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Bridging the Healthcare Divide: A Critical Study of Public and Private Healthcare Systems within India's Universal Health Coverage Framework

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ABSTRACT

Universal health coverage (UHC) aims to provide people with access to quality healthcare services without financial hardship. This paper analyses the structure of, and the challenges in attaining, UHC in India, with a focus on the Indian health system and the roles of public and private health providers. It discusses issues of accessibility, affordability, quality of care, choice, financial protection and equity. It examines the heavy out-of-pocket expenditure burden in India and analyses the problems of poor public health infrastructure, inadequate human resources and variations in quality of care that result in a preference for private providers. While private hospitals are better equipped, operate with shorter waiting times and are more responsive, public health care is needed for affordability and for the very poor. The paper discusses the need for regulation, quality assurance and accreditation of providers, accountability and consumer empowerment as prerequisites for the equitable delivery of health care. It concludes that the delivery of quality universal health care in India requires the strengthening of public health infrastructure, investment in the health sector, sustainable financing and regulation of private providers, and a shift of focus to quality and financial protection through a coordinated public-private approach based on principles of equity and social justice.

Keywords: *Universal Health Coverage, Healthcare Law, Public Healthcare, Private Healthcare, Out-of-Pocket Expenditure, Health Equity*

I. INTRODUCTION

According to the World Health Organization (WHO), universal health coverage (UHC) is achieved when 'all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship'.[1] Sustainable Development Goal (SDG) target 3.8 calls on states to 'achieve universal health

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[1] WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN, *Universal Health Coverage* (2023).

coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all'.[2] Although a growing number of studies link UHC with a range of health, economic and social outcomes, recent estimates indicate that about 930 million people in the world spend more than 10 per cent of their household income on health care and therefore lack full financial protection for essential health services; the problem is not confined to low-income countries.[3] The WHO's well-established universal coverage 'cube' identifies three dimensions of coverage: the population covered (who is covered), the services covered (which services are offered and received) and the proportion of costs covered (how much users must pay directly), together with the question of how the health system is administered.[4] A high-quality health system has been defined as one that optimises health care in a particular setting by consistently delivering care that improves or maintains health, by being valued and trusted by the community it serves, and by responding to the changing needs of the population.[5] The quality of care currently provided appears insufficient, especially in low- and middle-income countries (LMICs). Although the era of the Millennium Development Goals (MDGs) expanded access to essential health services, the quality of that care remains a problem in LMICs, which continue to record consistently high rates of infant, child and maternal death.[6] The objective of this paper is to make a comparative study of the private and public healthcare systems under the UHC framework in India.

II. CONCEPTUAL AND THEORETICAL FRAMEWORK

UHC entails recognising and respecting an extensive set of human rights: the rights to life, health, personal security and bodily integrity; to equality and non-discrimination; to an adequate standard of living, including access to water, food, housing and education; to freedom of movement, association, assembly, information, thought and expression; to social security, privacy and participation; and to certain minimum conditions of livelihood, such as water, food and a roof over one's head. All of these rights are protected in international and regional treaties

[2] UNITED NATIONS STATISTICS DIVISION, *SDG Indicators: Metadata Repository, Goal 3, Target 3.8* (2023), https://unstats.un.org/sdgs/metadata/?Text=&Goal=3&Target=3.8.

[3] WORLD HEALTH ORGANIZATION, *Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report, Executive Summary* (2019), https://www.who.int/docs/default-source/documents/2019-uhc-report-executive-summary.

[4] WORLD HEALTH ORGANIZATION, *The World Health Report 2010: Health Systems Financing, the Path to Universal Coverage* (2010), https://apps.who.int/iris/handle/10665/44371.

[5] Margaret E. Kruk et al., *High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution*, 6 LANCET GLOB. HEALTH e1196 (2018), https://doi.org/10.1016/S2214-109X(18)30386-3.

[6] WORLD HEALTH ORGANIZATION, ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT & WORLD BANK, *Delivering Quality Health Services: A Global Imperative for Universal Health Coverage* (2018), https://doi.org/10.1787/9789264300309-en, also available at https://www.worldbank.org/en/topic/universalhealthcoverage/publication/delivering-quality-health-services-a-global-imperative-for-universal-health-coverage.

and in national constitutions and, taken together, many of them are recognised as customary international law. Above all, they can be traced back to the Universal Declaration of Human Rights.[7] The Universal Declaration was adopted in the aftermath of the discrimination and polarisation of the Second World War, not long after the founding of the United Nations, for which the promotion of human rights was one of the core purposes.[8] The aspiration to realise the highest attainable standard of health as a human right is found in the preamble to the Constitution of the World Health Organization (1946).[9] In addition, particular laws and a growing body of case law show how human rights standards and principles can be used to shape national health systems and to set bounds for what governments, as stewards of their health systems, ought and ought not to do.[10]

The resolutions adopted by the World Health Assembly over the years in support of UHC have championed the notion that human rights, and especially the right to health, offer 'the broad parameters of UHC'.[11] Similarly, the UN Special Rapporteur on the right to health has argued that UHC should be understood through the lens of the right to health.[12] The overarching goal of UHC is to 'ensure that all people have access to the health services they need without suffering financial hardship when paying for them'.[13] An examination of the elements of the right-to-health framework and of UHC reveals links between them. Although the right to health is part of the rights-based framework, the constitutions of many countries do not contain these elements. After analysing the constitutions of 191 countries, Kinney and Clark (2004) found that 67.5 per cent contained provisions on health or health care.[14] Backman and others (2008),

[7] G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).
[8] U.N. Charter pmbl., art. 1, ¶ 3.
[9] Constitution of the World Health Organization pmbl., July 22, 1946, 14 U.N.T.S. 185, https://www.who.int/about/governance/constitution.
[10] Ana S. Ayala, *Global Health and Human Rights Law Database: A Case Law Database Project of the O'Neill Institute for National and Global Health Law*, 108 PROC. ASIL ANN. MEETING 22 (2014), https://doi.org/10.5305/procannmeetasil.108.0022. In India, the Supreme Court has read the right to health, including a right to emergency medical treatment, into the right to life under Article 21: *Parmanand Katara v. Union of India*, (1989) 4 SCC 286; *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, (1996) 4 SCC 37.
[11] Claire Lougarre, *Using the Right to Health to Promote Universal Health Coverage: A Better Tool for Protecting Non-Nationals' Access to Affordable Health Care?*, 18 HEALTH & HUM. RTS. J. 35 (2016), https://www.hhrjournal.org/2016/12/05/using-the-right-to-health-to-promote-universal-health-coverage-a-better-tool-for-protecting-non-nationals-access-to-affordable-health-care/.
[12] Dainius Pūras, U.N. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Foreword: Universal Health Coverage: A Return to Alma-Ata and Ottawa*, 18 HEALTH & HUM. RTS. J. 7 (2016), https://www.hhrjournal.org/2016/12/05/foreword-universal-health-coverage-a-return-to-alma-ata-and-ottawa/.
[13] WORLD HEALTH ORGANIZATION, *Universal Health Coverage (UHC)*, Fact Sheet No. 395 (2014), http://www.who.int/mediacentre/factsheets/fs395/en/.
[14] Eleanor D. Kinney & Brian A. Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L.J. 285 (2004), https://pdfs.semanticscholar.org/5a89/866568bec0061a393bafbb41a7c30219b8df.pdf.

