THE ROAD TO HEALTH FOR ALL: FINANCING, REGULATION, AND THE JUSTICIABLE RIGHT TO CARE IN INDIA

Akhila S T, Department of Law, University of Kerala

I. Introduction

Universal health coverage rests on a deceptively simple promise: that every person, wherever they live and however much they earn, can obtain the health services they need — preventive, curative, rehabilitative, and palliative — without being ruined by the cost of care. The philosophy of UHC rests on the proposition that health is a fundamental human right, a principle traceable to the 1948 Universal Declaration of Human Rights and operationalized by the 1978 Alma-Ata Declaration, which made primary health care the cornerstone of global health efforts. It acquired formal legal and political weight through the 2012 United Nations General Assembly resolution urging nations to prioritize health-care access for all. It became a binding global development target with the adoption of Sustainable Development Goal 3.8 in 2015, which calls for universal access to essential health services without financial hardship.

India's predicament is that of a rising economic power with a lagging health system. Out-of-pocket payments account for a strikingly large share of total health expenditure, one of the highest proportions in the world, and the cost of care is a considerable driver of poverty. The question this article addresses is therefore not whether India should pursue UHC, but why UHC is an inescapable daily necessity for Indian households, how the legal and regulatory architecture can be rebuilt to attain it, and when, by what milestones, attainment can realistically be achieved. Part II defines the concept. Part III explains the necessity of UHC in ordinary, day-to-day life. Part IV examines the constitutional and statutory foundations of the right to health. Part V analyzes the instruments of attainment, with particular attention to financing, insurance, and regulation. Part VI addresses the chronology of reform.

II. Universal Health Coverage: Concept and Content

The World Health Organization's conception of UHC, ensuring that all individuals and

communities receive the necessary, high-quality health services without financial hardship, spans a wide spectrum of care: preventive measures, treatment of illness and injury, rehabilitation, and palliative care. Three structural features distinguish UHC from ordinary health insurance. First, it is universal: coverage extends to the entire population regardless of socioeconomic status, geographic location, or personal circumstances. Second, it is comprehensive: it reaches beyond hospitalization to the outpatient and primary-care services that people use every day. Third, it is protective: its cardinal objective is the elimination of financial barriers that force households into poverty or cause them to forgo treatment altogether.

The High-Level Expert Group, constituted by the Planning Commission in October 2010 under the chairmanship of Prof. K. Srinath Reddy, articulated India's institutional definition of UHC, which defined UHC as: Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste, or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative, and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services.

This lineage is not new to India. The Bhore Committee report of 1946 was among the first instruments to advocate free, equitable health care for all citizens and proposed primary health centers accessible to every village. The National Health Policy of 1983 embraced "Health for All," aligning India with the Alma-Ata Declaration; the National Rural Health Mission of 2005 expanded rural infrastructure and maternal and child health services. Ayushman Bharat, launched in 2018, is the most recent and most ambitious installment of this continuum.

III. Why UHC Is a Daily Necessity: The Indian Household Reality

The necessity of UHC is best understood not as an abstraction of global health diplomacy but as a fact of ordinary Indian life: the moment when a family member falls ill, and the household must choose between treatment and solvency.

The out-of-pocket burden. At the heart of India's health-financing crisis is the dominance of direct household payments. OOP payments account for almost 62.6% of total health expenditure, among the highest shares in the world, and recent analysis places the figure at 63%

of current health spending, significantly above the average for lower-middle-income countries. Cross-country evidence confirms that India's OOP share exceeds 50% of total health expenditure, far beyond the 15–20% threshold that global health guidance regards as the ceiling beyond which households are exposed to impoverishment.[1] Public health expenditure stood at merely 1.04% of GDP in 2013, with the private sector growing rapidly yet remaining "largely unregulated, expensive, often providing care of dubious quality"

The consequences of Catastrophic expenditure and impoverishment are measurable and severe. Over 7% of India's population is pushed into poverty every year by health-care costs. Nationally representative analysis shows that 3.5% of the population falls below the poverty line on account of health payments and that 5% of households suffer catastrophic health expenditure.[2] At the 10% threshold of household consumption, 24% of households incurred catastrophic health expenditure in 2024, up from 21% in 2014, and among households that actually accessed any health care, the incidence reached 58%. Although the incidence of catastrophic spending declined from 12.5% in 2014 to 9.1% by 2018, its *intensity* increased over the same period. In other words, the protection problem has not been solved; it has merely shifted in form.

