforcing the idea that meaningful reform in a complex system like healthcare requires pluralism, humility, and persistent negotiation.

India stands at a pivotal moment in its journey toward universal healthcare. Despite notable gains in health outcomes, such as reduced mortality and improved vaccination coverage, the nation continues to underperform when benchmarked against other low-income countries, even after adjusting for GDP. A key reason lies in the persistent exclusion of critical voices, right from the policy design phase to the implementation phase. Historically, health commissions have been led by well-intentioned experts from elite institutions whose recommendations often fail to translate into meaningful change on the ground. While the Commission seeks to rectify this shortcoming, Prof. Khanna maintains that the Commission's report is not intended to prescribe rigid policies, but rather to provide a set of research-backed guidelines adaptable to local contexts. It aims to serve as a reference for inclusive, equitable, and efficient healthcare reform in India, grounded in both empirical data and participatory processes.

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