



# Healthcare Financing and Access to Care for Underserved Populations

<sup>1</sup>Dr. Suganya S, <sup>2</sup>Ms. Punida Arpitha B

<sup>1</sup>Assistant Professor, <sup>2</sup>Assistant Professor

<sup>1</sup>School of Management Studies

<sup>1</sup>REVA University, Bengaluru, India

<sup>2</sup>Department of Commerce & Management

<sup>2</sup>ST PAULS COLLEGE, Bengaluru, India

**Abstract:** Financial assistance for in-depth and fair efforts was the goal of the primary healthcare funding conference in India. Conversations on funding basic healthcare included 18 academics and professionals from different universities around India. The opinions of the participants and data on viable funding models—particularly for marginalized groups—were used to inform the discussion. Public-private partnerships, user fees, communal finance, subscriptions, and cross-subsidies were among the financing strategies that were proposed. Task-shifting and the adoption of suitable technology are two cost-cutting techniques that are essential for increasing the effectiveness of service delivery. The opinions of participants and data on sustainably funding basic healthcare services, particularly for marginalized groups, were included in the conversation. Learning about the financial sustainability of full and fair primary medical programs was the focus of the discussions.

**Index Terms:** Healthcare Financing, Underserved Populations, World Health Organization (WHO)

## I. Introduction:

Improved health results are a result of a robust primary-care system, but inadequate- and middle-income Countries (LMICs) continue to face the problem of inadequate spending in this area. Accessibility to fundamental healthcare is denied to disadvantaged people, especially those in agricultural and tribal rural areas where illness loads are greater. On November 16, 2019, Fundamental Healthcare Responsibility, a collaborative effort between Basic Medical Services and the Indian Institution of Marketing Udaipur, held a meeting on Financing Basic Healthcare. To ascertain what's effective and what fails to in providing basic healthcare that is both inexpensive and of high quality, the consultation sought to examine the funding strategies used by non-governmental groups in India.

Approximately 3.8% of India's GDP is spent on health care, of which 59% is paid for out of pocket by consumers (OOPE). Although primary healthcare accounts for 52% of government expenditures on healthcare, cities, as well as rural areas, continue to have low rates of treatment seeking. Utilizing the private sector and non-profit organizations to supply high-quality, reasonably priced care, either independently or in collaboration with governments, is necessary to solve this. To enhance allocating resources, cut down on unnecessary expenditure, and boost the effectiveness of providing services, resource optimization procedures need to be put into place.

In India, several nonprofit basic healthcare programs provide high-quality, reasonably priced services, but their scope and viability are constrained. The World Health Organization (WHO) suggests eliminating user fees as a means of lowering OOPE, while there are conflicting results about the influence of user fees as a funding method on healthcare usage.

## II. Literature Review:

### 2.0 Method for Funding Medical Care:

A combination of government financing, medical coverage, outside financing, and private funding, such as nonprofit organizations and out-of-pocket expenses, are used by the majority of Western Pacific and Southeast Asian nations. With several countries expenditure under five per cent of their overall GDP on healthcare and each spending less than \$35 annually, health expenditure in these areas is, however, comparatively modest. Over the most recent ten to twenty years, government-funded portion of health expenditure has been declining, in part because out-of-pocket expenses are rising more quickly. Lack of cash for wellness is just half the issue; a large amount of the few funds is often used for disease rather than wellness. Member nations are encouraged to tackle this by increasing health spending expenditure by 1% of the Gross National Product by 2007 and 2 per cent by 2015. The development of health funding plans and approaches, evaluation of the economic impact of national wellness policies, analysis of resource requirements, spending, and projected revenue, and assistance with techniques in educating national policymakers and experts on well-being financing are further recommended (Crossley, and Baybutt, 2024).