The importance of outpatient care and medicines cannot be overstated. Any discussion about the everyday necessity of UHC must face a key empirical truth: the heaviest burden is often where policy focus is weakest. Medicines account for the largest share—72%—of total out-of-pocket (OOP) payments, rising to 82% for outpatient services and 42% for inpatient care. Outpatient care causes nearly four times as much impoverishment due to health expenses as inpatient care in India, yet the flagship Ayushman Bharat scheme does not cover it. This explains why some experts argue that insurance schemes that cover only hospital costs, such as those being implemented nationally in India, will fail to adequately shield people living in poverty from financial ruin caused by health spending.

Who bears this burden? The risk of financial catastrophe is not random. Healthcare costs tend to be disproportionately higher for poorer households, households with children under five,

[1] Gina Lagomarsino et al., Moving towards Universal Health Coverage: Health Insurance Reforms in Nine Developing Countries in Africa and Asia, 380 The Lancet 933, 940 (2012), https://doi.org/10.1016/s0140-6736(12)61147-7.

[2] Rishab Shahrawat & K. D. Rao, Insured yet Vulnerable: Out-of-Pocket Payments and India's Poor, 27 Health Policy and Planning 213 (2011)

households with elderly members, and those using private facilities. Poverty linked to health expenses has increased in rural areas and among India's most vulnerable groups—such as religious communities, Scheduled Castes, scheduled tribes among social groups, and casual laborers within household types. At the same time, India's growing burden of non-communicable diseases means that chronic, lifelong health expenditures are an inevitable part of daily life. When care is unaffordable, households often forgo treatment. Hence, UHC is fundamentally about distribution, timing, and practicality: it can mean the difference between receiving treatment and facing abandonment, between maintaining solvency and falling into destitution—precisely at the moment when care is most needed ares.

IV. The Legal Basis: Why the State Must Secure Health

If universal health coverage (UHC) is a daily necessity, the question arises whether it also constitutes a legal right. The Indian Constitution does not explicitly establish a fundamental right to health. However, the Supreme Court has broadly interpreted Article 21, which guarantees the right to life and personal liberty, to include the right to health and medical care. The Directive Principles support this interpretation: Article 47 tasks the State with improving public health, while Articles 39(e) and 42 emphasize the Government's responsibility for citizens' health, especially children and workers.

The case law is extensive. From Rakesh Chandra Narayan v. State of Bihar, through Consumer Education & Research Center v. Union of India, to Paschim Banga Khet Mazdoor Samity v. State of West Bengal, which mandated emergency medical services and ruled that neglecting timely treatment in public hospitals violates Article `21, the Supreme Court has read the Constitution to require access to healthcare. More recently, Sukdeb Saha v. State of Andhra Pradesh explicitly recognized mental health as a fundamental right under Article 21. The judiciary has also intervened in related areas, compelling authorities to provide medical care and rehabilitation in environmental health cases like the Endosulfan litigation. Despite this judicial framework, an ongoing debate exists about whether the right to health should be explicitly stated in a constitutional amendment or further expanded through interpretation, rather than remaining implicit in Article 21.

Critics argue that an implied right leads to inconsistent application, unequal access, and limited enforceability. Notably, the National Health Policy 2017, approved by the Union Cabinet on March 15, 2017, remains "unspecific about 'Health as a fundamental right.'" The policy

emphasizes "assured" healthcare, marking a shift from sick care to wellness and from discretionary services to guaranteed coverage. However, a policy promise is not a legally enforceable right. The consensus among scholars is that constitutional recognition is necessary but not enough: enforceable laws, adequate resources, and accountability are needed to turn written rights into actual realities. This federal aspect is further complicated by the constitutional assignment of health as a "State subject," making UHC a collaborative effort rather than a centralized mandate.

V. How to Attain UHC: Instruments, Institutions, and Regulation

Attainment is a question of instrument design. India's roadmap can be organized around five levers.

A. Financing: taxation-led expansion. The Center and states combined and must lift public spending on health from 1.2% of GDP to at least 2.5% by the end of the Twelfth Plan and to at least 3% of GDP by 2024, with general taxation as the principal source of financing, complemented by mandatory deductions from salaried individuals [3] The National Health Policy 2017 reiterates the ambition: raising government health expenditure from 1.15% to 2.5% of GDP by 2025 [4] Some estimates go further, arguing that funding UHC in India would require government health expenditure of up to 6% of GDP.