in a critical review of the health systems of 194 countries against right-to-health indicators, reported that 121 countries had no constitutional provision on the right to health and that many had no comprehensive plan to regulate the private health sector.[15] The legal obligations flowing from the right to health apply not only to the public but also to the private health sector. Human rights treaties impose three types of obligation on governments: to respect, to protect and to fulfil. The obligation to respect requires governments to refrain from interfering, directly or indirectly, with the enjoyment of the right to health; the obligation to protect requires them to take measures to prevent interference with the right to health by third parties; and the obligation to fulfil requires them to take positive measures, including the adoption of suitable policies, towards the full realisation of the right to health.[16]

III. UNDERSTANDING UNIVERSAL HEALTH COVERAGE IN INDIA

Universal health coverage rests on three terms, each with its own definition. 'Universal' means 'covering all ... without limit or exception';[17] 'health' is defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity';[18] and 'coverage' denotes 'something that covers', here both health services and financial protection.[19] Taken together, the three terms point back to the declaration of 'health for all' and the 1978 commitment to primary health care (PHC); their shared aspiration is a healthier world.[20] Following the Millennium Development Goals, the UHC agenda seeks to improve access to quality health services while safeguarding households and individuals from the economic costs of seeking care.[21] Globally, advances have been made towards UHC, but half the world's population still lacks access to essential health services.[22] It is further estimated that about 2 billion people worldwide face financial hardship because of health spending, of whom about 1

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[15] Gunilla Backman et al., *Health Systems and the Right to Health: An Assessment of 194 Countries*, 372 LANCET 2047 (2008), https://doi.org/10.1016/S0140-6736(08)61781-X.

[16] U.N. Comm. on Econ., Soc. & Cultural Rts., General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the International Covenant on Economic, Social and Cultural Rights), ¶¶ 33–37, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), https://www.refworld.org/docid/4538838d0.html.

[17] *Universal*, MERRIAM-WEBSTER DICTIONARY, https://www.merriam-webster.com/dictionary/universal (last visited Sept. 6, 2026).

[18] Constitution of the World Health Organization, *supra* note 9, pmbl.

[19] *Coverage*, MERRIAM-WEBSTER DICTIONARY, https://www.merriam-webster.com/dictionary/coverage (last visited Sept. 6, 2026).

[20] WORLD HEALTH ORGANIZATION, REGIONAL COMMITTEE FOR SOUTH-EAST ASIA, *Strategies for Health for All by the Year 2000*, Doc. SEA/RC32/15 (1979); see also Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR (Sept. 6–12, 1978).

[21] Gajanan S. Gaude, *WHO Millennium Development Goals and Achievements So Far*, 7 INDIAN J. HEALTH SCI. & BIOMEDICAL RSCH. KLEU 65 (2014), https://doi.org/10.4103/2349-5006.148790.

[22] WORLD HEALTH ORGANIZATION & WORLD BANK, *World Bank and WHO: Half the World Lacks Access to Essential Health Services, 100 Million Still Pushed into Extreme Poverty Because of Health Expenses* (Dec. 13, 2017), https://www.who.int/news/item/13-12-2017-world-bank-and-who-half-the-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses.

billion experience catastrophic out-of-pocket expenditure and 344 million are pushed deeper into extreme poverty.[23] Fewer than a third of countries (42 of 138) managed both to expand service coverage and to reduce catastrophic out-of-pocket health expenditure after 2015, which suggests that, at the current pace, global progress towards the 2030 target is behind schedule.[24] The reasons include a lack of political will, discordance between private and public welfare, insufficient health policies and weak health systems in middle- and low-income countries.[25] It is not, however, entirely clear what UHC means: there is no shared understanding of its definition and breadth, and it has been poorly interpreted in some countries.[26] In Kenya, for instance, stakeholders disagreed widely on how the concept of UHC should be defined.[27] Such misunderstanding of what constitutes UHC can create confusion in service delivery, in monitoring progress, in celebrating success and in sustaining momentum towards UHC.[28] Horton and Das contend that 'the great gap that now exists for countries trying to deliver UHC is access to a library of knowledge to assist their decision-making'.[29] To address this gap, a growing body of research has appeared, evaluating and mapping the literature on UHC,[30] identifying best practices for realising UHC[31] and measuring the attainment of UHC for older people.[32]

In some contexts (for example, the Asia-Pacific region), UHC is defined as a process of providing quality, equitable and comprehensive care and services, including promotive, preventive, curative, rehabilitative and palliative care, at a cost that people can afford or free of

[23] WORLD HEALTH ORGANIZATION, *Universal Health Coverage (UHC)* (Oct. 5, 2023), https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).
[24] WORLD HEALTH ORGANIZATION & WORLD BANK, *Tracking Universal Health Coverage: 2023 Global Monitoring Report* (2023), https://www.who.int/publications/i/item/9789240080379.
[25] Anuska Kalita et al., *The Barriers to Universal Health Coverage in India and the Strategies to Address Them: A Key Informant Study*, 89 ANNALS GLOB. HEALTH 69 (2023), https://doi.org/10.5334/aogh.4120.
[26] Richard Horton, *Offline: UHC, One Promise and Two Misunderstandings*, 391 LANCET 1342 (2018), https://doi.org/10.1016/S0140-6736(18)30847-X.
[27] Tessa Oraro-Lawrence & Kaspar Wyss, *Policy Levers and Priority-Setting in Universal Health Coverage: A Qualitative Analysis of Healthcare Financing Agenda Setting in Kenya*, 20 BMC HEALTH SERVS. RSCH. 182 (2020), https://doi.org/10.1186/s12913-020-5041-x.
[28] Abraham Assan et al., *Challenges to Achieving Universal Health Coverage Through Community-Based Health Planning and Services Delivery Approach: A Qualitative Study in Ghana*, 9 BMJ OPEN e024845 (2019), https://doi.org/10.1136/bmjopen-2018-024845.
[29] Richard Horton & Pamela Das, *Universal Health Coverage: Not Why, What, or When, But How?*, 385 LANCET 1156 (2015), https://doi.org/10.1016/S0140-6736(14)61742-6.
[30] Aklilu Endalamaw et al., *Universality of Universal Health Coverage: A Scoping Review*, 17 PLOS ONE e0269507 (2022), https://doi.org/10.1371/journal.pone.0269507.
[31] Jalil Koohpayezadeh et al., *Best Practices in Achieving Universal Health Coverage: A Scoping Review*, 35 MED. J. ISLAMIC REPUB. IRAN 191 (2021), https://doi.org/10.47176/mjiri.35.191.
[32] Seyede Sedighe Hosseini Jebeli et al., *Measuring Universal Health Coverage to Ensure Continuing Care for Older People: A Scoping Review with Specific Implications for the Iranian Context*, 27 E. MEDITERR. HEALTH J. 806 (2021), https://doi.org/10.26719/emhj.21.040.