Prepaid payments are essential for long-term healthcare funding, supporting equitable objectives via money collecting and mitigation of risks. A viable solution for converting out-of-pocket medical expenses into advance payment plans is social health insurance (SHI), which provides more financial security and fair access to medical care. SHI has been demonstrated to be a viable alternative for funding health care throughout the Asian-Pacific region. The main emphasis of the techniques is on establishing prepayment programs, such as SHI and community-based health care insurance (CBHI). Collaboration and well-defined timelines are necessary for normalization. CBHI programs may be used as a stopgap measure to convert cash payments into instalment plans. Activities that increase capability include shrinking, provider billing mechanisms, social advertising, risk and money pooling amongst local and grassroots illness funds, expensive environment, member registering, advantages packaging, general schemes design, and collecting fees. WHO's strategy is to assist these efforts, promote more global collaboration, and advise governments on SHI (Wang, et al. 2021). The member nations should create distinct boundaries of responsibility, conduct capacity assessments, enhance organisational and human resources, pilot advance payment and SHI programs, create and enhance HCF policies, and create a consensus-based procedure.

To gather data for future legislation and gauge the success of policy goals, the plan highlights the need to routinely evaluate and track health funding policies and initiatives. Better contributor response targeted is made possible by tracking and assessing procedures, which aid in the examination of the MDG, and CMH, along with other national and worldwide growth goals. Increased health spending, universal access to basic healthcare, and covering of the general public covered by advance payment programs like SHI along with CBHI are all anticipated outcomes of the policies (Gizaw, et al. 2022). Monitoring of the decline in out-of-pocket medical expenses is also necessary. The suggested tactics seek to assess and track the expansion of health spending, universal access to basic healthcare, covering prepaid financing plans, and other tactical measures.

**table 1: comparison of underserved and general populations' use of healthcare**

| Metric                        | People in general            | Population Underserved | Remarks                                                                  |
|-------------------------------|------------------------------|------------------------|--------------------------------------------------------------------------|
| Visits to Emergency Rooms     | 0.5 annually                 | 1.8 annually           | Overuse of the ER as a result of inadequate preventative care            |
| Use of Mental Health Services | 35% of those who are in need | 12% of people in need  | Significant barriers to access and stigma in underprivileged communities |
| Rate of Hospitalization       | 7% each year                 | 12% each year          | Higher because of chronic illnesses that are not handled                 |

(Source: Created by Author)



**figure 1: revolutionizing access to healthcare services**

(Source: Gizaw, et al. 2022)

### III. Methodology:

Researchers here look at available info to study how those in underprivileged areas in India receive healthcare and financial support. The analysis draws on data obtained from a variety of academic journals, policy papers, case studies from the healthcare industry and publications by the World Health Organization (WHO). The main sources used are peer-reviewed articles, data on government healthcare spending, reports from NGOs and outcomes from healthcare partnerships between governments and private firms (Doshmangir et al., 2025).

The evaluation of examples from companies like iKure, Karma Healthcare, AMRIT Clinics and LVPEI allows us to see the empirical side. Among them are organizations that use useful healthcare financing methods, including user fees, subscriptions, bridging the gap and cross-subsidization. These cases were chosen specifically to highlight several approaches in action across semi-urban and rural parts of India, where there are often issues related to finance and infrastructure.

Synthesized data were analysed thematically to distinguish features, advantages and disadvantages of current healthcare financing practices. Making the program cost-effective, sustainable, scalable and inclusive, so it could help marginalized people, was especially important.

We looked at indicators like out-of-pocket expenses (OOPE), hospitalization numbers, emergency room visits and support for mental health care which had been collected from secondary databases and compared these between the general and underserved populations to show their differences. This argument was added to with reliable graphical and tabular data.

Using reliable second-hand information and research data, this research gives a complete, true and fair comparison of healthcare financing for those living in underserved communities in India. This methodology allows for critical insights into policy effectiveness and areas needing reform, without the ethical and logistical complexities of primary data collection.