B. Risk pooling and insurance: the legal-institutional layer. Insurance is the risk-pooling instrument through which prepayment is organized. India has experimented with publicly funded schemes for two decades: the Rashtriya Swasthya Bima Yojana, launched in 2008, expanded inpatient benefits to more than 142 million people Ayushman Bharat — Pradhan Mantri Jan Arogya Yojana, approved by the Union Cabinet in March 2018, is the world's largest fully government-funded health insurance programme, providing a cover of ₹5,00,000 (over US$7,000) per family per year to about 100 million families and more than 500 million persons, roughly 40% of India's population [5] PM-JAY covers over 1,390 medical procedures across a network of over

[3] JS Thakur, Key Recommendations of High-Level Expert Group Report on Universal Health Coverage for India., 36 PubMed (2011),

[4] Anamika Pandey et al., Variations in Catastrophic Health Expenditure across the States of India: 2004 to 2014,

[5] Blake Angell et al., The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the Path to Universal Health Coverage in India: Overcoming the Challenges of Stewardship and Governance, 16 PLoS Medicine, 2

24,000 hospitals, is built on the 2011 Socio-Economic Caste Census for beneficiary identification, and extends to secondary and tertiary hospitalization in public and impanelled private hospitals and several States have expanded coverage beyond the poorest and some have even universalized it.

C. Yet the insurance architecture has structural gaps. AB-PMJAY excludes outpatient consultations, and this exclusion is consequential precisely because outpatient care drives impoverishment The "missing middle" households above the poverty line but without formal cover, remains exposed insurance rules to health business—requires continuous strengthening to secure solvency and consumer protection Whether insurance alone is a sustainable strategy for Indian UHC is itself contested: scholars caution that insurance-based financing, without complementary public provision and tax financing, cannot deliver equity.[6]

D. Primary health care: the neglected center of gravity. Health-care expenditure is devoted to primary care, which is defined in the National Health Package as the assured entitlements of every citizen, the free provision of essential medicines through expanded public procurement, and the abolition of user fees as a source of government revenue. The NHP 2017 similarly commits at least 70% of the health budget to primary health care. [7]The operational vehicle is the Health and Wellness Center, which packages preventive, promotive, and outpatient services, including non-communicable disease management, maternal and child health, and immunization, at the community level. Strengthening this layer simultaneously improves access and reduces dependence on hospitals, easing financial pressure on households and fiscal pressure on the State.

E. Stewardship and regulation. UHC is unattainable without a credible regulator like a System Support Unit for legal, financial, and regulatory norms; a National Health and Medical Facilities Accreditation Unit for mandatory accreditation of all health-care providers public and private; and a Health System Evaluation Unit for independent performance appraisal alongside a National Health Promotion and Protection Trust and

(2019),

[6] Archana Bakshi, Is Health Insurance a Sustainable Strategy for Achieving Universal Health Coverage in India? 153 (2023), http://dx.doi.org/10.4324/9781032640488-19..

[7] Devajana Chinnappa Nanjunda, Universal Health Coverage in India: Where Rubber Hits the Road?, 56 Annals of the National Academy of Medical Sciences (India) 208, 209 (2020)

participatory Health Councils at the village level Such stewardship is urgent because India's private sector is large, growing, and under-regulated. Digital tools like the National Digital Health Mission and electronic health records can extend service delivery to remote areas and enable continuous monitoring of population health

VI. When: The Chronology of Attainment

The question "when" admits of three horizons. The near term (by 2025) is fixed by the NHP 2017: government health expenditure at 2.5% of GDP, a 50% increase in public-facility utilisation, and a 25% reduction in household catastrophic-expenditure incidence India's international commitments fix the medium term (by 2030): SDG 3.8 and the architecture of Ayushman Bharat were explicitly designed as a first step towards delivering UHC by 2030 The long term requires consolidation beyond target dates: analysts urge raising public spending gradually to 5% of GDP and resolving the deficits of primary care if UHC is to be genuinely universal. [8]

The chronology is also a question of sequencing. The federal structure dictates that some States will progress faster than others; indeed, several have already universalized coverage under PM-JAY, but sequencing should not become postponement: poverty has fallen in India, yet the *share* of health-expenditure-induced poverty within overall poverty has risen substantially over the past two decades. Every year of delay deepens that share.

VII. Conclusion

Universal health coverage in India is neither a charity nor a luxury; it is the daily precondition for households' economic security and the constitutional promise of Article 21. The path from aspiration to attainment runs through three commitments: adequate public financing routed through general taxation; a regulated, risk-pooling insurance architecture that includes the outpatient and primary care that ordinary lives actually require; and legal recognition — constitutional and statutory — that transforms assured care from policy rhetoric into justiciable entitlement. The how is known, the when is calendared, and the why is written in the

[8] JAGADISH ROY, From Bhore Committee to National Health Policy of 2017: A Drive Towards Universal, Comprehensive and Basic Health Care in India, 3 International Journal of Social Science Research (IJSSR) 595 (2026)

impoverishment of millions of households every year. What remains is the political and legal will to complete the journey. Every delay deepens the situation.