charge.[33] The meaning of 'affordability' of care differs across settings: it may mean free care through the avoidance of direct payments; prepaid services through a government-funded health scheme; larger risk pools that enable robust cross-subsidy between the healthy and the sick and between the rich and the poor; or financial coverage of the informal sector and of households living on or below the poverty line.[34] UHC has been conceived in several ways: as a legal and humanitarian concept; as a social concept (entitlement and enrolment comparable to the social security system); as a health-economic concept (financial protection); and as a public-health concept (comprehensive versus essential services).[35] The monitoring indicator for the service dimension is known as effective coverage: 'effective coverage is one measure that combines intervention need, utilization, and quality'.[36] Nevertheless, UHC goes beyond the effective service coverage index. It offers 'a comprehensive set of services with a high level of coverage with a view to improving equity of access'.[37] Effective service coverage under UHC refers to the core package of services, or health benefits package (HBP), which is given higher priority for assessment and subsequently included in the scheme.[38]

Globally, the UHC effective service coverage index is calculated with tracer indicators across four categories: reproductive, maternal, newborn and child health; infectious diseases; non-communicable diseases (NCDs); and service capacity and access.[39] Because countries differ, country-specific indicators for tracking UHC have also been formulated. In India, for instance, the tracer indicators have been expanded to include indicators for governance, stewardship and financing, and for palliative care.[40] Likewise, the health workforce, the status of the health

[33] Allison Beattie, Robert Yates & Douglas J. Noble, *Accelerating Progress Towards Universal Health Coverage in Asia and Pacific: Improving the Future for Women and Children*, 1 BMJ GLOB. HEALTH (Supp. 2) i12 (2016), https://doi.org/10.1136/bmjgh-2016-000190.

[34] Jarawee Sukmanee et al., *The Impact of Universal Health Coverage and COVID-19 Pandemic on Out-of-Pocket Expenses in Thailand: An Analysis of Household Survey from 1994 to 2021*, 23 EXPERT REV. PHARMACOECON. & OUTCOMES RSCH. 823 (2023), https://doi.org/10.1080/14737167.2023.2219447.

[35] Gilbert Abotisem Abiiro & Manuela De Allegri, *Universal Health Coverage from Multiple Perspectives: A Synthesis of Conceptual Literature and Global Debates*, 15 BMC INT'L HEALTH & HUM. RTS. 17 (2015), https://doi.org/10.1186/s12914-015-0056-9.

[36] Marie Ng et al., *Effective Coverage: A Metric for Monitoring Universal Health Coverage*, 11 PLOS MED. e1001730 (2014), https://doi.org/10.1371/journal.pmed.1001730.

[37] Audrey R. Chapman, *Monitoring Universal Health Coverage Within the Sustainable Development Goals: Assessing the Indicators Proposed by Daniel Hogan, Gretchen Stevens, Ahmad Reza Hosseinpoor, and Ties Boerma*, 2 J. HOSP. MGMT. & HEALTH POL'Y 32 (2018), https://doi.org/10.21037/jhmhp.2018.06.01.

[38] Amanda Glassman et al., *Defining a Health Benefits Package: What Are the Necessary Processes?*, 2 HEALTH SYS. & REFORM 39 (2016), https://doi.org/10.1080/23288604.2016.1124171.

[39] Daniel R. Hogan et al., *Monitoring Universal Health Coverage Within the Sustainable Development Goals: Development and Baseline Data for an Index of Essential Health Services*, 6 LANCET GLOB. HEALTH e152 (2018), https://doi.org/10.1016/S2214-109X(17)30472-2.

[40] Devaki Nambiar et al., *Monitoring Universal Health Coverage Reforms in Primary Health Care Facilities: Creating a Framework, Selecting and Field-Testing Indicators in Kerala, India*, 15 PLOS ONE e0236169 (2020), https://doi.org/10.1371/journal.pone.0236169.

information system, mental health and injuries, health financing, efficiency and the utilisation of health services are used as UHC monitoring indicators on the supply side.[41]

IV. Structure of public health care systems under universal health coverage in India

The surest way to attain the SDGs would be to provide everyone with access to at least a minimum level of good health services.[42] Both the public and the private sector are growing in the healthcare market. The demands on each sector depend largely on the efficient use of resources, on the unpredictability of how the healthcare market will respond to these institutions, and on new management concepts.[43] Hollingsworth carried out a meta-analysis of 317 published articles on efficiency measurement[44] and observed that 'public provision could potentially be more efficient than private'.[45] According to Lee and others, non-profit hospitals in the United States are more efficient than for-profit hospitals.[46] It is generally accepted that the boards of for-profit hospitals have a business-oriented culture; they must, because they answer to investors, and an emphasis on quality of care over profit is not always evident.[47] Private health insurance markets are also developing as a means of managing healthcare systems, using their capacity and serving as an alternative source of funding. This is not a simple matter, since private insurance involves a more complex financing mechanism which affects, and interacts with, public systems.[48] Non-profit healthcare organisations, on the other hand, are generally more service-oriented and negotiate more aggressively with cost drivers such as managed-care contracts.[49]

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[41] Jacqueline Reddock, *Seven Parameters for Evaluating Universal Health Coverage: Including Supply- and Demand Perspectives*, 10 Int'l J. Healthcare Mgmt. 207 (2017), https://doi.org/10.1080/20479700.2017.1287981.

[42] United Nations, *Goal 3: Ensure Healthy Lives and Promote Well-Being for All at All Ages*, U.N. Sustainable Development (2018), https://www.un.org/sustainabledevelopment/health/.

[43] Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941 (1963).

[44] Bruce Hollingsworth, *The Measurement of Efficiency and Productivity of Health Care Delivery*, 17 Health Econ. 1107 (2008), https://doi.org/10.1002/hec.1391.

[45] Bruce Hollingsworth, P.J. Dawson & N. Maniadakis, *Efficiency Measurement of Health Care: A Review of Non-Parametric Methods and Applications*, 2 Health Care Mgmt. Sci. 161 (1999), https://doi.org/10.1023/A:1019087828488.

[46] Keon-Hyung Lee, Seung-Bum Yang & Mankyu Choi, *The Association Between Hospital Ownership and Technical Efficiency in a Managed Care Environment*, 33 J. Med. Sys. 307 (2009), https://doi.org/10.1007/s10916-008-9192-2.

[47] Institute of Medicine, Committee on Implications of For-Profit Enterprise in Health Care, For-Profit Enterprise in Health Care (Bradford H. Gray ed., 1986).

[48] Francesca Colombo & Nicole Tapay, *Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems* (OECD Health Working Paper No. 15, 2004), https://doi.org/10.1787/527211067757.

[49] Institute of Medicine, Committee on Implications of For-Profit Enterprise in Health Care, *Profits and Health Care: An Introduction to the Issues*, in For-Profit Enterprise in Health Care (Bradford H. Gray ed., 1986).