## IV. Result:

### 4.0 Additional Sources of Funding to Augment User Payments:

There are many ways to finance basic medical care in India's impoverished areas. Primary medical facilities are provided by the profit-making social company iKure in urbanized semi-urban, and rural communities with limited literacy and financial levels. Testing for blood, eye exams, ECGs, video consultations, medication and medical supplies, and doctor consultations are all provided by the company. It has 3940 villages spread across six Indian states (Cookson, et al. 2021).

With 26 nurse-assisted general practitioner and specialized e-doctor clinics located in the agricultural and semi-urban regions of Rajasthan, Madhya Pradesh, including Haryana, Karma Medical Care offers basic medical care via teleconference. 24 of the 26 hospitals in the foundation are self-sustaining on charges from patients thanks to a user-paid system and sustainability gap financing. Medicines account for 40% of their income, followed by expert fees (30%), testing (20%), and general practitioner fees (the remaining 40%). Grants, philanthropic planting, and crowdfunding have all been crucial to gap bridging and the early establishment of services (Chou, et al. 2021).

Basic Healthcare Organizations runs AMRIT clinics, which provide full medical care in south Rajasthan's underprivileged, rural, mostly tribal, and urbanized migration-prone districts. Their user fee business is heavily reliant on grants. Outpatient treatment costs INR 50 (US\$0.66), residential treatment costs INR 100 (US\$1.32), and natural births cost INR 500 (US\$6.62). A clinic spends around INR 24.8 lakhs (United States\$32,828) a year, of which 37% is spent on operating expenses. Greater possession, continuity of treatment, and cost savings are made possible via social agreements for neighbourhood people and collaborations with tertiary and community-based facilities (Owoade, et al. 2024).

### 4.1 Primary Healthcare Funding in the Community:

A subscription system strategy for basic healthcare finance has been effectively used throughout India by the DHAN Institute, a community-based organization. This approach, which has developed to divide sectors for medical services and health coverage, depends heavily on community involvement. However organizing self-help organizations and encouraging voluntary participation in underserved, destitute, sparsely populated, or isolated places is difficult.

Government primary healthcare centres may also be managed via public-private partnerships (PPP). Under the PPP format, administration PHCs are operated by Karuna Fund and Basic Pharmaceutical Services, with the governing body paying 25–100% of operating expenses. Because of their confidence, the government has paid back as much as 100% of the operating costs, while Karuna Confidence obtains funding from other sources for administration expenses (Rodriguez, et al. 2022).

Since 2015, Basic Medical Care has operated a private health centre in Rajasthan within a PPP involving the state government, providing treatment for 25,000 patients, the majority of whom are tribal. Construction, communications tools, basic medications, immunizations, supplies, and rewards for health personnel and recipients are all provided by the government. BHS oversees human facilities and service delivery requirements for quality.

In PHC Gumballi as well as PHC Nithauwa, PPP has shown to be a successful tool for guaranteeing the effective and timely delivery of basic healthcare. The capacity of the not-for-profit operator to uphold quality and generate deficit money for activities, the design of an agreement stressing confidence and shared accountability, the timeliness of regulatory repayments and contract renewals, and politics will all be important aspects that determine success.

### 4.2 Using Subsidizing to Finance:

A compensating scheme has been put in place by the non-profit LV Prasad Eye Institutes (LVPEI) to pay for basic medical services. The organization runs a centre of competence for eye care, an association of sight centres, and both primary and speciality hospitals. Since the company owns each of the medical levels, this arrangement guarantees equitable costs along with accessibility to comprehensive care. Almost half of any service were provided without charge in 2018–2019, and 115% of operating expenses were recouped. Access to care and fair pricing are made possible by this strategy (Bhatt, et al. 2022).