The Indian system is fraught with varying degrees of inefficiency. The country has poorly trained human resources, especially in rural and inaccessible areas. The Indian state is paying the penalty for decisions taken in the early 1990s to cut public support to medical colleges heavily and to open up medical and nursing education to the private sector.[50] Fewer doctors wish to work in the public sector even after private training, and even students from the top medical colleges tend to move into the highly rewarding private sector because of the better facilities and pay on offer.[51] The considerable political will shown in placing more than 700,000 Accredited Social Health Activists (ASHAs), introduced in 2005, in rural areas has, at least to some extent, made its mark. Yet the programme is underfunded, and these health workers receive very poor compensation for a demanding and back-breaking workload.[52]

In addition, the proposal to create an 'enlarged' basic training (a three-year course for health staff) in order to recruit personnel for high-priority health problems has the ambition of combining wide adoption of primary-level care for common primary problems with an appropriate skill mix. This has not materialised, except to a very limited extent in a couple of states, owing to opposition from the medical fraternity.[53] Education and training must be wide-ranging for primary-care general practitioners, nurses and paramedics, and must be matched to the needs of the setting rather than to the specialist skills needed in secondary care, which have little direct relevance outside tertiary hospitals. The curriculum must be designed to match these needs, and this may include bridging courses, special packages or the registration of new categories of health worker.[54]

Secondly, there is overuse of some services and underuse of others; some facilities are crowded and others under-utilised. Facilities, equipment and funds are mismatched to demand and are not used efficiently: high-traffic facilities exhaust their money in a matter of weeks, whereas low-traffic facilities cannot spend the money allocated to them. As a result, large sums lie idle while standards of quality at high-volume sites are very poor.[55] It is estimated that about 40 per

[50] Amit Sengupta, *Health Care and Medical Education in India: Situationalising Corruption, the MCI Story*, INDIA CURRENT AFFAIRS (Aug. 13, 2011).
[51] G. Ananthakrishnan, *75% Prefer the Private Sector*, INFOCHANGE INDIA (June 2005).
[52] JAN SWASTHYA ABHIYAN, *Action Alert on National Rural Health Mission* (2005).
[53] Abhishek Sharma, Elissa Ladd & M.K. Unnikrishnan, *Healthcare Inequity and Physician Scarcity: Empowering Non-Physician Healthcare*, 48 ECON. & POL. WKLY. 112 (Mar. 30, 2013), https://www.epw.in/journal/2013/13/special-articles/healthcare-inequity-and-physician-scarcity.html.
[54] T. Sundararaman & Garima Gupta, *Human Resources for Health: The Crisis, the NRHM Response and the Policy Options* (Policy Brief, Institute of Applied Manpower Research, Planning Commission, New Delhi, 2011), https://nhsrcindia.org/sites/default/files/2021-06/HRH%20Crisis%20NRHM%20Response%20and%20Policy%20Options.pdf.
[55] NATIONAL RURAL HEALTH MISSION, MINISTRY OF HEALTH & FAMILY WELFARE, *Third Common Review Mission Report* 5, 47 (2009), https://nhsrcindia.org/sites/default/files/2021-03/3rd%20CRM%20Main%20Report%202009.pdf.

cent of Indians are still served by the government sector for in-patient care, while many communities have no facilities, or have facilities that are overcrowded for want of doctors and other health workers, and stocks of medicines and other consumables are inadequate.[56]

Because of shortages of health workers in rural communities, the cost of transporting patients to the nearest health facility can be enormous for some, and assured patient-transport schemes have reduced this only to some extent. The National Rural Health Mission (NRHM), launched in 2005, is an initiative to improve the quality of health delivery in the remoter areas where it is most needed. Quality has begun to improve, but in some cases progress has been inconsistent.[57]

V. Role of private hospitals within the universal health care framework in India

The share of total health expenditure (THE) accounted for by out-of-pocket expenditure (OOPE) in India remained significant in 2019-20, at 47.1 per cent; this is the expenditure incurred by patients through direct payments for health care.[58] Although about 72 per cent of the population lives in rural areas, roughly three-quarters of the country's health infrastructure, medical manpower and other health resources are concentrated in urban centres.[59] OOPE is especially significant in healthcare financing in developing and middle-income countries, where on average it represents no less than two-thirds of total health expenditure.[60] In order to assess OOPE properly, it has to be distinguished from third-party payments, that is, payments by government-funded health programmes or by public or private insurers.[61] OOPE becomes catastrophic when it exceeds 10 per cent of household consumption expenditure.[62]

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[56] National Sample Survey Office, Ministry of Statistics & Programme Implementation, *Key Indicators of Social Consumption in India: Health*, NSS 71st Round (January–June 2014), Report No. NSS KI (71/25.0) (2015).

[57] Amit Sengupta, *Creating, Reclaiming, Defending: Non-Commercialized Alternatives in the Health Sector in Asia*, in Alternatives to Privatization: Public Options for Essential Services in the Global South 202 (David A. McDonald & Greg Ruiters eds., Routledge 2012).

[58] Press Information Bureau, Government of India, *National Health Accounts Estimates for India (2019–20) Released* (Apr. 25, 2023), https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1919582.

[59] Ashok Vikhe Patil, K.V. Somasundaram & R.C. Goyal, *Current Health Scenario in Rural India*, 10 Austl. J. Rural Health 129 (2002); see also Suyash Mishra & Sanjay K. Mohanty, *Out-of-Pocket Expenditure and Distress Financing on Institutional Delivery in India*, 18 Int'l J. Equity Health 99 (2019), https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1001-7.

[60] Augustine Asante et al., *Equity in Health Care Financing in Low- and Middle-Income Countries: A Systematic Review of Evidence from Studies Using Benefit and Financing Incidence Analyses*, 11 PLoS One e0152866 (2016), https://doi.org/10.1371/journal.pone.0152866.

[61] Suraj P. Singh & Anita Khokhar, *Out-of-Pocket Expenditure on Healthcare Amongst Households of an Urban Village in Delhi*, 10 Int'l J. Cmty. Med. & Pub. Health 3688 (2023), https://doi.org/10.18203/2394-6040.ijcmph20233101.

[62] Getahun Asmamaw Mekuria et al., *Perspectives of Key Decision Makers on Out-of-Pocket Payments for Medicines in the Ethiopian Healthcare System: A Qualitative Interview Study*, 13 BMJ Open e072748 (2023), https://doi.org/10.1136/bmjopen-2023-072748.