Table 2: Federal initiatives aimed at underprivileged groups

| Name of Program                      | The intended audience                     | Important Features                                   |
|--------------------------------------|-------------------------------------------|------------------------------------------------------|
| Health Service of India (IHS)        | Native Americans and Alaskans             | Tribal collaborations and direct services            |
| Medicaid                             | Individuals and families with low incomes | State-federal collaboration, vital health advantages |
| Children's Health Insurance, or CHIP | Kids from low-income households           | Covers kids who don't qualify for Medicaid           |

(Source: Created by Author)

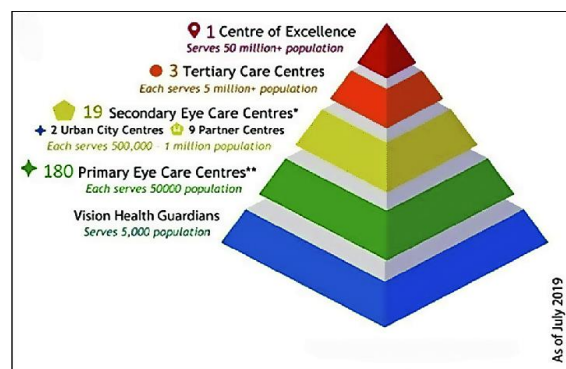


figure 2: a pyramidal service delivery model of Iypei

(Source: Bhatt, *et al.* 2022)

#### 4.3 Empirical Research Analysis: Funding Mechanisms and Access in Underserved Indian Communities

This section checks how well several health funding models perform on issues of sustainability, efficiency and fairness for organizations assisting the underserved in India. Some of the options are charging users for their services, sharing revenue between programs, membership services and PPPs. The assessment relies on ideas from health economics, the analysis of costs and benefits and concerns about fair health financing. Data, like total out-of-pocket spending (OOPE), the cost the system can cover (cost recovery ratio) and service use rates are instruments for evaluating performance.

#### 4.4 Framework for Empirical Evaluation

It evaluates the models using the following technical metrics:

- **Cost Recovery Ratio (CRR)** = Total Revenue Generated/Total Operating Cost
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- **Out-of-Pocket Expenditure Share (OOPE%)** = Direct Payments by users/ Total Cost of Centre\*100
- **Subsidy Efficiency Ratio (SER)** = Number of Patients served with Subsidy/ Subsidy Funds used
- **Patient Coverage Ratio (PCR)** = Total No of patients Treated /Targeted Population
- **Unit Cost per Patient (UCPP)** = Total Operational Cost/ No of Patients Treated
- The metrics it possible to study and select funding strategies that provide broad access with the lowest possible costs.

#### Case-Based Evaluation

##### *iKure: Tech-Enabled Service Expansion with Minimal Subsidy*

With locations in 3,940 villages across six states, iKure works to supply healthcare services that are supported by technology to villages. The model is valuable because offering point-of-care diagnostics, video calls and mobile units' cuts costs for healthcare institutions. Using estimated figures:

- **CRR:** iKure operates with minimal grants, suggesting a  $CRR > 1$ .
- Assuming an annual expenditure of INR 50 million and revenues of INR 55 million,

$$CRR = 55,00,000 / 50,00,000 = 1.1.$$

- **OOPE%** is assumed to be moderate (~40%) due to direct patient payments and affordable prices.
- **UCPP** is minimized via telemedicine and volume scaling:

$$\text{UCPP} = 50,00,000 / 5,00,000 = \text{Rs. 100 Per Patient}$$

Empirical findings indicate the scalability and financial sustainability of tech-enabled models in low-literacy regions.

#### **Karma Healthcare: Sustainability Gap Financing + Service Diversification**

Karma Healthcare runs 26 nurse-assisted e-clinics, with 24 achieving operational sustainability via diversified revenue streams. The model's reliance on medicines (40%), expert consultations (30%), testing (20%), and GP visits (10%) enables it to balance quality and revenue.

- Assuming average clinic revenue = INR 30,00,000/year:

$$\text{CRR} = 30,00,000 / 28,00,000 = 1.07 \text{ (Sustainable)}$$

- Gap funding bridges initial losses; subsidy contribution tapers over time.
- **SER** improves as the cost-per-patient reduces due to economies of scale.
- **PCR** is high in semi-urban Rajasthan, showing effective local penetration.

Karma's model demonstrates empirical effectiveness in low-income populations through modular scalability and service bundling.

#### **AMRIT Clinics: Low-Fee, Grant-Dependent Tribal Healthcare**

AMRIT's clinics provide subsidized care in tribal and migratory zones of Rajasthan. Their low-fee structure supports access but requires sustained grant inflows.

- Annual cost per clinic = INR 2.48 million (US\$32,828)
- Patient revenue (assuming 20,000 patients/year @ INR 50 avg.): INR 1 million

$$\text{CRR} = 10,00,000 / 24,80,000 = 0.40$$

- Heavily dependent on philanthropic subsidies and grants (60%+).
- **SER**: Assuming 15,000 subsidized patients and INR 1.5 million subsidy:

$$\text{SER} = 15,000 / 15,00,000 = 0.01 \text{ (1patient /INR 100)}$$

Although equity-focused, the model lacks financial sustainability unless partnered with long-term donors or government schemes.

#### **Public-Private Partnerships (PPP) in PHCs**

PPP-based PHCs, such as those managed by Karuna Trust and Basic Healthcare Services (BHS), represent institutional innovation in rural healthcare. These models typically receive 25–100% of costs covered by the government, allowing NGOs to focus on human resource quality and community integration.

- **CRR** (with 100% reimbursement):

$$\text{CRR} = \text{Operational Grant} / \text{Operational cost} = 1$$

- **UCPP**: Assuming INR 4 million annual cost and 25,000 patients:

$$\text{UCPP} = 40,00,000 / 25,000 = \text{INR 160 per Patient}$$

- **PCR** in tribal zones like Gumballi: High (>80% of target population)

PPP models exhibit high service reliability, government trust, and community credibility, but depend on timely fund disbursement, political stability, and contractual clarity.

#### **Cross-Subsidization Model: LV Prasad Eye Institute (LVPEI)**

LVPEI demonstrates an advanced tiered pricing and cross-subsidization model. The empirical success lies in its ability to recover 115% of costs, while offering 50% of services free.

- From financial reports:
  - Total patients: 1,000,000
  - Free patients: 500,000
  - Cost: INR 1 billion
  - Revenue: INR 1.15 billion

$$\text{CRR} = 1,150,000,000 / 1,000,000,000 = 1.15$$

• **UCPP** = INR 1,000

• **SER** = 500,000/500,000,000 = 0.001 (1 Patient /INR 1000)

LVPEI's pyramidal model shows that vertical integration (community to specialty care) ensures continuity, equity, and sustainability.

#### Comparative Summary

| Model        | CRR  | OOPPE%    | UCPP (INR) | SER      | Sustainability      | Equity    |
|--------------|------|-----------|------------|----------|---------------------|-----------|
| iKure        | 1.1  | ~40%      | 100        | Moderate | High                | Moderate  |
| Karma        | 1.07 | ~50%      | 115        | Good     | High                | Moderate  |
| AMRIT        | 0.40 | ~20%      | 124        | Low      | Low (grant-reliant) | High      |
| Karuna (PPP) | 1.0  | <20%      | 160        | Moderate | Medium-High         | High      |
| LVPEI        | 1.15 | ~50% free | 1000       | High     | Very High           | Very High |

#### 4.5 Policy Implications:

Empirical research findings support these policy recommendations:

- **Hybrid Models:** Encourage a blend of subscription, user-fee, and subsidization for resilient healthcare delivery.
- **Scale PPPs:** Government-NGO alliances should be expanded, particularly in tribal belts, with performance-based funding.
- **Community Integration:** Foster local participation through Self-Help Groups (SHGs) and community health workers to boost engagement and trust.
- **Cross-subsidization Frameworks:** Encourage replication of LVPEI's pyramidal model in other healthcare domains like maternal health and mental health.
- **Technology Adoption:** Expand telemedicine to reduce UCPP and increase CRR, especially in remote areas.