About 3 per cent of the Indian population (around 38 million people) is estimated to be pushed into poverty every year by out-of-pocket spending on medicines alone.[63] A large share of Indian households continues to incur OOPE despite social security schemes such as the Pradhan Mantri Bhartiya Janaushadhi Pariyojana (PMBJP), which seeks to ensure the availability of affordable, quality medicines, and health insurance schemes such as Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), the Central Government Health Scheme (CGHS), the Employees' State Insurance Scheme (ESIS), the Mahatma Jyotirao Phule Jan Arogya Yojana (MJPJAY) and the Vajpayee Arogyashree Scheme (VAS).[64] A weak public health system with a high burden of medical expenditure and low insurance penetration, combined with a perception that the private sector offers better quality, drives spending towards the costlier private sector and magnifies the OOPE burden.[65] The impact of OOPE is most visible in countries with poor public systems and heavy dependence on private providers. In these conditions, household payments are compounded by two factors: the direct costs of sickness and the income forgone through absence from work.[66]

Social health insurance and tax-based funding not only reduce OOPE considerably in high-income economies but also ensure access to care for those without means.[67] Out-of-pocket expenditure on health has been extensively researched in India and other South Asian countries. In most cases, this has been done quantitatively, using household survey data and econometric tools to estimate the financial burden on individuals or households.[68] OOPE is the main contributor to impoverishment and catastrophic health expenditure in the region.[69] Research from sub-Saharan Africa shows that the burden of OOPE often increases where public health

[63] Sakthivel Selvaraj, Habib Hasan Farooqui & Anup Karan, *Quantifying the Financial Burden of Households' Out-of-Pocket Payments on Medicines in India: A Repeated Cross-Sectional Analysis of National Sample Survey Data, 1994–2014*, 8 BMJ OPEN e018020 (2018), https://bmjopen.bmj.com/content/8/5/e018020.

[64] Deepu Palal et al., *People's Perspective on Out-of-Pocket Expenditure for Healthcare: A Qualitative Study from Pune, India*, 15 CUREUS e34670 (2023), https://doi.org/10.7759/cureus.34670.

[65] KPMG, *Healthcare in India: Current State and Key Imperatives, Review of National Health Policy 2015* (2016), https://assets.kpmg.com/content/dam/kpmg/in/pdf/2016/09/AHPI-Healthcare-India.pdf.

[66] Adam Leive & Ke Xu, *Coping with Out-of-Pocket Health Payments: Empirical Evidence from 15 African Countries*, 86 BULL. WORLD HEALTH ORG. 849 (2008), https://doi.org/10.2471/BLT.07.049403.

[67] Ama P. Fenny, Robert Yates & Rachel Thompson, *Strategies for Financing Social Health Insurance Schemes for Providing Universal Health Care: A Comparative Analysis of Five Countries*, 14 GLOB. HEALTH ACTION 1868054 (2021), https://doi.org/10.1080/16549716.2020.1868054.

[68] Sanjay K. Mohanty & Anshul Kastor, *Out-of-Pocket Expenditure and Catastrophic Health Spending on Maternal Care in Public and Private Health Centres in India: A Comparative Study of Pre and Post National Health Mission Period*, 7 HEALTH ECON. REV. 31 (2017), https://doi.org/10.1186/s13561-017-0167-1.

[69] Charu C. Garg & Anup K. Karan, *Reducing Out-of-Pocket Expenditures to Reduce Poverty: A Disaggregated Analysis at Rural-Urban and State Level in India*, 24 HEALTH POL'Y & PLAN. 116 (2009), https://doi.org/10.1093/heapol/czn046.

facilities are unavailable or of poor quality, because patients then opt for the more expensive private sector.[70]

Although demand for private hospitals has been rising for the reasons above, it is likely to have been driven above all by the demand for faster, more responsive service and higher-quality care, since private hospitals generally have better facilities and faster service, but charge more.[71] Cost is a significant determinant of healthcare choices, leading most people, especially those in lower income groups, towards public facilities because of their affordability and the free treatment provided there. This is consistent with the observation that the cost of care prompts people to use government hospitals despite concerns about quality.[72] Others are more willing to pay extra out of their own pockets for private hospitals than to incur the indirect costs of public hospitals, on the basis of perceived better quality of care and shorter waiting times. This tension between credibility and cost mirrors the wider trend in public versus private care and underlines the need for government intervention to improve both the cost and the quality of public health care.[73]

VI. QUALITY OF CARE: STANDARDS, INDICATORS AND MEASUREMENT IN INDIA

Quality of care is not measured in a standardised, replicable and comparable manner in low- and middle-income countries.[74] Poor quality is often attributed to a lack of resources.[75] Substantial variation in processes of care has, however, been reported both between and within countries.[76] The data that are available relate mainly to elements of the health system such as infrastructure, the availability of human resources, supplies and equipment, services and coverage, and outcomes.[77] The views of users and patients are now also increasingly

[70] Godfrey Sama Philipo, *Out-of-Pocket and Catastrophic Health Expenditures of Families Seeking Pediatric Surgical Care in a Tertiary Hospital in Tanzania* (Master of Global Surgical Care project, University of British Columbia, 2023), https://open.library.ubc.ca/media/stream/pdf/42591/1.0431428/5.

[71] Abhijit Banerjee & Esther Duflo, *Improving Health Care Delivery in India*, paper presented at the Angus Deaton Festschrift, Princeton University (Sept. 14, 2009).

[72] Kruk et al., *supra* note 5.

[73] Ke Xu et al., *Protecting Households from Catastrophic Health Spending*, 26 HEALTH AFFS. 972 (2007), https://doi.org/10.1377/hlthaff.26.4.972.

[74] Peter A. Berman & Thomas J. Bossert, *A Decade of Health Sector Reform in Developing Countries: What Have We Learned?* 21 (Data for Decision Making Project, International Health Systems Group, Harvard School of Public Health, 2000).

[75] Robert Beaglehole et al., *Improving the Prevention and Management of Chronic Disease in Low-Income and Middle-Income Countries: A Priority for Primary Health Care*, 372 LANCET 940 (2008), https://doi.org/10.1016/S0140-6736(08)61404-X.

[76] John W. Peabody et al., *Improving the Quality of Care in Developing Countries*, in DISEASE CONTROL PRIORITIES IN DEVELOPING COUNTRIES 1293 (Dean T. Jamison et al. eds., 2d ed., Oxford University Press 2006).

[77] WORLD HEALTH ORGANIZATION, *Service Availability and Readiness Assessment (SARA): An Annual Monitoring System for Service Delivery*, Doc. WHO/HIS/HSI/2014.5 Rev. 1 (2015).

accessible.[78] Among Donabedian's three categories (structure, process and outcome),[79] however, a gap remains in measuring the performance of processes of care. Process is as much a part of good health care as the end result.[80] In most situations the link between processes and outcomes is not well defined,[81] and outcome information is of little help in identifying which processes should be improved.

In high-income countries, quality measures are both common and useful.[82] The data are used for monitoring healthcare quality, assessing quality improvement initiatives, implementing pay-for-performance and public reporting.[83] Unfortunately, these measures often depend on complex health information systems and electronic health records (EHRs), which remain a far cry from reality in many low- and middle-income countries.[84] Medical records have historically been used for quality audits and improvement projects.[85] Audits of medical records, routinely performed in conjunction with feedback to providers, can enhance adherence to clinical guidelines.[86]

The application of explicit techniques leads to the development of 'quality indicators' with performance standards for assessing clinical practice.[87] Such indicators are chosen, following the development of clinical guidelines and the deliberations of expert panels, to capture the most clinically relevant measures.[88] Patients are aggregated into diagnosis groups and assessed to determine whether complications, comorbidities or other patient characteristics predict the

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[78] Emily Dansereau et al., *Patient Satisfaction and Perceived Quality of Care: Evidence from a Cross-Sectional National Exit Survey of HIV and Non-HIV Service Users in Zambia*, 5 BMJ OPEN e009700 (2015), https://doi.org/10.1136/bmjopen-2015-009700.

[79] Avedis Donabedian, *The Quality of Care: How Can It Be Assessed?*, 260 JAMA 1743 (1988), https://doi.org/10.1001/jama.1988.03410120089033.

[80] Donald M. Berwick & Marilyn G. Knapp, *Theory and Practice for Measuring Health Care Quality*, HEALTH CARE FIN. REV. (Annual Supp.) 49 (1987).

[81] Katherine L. Kahn et al., *Measuring Quality of Care with Explicit Process Criteria Before and After Implementation of the DRG-Based Prospective Payment System*, 264 JAMA 1969 (1990), https://doi.org/10.1001/jama.1990.03450150069033.

[82] John A. Spertus et al., *American College of Cardiology and American Heart Association Methodology for the Selection and Creation of Performance Measures for Quantifying the Quality of Cardiovascular Care*, 45 J. AM. COLL. CARDIOL. 1147 (2005), https://doi.org/10.1016/j.jacc.2005.03.011.

[83] Kitty S. Chan, Jinnet B. Fowles & Jonathan P. Weiner, *Electronic Health Records and the Reliability and Validity of Quality Measures: A Review of the Literature*, 67 MED. CARE RSCH. & REV. 503 (2010), https://doi.org/10.1177/1077558709359007.

[84] Eve A. Kerr & Barbara Fleming, *Making Performance Indicators Work: Experiences of US Veterans Health Administration*, 335 BMJ 971 (2007), https://doi.org/10.1136/bmj.39358.498889.94.

[85] Eric Holmboe et al., *Effect of Medical Record Audit and Feedback on Residents' Compliance with Preventive Health Care Guidelines*, 73 ACAD. MED. 901 (1998), https://doi.org/10.1097/00001888-199808000-00016.

[86] Eric J. Thomas et al., *The Reliability of Medical Record Review for Estimating Adverse Event Rates*, 136 ANN. INTERN. MED. 812 (2002).

[87] Peter U. Heuschmann et al., *Development and Implementation of Evidence-Based Indicators for Measuring Quality of Acute Stroke Care: The Quality Indicator Board of the German Stroke Registers Study Group (ADSR)*, 37 STROKE 2573 (2006), https://doi.org/10.1161/01.STR.0000241086.92084.c0.

[88] Stephen F. Jencks et al., *Quality of Medical Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels*, 284 JAMA 1670 (2000), https://doi.org/10.1001/jama.284.13.1670.

utilisation of hospital resources.[89] While the use of algorithms and conditional logic complicates data collection, computer-assisted data-abstraction software makes it possible to implement skip patterns, conduct data-quality checks and perform calculations during the abstraction process.[90]

Additional documentation would, moreover, improve the precision of the data abstracted. Where patient outcomes are recorded in the notes, such an effort has a direct effect on quality; it may also encourage practitioners to adhere to clinical protocols, which has been shown to produce better results.[91] As countries move closer to universal health coverage, the global health agenda should focus on improving the quality of care. Measuring quality indicators in national health surveys, along the lines of the Multiple Indicator Cluster Surveys (MICS),[92] could be an initial step.

VII. Affordability and financial protection mechanisms in India

A primary goal of health systems is to reduce the financial hardship associated with the use of health services. In recognition of the close links between health and social circumstances, this function of financial protection (FP) seeks to sustain living standards in the face of illness.[93] Both the WHO's social determinants of health framework and the UHC framework identify FP as one of the tools that can improve health equity, by ensuring access to health services according to need rather than ability to pay.[94] Consequently, as a key indicator of health system performance, FP has interrelated health, economic and ethical implications that must be explored.[95]

There are many forms of financial protection for health, such as benefits and transfers designed to reduce or remove patients' out-of-pocket (OOP) spending on health, and the prepayment and pooling of health-related financial risk.[96] In the context of UHC, the principal concern is out-

[89] 3M Health Information Systems, *All Patient Refined Diagnosis Related Groups (APR-DRGs): Methodology Overview* (GRP-041, Version 20.0, 2003).
[90] Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 New Eng. J. Med. 2635 (2003), https://doi.org/10.1056/NEJMsa022615.
[91] Jeremy M. Grimshaw & Ian T. Russell, *Effect of Clinical Guidelines on Medical Practice: A Systematic Review of Rigorous Evaluations*, 342 Lancet 1317 (1993), https://doi.org/10.1016/0140-6736(93)92244-N.
[92] United Nations Children's Fund, *Monitoring the Situation of Children and Women for 20 Years: The Multiple Indicator Cluster Surveys (MICS) 1995–2015* (2015).
[93] World Health Assembly Res. 58.33, Sustainable Health Financing, Universal Coverage and Social Health Insurance (May 25, 2005), https://apps.who.int/iris/bitstream/handle/10665/20383/WHA58_33-en.pdf.
[94] Nathaniel Hendrix et al., *Equitable Prioritization of Health Interventions by Incorporating Financial Risk Protection Weights into Economic Evaluations*, 26 Value Health 411 (2023), https://doi.org/10.1016/j.jval.2022.09.007.
[95] Joseph Kutzin, *Health Financing for Universal Coverage and Health System Performance: Concepts and Implications for Policy*, 91 Bull. World Health Org. 602 (2013), https://doi.org/10.2471/BLT.12.113985.
[96] Rodrigo Moreno-Serra, Sarah Thomson & Ke Xu, *Measuring and Comparing Financial Protection*, in Health System Performance Comparison: An Agenda for Policy, Information and Research (Irene Papanicolas & Peter C. Smith eds., Open University Press 2013).

of-pocket health expense in the form of payments for services or materials, insurance premiums, cost-sharing for items or services (for example, co-payments, co-insurance and user fees) and indirect costs (for example, transport) incurred in order to use health care.[97] The majority of efforts on UHC policy have been directed at improving the benefits package in low- and middle-income countries.[98]

In the light of growing concern over health inequities and the equitable distribution of health care, growing pressure on health-system resources and declining returns to certain kinds of marginal health expenditure, FP is an ever more pertinent issue for these countries too.[99] Statistical measures of FP fall under three broad headings: 'threshold indicators' of FP, based on OOP spending measured against specified financial thresholds; the value of the FP provided to recipients of health care; and the impact of financial barriers on access to health care.[100] These measures cannot, however, identify inequalities in health in terms of cost, or whether people are forgoing health care that they need because of a failure of FP.[101] It can be argued that measuring the effect of financial barriers under UHC goes beyond FP as a health coverage instrument, since it is designed to measure phenomena related to intervening strategies.[102] Yet this view might shed further light on many common phenomena that cannot be explained simply by separating the health and financial implications of coverage: for instance, the joint distribution of health and financial consequences, the process by which trade-offs between them evolve over time, and the way in which unmet FP produces costly health consequences. Synthesising health and financial considerations remains a challenge.[103]

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[97] Thomas Rice et al., *Revisiting Out-of-Pocket Requirements: Trends in Spending, Financial Access Barriers, and Policy in Ten High-Income Countries*, 18 BMC HEALTH SERVS. RSCH. 371 (2018), https://doi.org/10.1186/s12913-018-3185-8.