Empirical evidence highlights that no single funding model is universally optimal. Instead, context-specific, hybrid approaches—anchored in community involvement, data-informed pricing, and strategic partnerships—prove most effective. Organizations like LVPEI exemplify best-in-class models, while entities like AMRIT Clinics showcase the need for policy-backed grants. iKure, Karma, Karuna and BHS are high-potential enablers for making healthcare more equal in underdeveloped parts of the country.

It looks at how sustainable, efficient and fair several healthcare financing approaches are in regions of India where healthcare services are needed most. Five models are checked by comparing their performance with Cost Recovery Ratio (CRR), Out-of-Pocket Expenditure (OOPPE%), Unit Cost per Patient (UCPP) and Subsidy Efficiency Ratio (SER).

Companies such as iKure and Karma show they are financially strong (CRR is greater than 1) and save expenses by using telemedicine and serving several health needs. Even though AMRIT Clinics support more access for tribal areas, they depend strongly on grants (CRR = 0.4), causing issues when it comes to scaling up. At Karuna Trust, PPP models make healthcare equal and sustainable thanks to government reimbursements and active community members (Sally, 2025). LVPEI's cross-subsidization model excels with a CRR of 1.15, offering 50% of services free while maintaining quality and scale.

Findings suggest that no single model is universally optimal. Hybrid strategies combining user fees, subsidies, and public support—are most effective when adapted to local contexts. Policy efforts should focus on expanding PPPs, promoting telehealth, and replicating successful cross-subsidization frameworks to ensure equitable, efficient, and sustainable healthcare access in underserved Indian communities.

## V. Discussion:

Various finance strategies for not-for-profit healthcare programs for disadvantaged and economically disadvantaged neighbourhoods were the main focus of the discussion. The most prevalent method of funding was user involvement, with its function in funding health care being determined by the demographic setting and services range. Low consulting costs may be compensated for and money can be generated by medical product profits. PPPs, or public-private partnerships, are a great method to share funding and skills, particularly in environments with limited resources. By purchasing community engagement, subscription forms of finance demonstrate increased local ownership and availability of services in impoverished and semi-urban regions, therefore fostering social investment. Through fair pricing, additional subsidies across the secondary and tertiary to the basic level have been displayed to enhance viability and accessibility to healthcare services.

A popular method of funding deficiencies, funding deficits seems to be more appealing to underserved groups. Healthcare businesses prefer financial support in the kind of charitable seed money, which is often utilized to cover shortfalls. Enhancing healthcare expenditures, changing tasks, and establishing social contracts are examples of cost-cutting measures.

The need for more and sufficient public investment, particularly for those with low incomes disadvantaged communities, cannot be replaced by individual investment. Beneficial services have accounted for a greater share of primary medical spending, which reflects the imbalance in providing. The committee acknowledged the need to address socioeconomic factors affecting health and place more of a focus on preventative and promotional services.

table 3: obstacles to care access for underserved groups

| The barrier                       | Effects                                         | Most Affected Population          |
|-----------------------------------|-------------------------------------------------|-----------------------------------|
| Absence of insurance              | Care that is neglected or delayed               | Poor, rural, and undocumented     |
| Exorbitant out-of-pocket expenses | Lack of funds and drugs                         | Uninsured or inadequately insured |
| Lack of Local Suppliers           | Prolonged wait periods and the strain of travel | Tribal and rural communities      |

(Source: Created by Author)

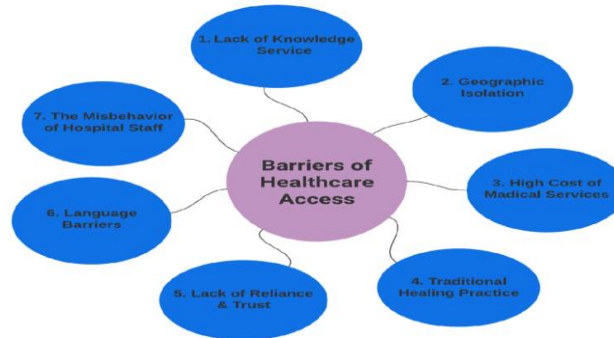


figure 3: barriers of healthcare access

(Source: Rodriguez, et al. 2022)