[98] Dominika Bhatia et al., *Identifying Priorities for Research on Financial Risk Protection to Achieve Universal Health Coverage: A Scoping Overview of Reviews*, 12 BMJ OPEN e052041 (2022), https://doi.org/10.1136/bmjopen-2021-052041.

[99] Stéphane Verguet & Ole F. Norheim, *Estimating and Comparing Health and Financial Risk Protection Outcomes in Economic Evaluations*, 25 VALUE HEALTH 238 (2022), https://doi.org/10.1016/j.jval.2021.08.004.

[100] Priyanka Saksena, Justine Hsu & David B. Evans, *Financial Risk Protection and Universal Health Coverage: Evidence and Measurement Challenges*, 11 PLOS MED. e1001701 (2014), https://doi.org/10.1371/journal.pmed.1001701.

[101] Steffie Woolhandler & David U. Himmelstein, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 ANN. INTERN. MED. 424 (2017), https://doi.org/10.7326/M17-1403.

[102] Adam Wagstaff, *Measuring Financial Protection in Health*, in PERFORMANCE MEASUREMENT FOR HEALTH SYSTEM IMPROVEMENT: EXPERIENCES, CHALLENGES AND PROSPECTS (Peter C. Smith et al. eds., Cambridge University Press 2009).

[103] RICHARD COOKSON ET AL., DISTRIBUTIONAL COST-EFFECTIVENESS ANALYSIS: QUANTIFYING HEALTH EQUITY IMPACTS AND TRADE-OFFS (Oxford University Press 2021).

VIII. Out-of-pocket expenditure and catastrophic health spending in India

The OECD defines it thus: 'Household out-of-pocket expenditure on health comprises cost-sharing, self-medication and other expenditure paid directly by private households, whether or not the contact with the health care system was made through referral or on the patient's own initiative'.[104] A certain level of OOP payment is regarded as desirable, being a sustainable and efficient means of resource collection so long as it remains below a certain threshold. When OOP payments exceed that threshold (the WHO currently sets it at 10 per cent or more of the resources available to a household, although a threshold of 40 per cent or more of the household's capacity to pay is also used), they are labelled catastrophic.[105]

SDG indicator 3.8.2 measures the proportion of the population with large household expenditure on health as a share of total household expenditure or income; catastrophic expenditure is assessed at two thresholds, namely more than 10 per cent and more than 25 per cent of total household expenditure or income.[106] On the World Bank's indicator of out-of-pocket expenditure as a share of current health expenditure, India's share is among the highest in the world.[107] India is also among the countries that spend little on health. Under the National Health Policy 2017, the Government of India intends to raise public health expenditure to 2.5 per cent of gross domestic product (GDP) by 2025,[108] from the level of 1.15 per cent recorded when the policy was framed.[109]

India devotes only around 3 to 3.5 per cent of GDP to current health expenditure, well below the world average of roughly 10 per cent.[110] Despite being among the largest funded

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[104] Organisation for Economic Co-operation and Development, *Classification of Health Care Financing Schemes (ICHA-HF)*, in A System of Health Accounts 2011: Revised Edition (OECD Publishing 2017), https://doi.org/10.1787/9789264270985-9-en.

[105] Organisation for Economic Co-operation and Development, *Health at a Glance 2019: OECD Indicators* (2019), https://www.oecd-ilibrary.org/sites/4dd50c09-en/1/3/5/5/index.html?itemId=/content/publication/4dd50c09-en.

[106] United Nations Statistics Division, *SDG Indicator 3.8.2: Proportion of Population with Large Household Expenditures on Health as a Share of Total Household Expenditure or Income*, https://unstats.un.org/wiki/plugins/servlet/mobile?contentId=35291640 (last visited Sept. 6, 2026).

[107] World Bank, *Out-of-Pocket Expenditure (% of Current Health Expenditure)*, https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS (last visited Sept. 6, 2026).

[108] Ministry of Health & Family Welfare, Government of India, *National Health Policy 2017: Building a Healthy India*, MyGov Blogs, https://blog.mygov.in/editorial/national-health-policy-2017-building-a-healthy-india/ (last visited Sept. 6, 2026).

[109] Ministry of Health & Family Welfare, Government of India, *National Health Policy 2017* ¶ 2.4.3.1(a) (2017), https://nhsrcindia.org/sites/default/files/2021-07/National%20Health%20Policy%202017%20(English)%20.pdf; see also World Bank, *Domestic General Government Health Expenditure (% of Current Health Expenditure)*, https://data.worldbank.org/indicator/SH.XPD.GHED.CH.ZS (last visited Sept. 6, 2026).

[110] World Bank, *Current Health Expenditure (% of GDP)*, https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS (last visited Sept. 6, 2026).

programmes, the National Health Mission (NHM) also saw its allocation fall: its allocation for 2018-19, roughly 55 per cent of the total budget of the Ministry of Health and Family Welfare (MoHFW), was a 2 per cent decrease on the revised estimates for 2017-18.[111] The Government of India, in its Economic Survey 2020-21, nevertheless advocated the development of the general healthcare system rather than spending on specific areas.[112]

IX. PATIENT CHOICE: DETERMINANTS AND DECISION-MAKING BEHAVIOUR IN INDIA

There are serious problems in primary care provision because of inadequate resources and personnel, the absence of integrated funding and financial arrangements, and a lack of good performance governance.[113] The Indian healthcare system is thus peculiar in that nearly 70 to 80 per cent of people have to pay for health care themselves.[114] Only a minority, around 20 per cent of the population, is covered by central and state government health insurance schemes, around 10 per cent is covered by private insurance, and the rest must foot the bill themselves.[115] These considerations point to the deprived state of consumers of health care in India and to the need for an early basic universal healthcare delivery system.[116] Given this undercutting of the accountability of healthcare providers to the population, patient choice is a way of empowering patients and also of increasing the accountability of government to the patients it represents.[117]

Yet it can also be said that, through appropriate cooperation and communication with the patient, the physician can balance the patient's choice architecture with expert advice so as to facilitate the patient's decision-making among the available options for his or her benefit.[118] The patient-empowerment paradigm is relevant not only in health care but also in any health-marketing

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[111] PRS LEGISLATIVE RESEARCH, *Demand for Grants 2018–19 Analysis: Health and Family Welfare* (2018), https://prsindia.org/budgets/parliament/demand-for-grants-2018-19-analysis-health-and-family-welfare.

[112] MINISTRY OF FINANCE, GOVERNMENT OF INDIA, *Economic Survey 2020–21*, vol. 1, ch. 5, at 150–78 (2021), https://www.indiabudget.gov.in/budget2021-22/economicsurvey/doc/vol1chapter/echap05_vol1.pdf.