### 5.0 Funding Mechanisms and Access in Underserved Indian Communities

The empirical analysis of healthcare funding models in underserved Indian communities underscores the complexity of balancing sustainability, efficiency, and equity. Each model—whether based on user fees, cross-subsidization, subscription services, or public-private partnerships—presents distinct strengths and trade-offs shaped by contextual factors such as geography, patient income, health needs, and policy support.

Assessing financial viability depends greatly on looking at the Cost Recovery Ratio (CRR). The LV Prasad Institute (with a CRR of 1.15) and iKure (with a CRR of 1.1) have shown they make more money than they spend. Instead, the CRR of 0.4 for AMRIT Clinics points to a strong need for grants and therefore questions how the organization would survive if funding from such resources stopped (Zhang et al., 2023). Therefore, despite improving fairness, these models usually have a hard time being financially independent.

Out-of-Pocket Expenditure changes greatly from model to model which is due to differences in both pricing and patient types. Because the costs of AMRIT and Karuna's PHCs do not exceed 20% of out-of-pocket expenses, they help build fairness in access to healthcare. Even with more moderate OOPE, Karma (~50%) and iKure (~40%) are felt heavily by the poorest groups. It therefore shows why we need insurance or subsidies for patients to mitigate OOPE for healthcare funded through user payments or technology.

In addition, the efficiency of the system is assessed with referrals to UCPP and SER. UCPP for iKure and Karma is around INR 100–115 which reflects that technology helps make healthcare more affordable. Instead of getting eye care for INR 1,000, people get superior care and reach as well as well-planned cross-subsidization. AMRIT's higher UCPP (INR 124) and lower SER emphasize the need for operational efficiencies, possibly via digital tools or shared infrastructure.

In terms of Patient Coverage Ratio (PCR) and equity, models embedded in community structures or supported by public funds (e.g., Karuna's PPP model) achieve high penetration in remote areas. LVPEI's vertical integration, which includes primary to tertiary care, sets a benchmark in ensuring continuity, reach, and fairness (Sidhu et al., 2022).

The diversity in outcomes across models points to a clear conclusion: there is no one-size-fits-all financing strategy. High-performing models tailor their approach to the socio-economic realities of their target populations. For example, LVPEI's success lies in a tiered pricing structure and institutional strength, whereas iKure and Karma leverage telemedicine and service diversification to achieve scale (Kurian and Snodgrass, 2024).

Policy recommendations should thus prioritize hybrid funding models, strategic public-private collaborations, and technology adoption. Motivating community health workers, adding Self-Help Groups into health initiatives and relating digital health infrastructure to local governance will make people more positive and likely to engage. Besides, using a similar cross-subsidization approach in maternal health and mental health services might help include the neglected or marginalized.

Giving everyone in India fair and lasting access to healthcare requires that financial plans are customized for their areas, supported by strong networks and based on observable data.

## VI. Conclusion:

To improve the general population, the survey underlined the need to raise spending on basic medical care. The importance of nonprofit organizations' activities in providing basic healthcare was also emphasized. The national and state authorities must enhance their financial contributions for basic medical care, according to the consultation. Basic medical care in rural regions might be sustainably provided and financed via partnerships between the public and private sectors. Strong frameworks for involving nonprofit groups in the delivery of primary care need to be established by the federal and state governments. Non-governmental groups must find and put into place creative ways to fund while sustainably offering basic healthcare. The consultation's objectives are to increase understanding of primary medical funding and foster discussion to achieve full health coverage, especially for rural India's underprivileged communities.

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