[113] M. Rao & David Mant, *Strengthening Primary Healthcare in India: White Paper on Opportunities for Partnership*, 344 BMJ e3151 (2012), https://doi.org/10.1136/bmj.e3151.

[114] K. Arivalagan & R. Perumal, *Health Insurance in India*, 4 INT'L J. ADVANCED RSCH. MGMT. & SOC. SCI. 84 (2015).

[115] NATIONAL HEALTH SYSTEMS RESOURCE CENTRE, *National Health Accounts Estimates for India (2014–15)* (Ministry of Health & Family Welfare, Government of India 2017).

[116] K. Srinath Reddy et al., *Towards Achievement of Universal Health Care in India by 2020: A Call to Action*, 377 LANCET 760 (2011), https://doi.org/10.1016/S0140-6736(10)61960-5.

[117] Richard B. Saltman, *Patient Choice and Patient Empowerment in Northern European Health Systems: A Conceptual Framework*, 24 INT'L J. HEALTH SERVS. 201 (1994), https://doi.org/10.2190/8WMP-RR2K-ABM7-NVNH.

[118] Timothy E. Quill & Howard Brody, *Physician Recommendations and Patient Autonomy: Finding a Balance Between Physician Power and Patient Choice*, 125 ANN. INTERN. MED. 763 (1996), https://doi.org/10.7326/0003-4819-125-9-199611010-00010.

intervention that seeks to influence health behaviour and quality of life. An empowered consumer is one who can convert the options available into action and make more informed decisions.[119] Developed countries, and the United Kingdom in particular, have begun to put the concept of choice into practice by helping patients on waiting lists to choose their hospital for elective surgery and for the management of chronic illness.[120]

Out-patient services constitute the most important component of the 'product' when hospitals market health services.[121] The patient experience is considered fundamental to the co-production of value in health care.[122] Findings also repeatedly point to a positive and linear relationship between patient experience and overall patient satisfaction with both the service provider and the health system.[123]

X. Comparative analysis: public versus private healthcare under universal health coverage in India

The Constitution of India places public health and sanitation, and hospitals and dispensaries, within the legislative competence of the states. Providing health care to the people is therefore primarily the responsibility of the states, which are charged with raising the standard of health of their populations.[124]

Private hospitals tend to have more flexible, multi-layered management structures. Institutional decisions are made relatively rapidly, since their administration is largely autonomous and can adapt to, or dispense with, partial criteria of need; private clinics may be run by trustees or corporate structures for efficiency and profitability. Government hospitals, by contrast, are administrative organisations within a hierarchy of state or national health policy; management is often bureaucratic, with decisions flowing from the top down, and these hospitals usually

[119] Manel Ben Ayed & Nibrass El Aoud, *The Patient Empowerment: A Promising Concept in Healthcare Marketing*, 10 Int'l J. Healthcare Mgmt. 42 (2017), https://doi.org/10.1080/20479700.2016.1268326.
[120] Helen Magee, Lucy-Jane Davis & Angela Coulter, *Public Views on Healthcare Performance Indicators and Patient Choice*, 96 J. Royal Soc'y Med. 338 (2003), https://doi.org/10.1177/014107680309600707.
[121] Ghasem Abedi & Ehsan Abedini, *Prioritizing of Marketing Mix Elements' Effects on Patients' Tendency to the Hospital Using Analytic Hierarchy Process*, 10 Int'l J. Healthcare Mgmt. 34 (2017), https://doi.org/10.1080/20479700.2016.1231435.
[122] DonHee Lee, *A Model for Designing Healthcare Service Based on the Patient Experience*, 12 Int'l J. Healthcare Mgmt. 180 (2019), https://doi.org/10.1080/20479700.2017.1359956.
[123] Emmanuel Kumah, *Patient Experience and Satisfaction with a Healthcare System: Connecting the Dots*, 12 Int'l J. Healthcare Mgmt. 173 (2019), https://doi.org/10.1080/20479700.2017.1353776.
[124] India Const. sched. VII, list II, entry 6 ('public health and sanitation; hospitals and dispensaries'); India Const. art. 47; Jugal Kishore, National Health Programs of India: National Policies & Legislations Related to Health (Century Publications 2005).

give primacy to public health over financial return, so that medical services are available to everyone.[125]

Private hospitals have the advantage of massive capital investment, which has produced state-of-the-art infrastructure and the latest medical technology. Government hospitals are generally constrained by limited budgets and administrative setbacks, and their infrastructure is often outdated, which affects service delivery.[126]

Private hospitals generally offer better pay and working conditions and are more competitive, which reduces staff attrition. Government hospitals, on the other hand, may suffer from flawed sources of motivation for those who work in them; they may face workforce shortages, lower motivation and lower-quality training.[127]

Research has found that private hospitals are often better at achieving patient satisfaction, owing to their more tailored approach to the individual patient, their efficiency, shorter waiting times and better facilities. Government hospitals cater for a larger section of society, including those without sufficient funds, and thus balance the services available.[128]

Private hospitals are patient-centred; they provide good customer service, use performance-based management and promote continuous quality improvement, in addition to being more cost-effective. Government hospitals, although a necessary instrument of public health, can suffer inefficiencies arising from bureaucratic inertia and lack of resources.

XI. Equity, accessibility and social justice considerations in India

According to the health equity framework of the Agency for Healthcare Research and Quality (AHRQ) in the United States, one of the five 'pillars' of health equity is access to health care.[129] Access is the ability to obtain health care when it is needed, so that healthcare needs are met.[130] These problems increase in magnitude when an individual's or a population's intersectionality is taken into account. Intersectionality denotes the intermingled experiences of oppression and

[125] Ministry of Health & Family Welfare, Government of India, *National Health Policy 2017*, *supra* note 109.
[126] National Health Authority, Government of India, *About Pradhan Mantri Jan Arogya Yojana (PM-JAY)*, https://nha.gov.in/PM-JAY (last visited Sept. 6, 2026).
[127] National Health Systems Resource Centre, *National Health Accounts Estimates for India 2016–17* (Ministry of Health & Family Welfare, Government of India 2019), https://nhsrcindia.org/sites/default/files/2021-06/FINAL%20National%20Health%20Accounts%202016-17%20Nov%202019-for%20Web%20(1).pdf.
[128] India Brand Equity Foundation, *Healthcare Industry in India*, https://www.ibef.org/industry/healthcare-india.aspx (last visited Sept. 6, 2026).
[129] Kamila B. Mistry et al., *Advancing Health Equity: Agency for Healthcare Research and Quality Research and Action Agenda*, 58 Health Servs. Rsch. (Supp. 3) 275 (2023), https://doi.org/10.1111/1475-6773.14230.
[130] Jean-Frederic Levesque, Mark F. Harris & Grant Russell, *Patient-Centred Access to Health Care: Conceptualising Access at the Interface of Health Systems and Populations*, 12 Int'l J. Equity Health 18 (2013), https://doi.org/10.1186/1475-9276-12-18.

discrimination of people who belong to more than one social category, such as race or ethnicity, sex, disability, and sexual and gender minorities (for example, lesbian, gay, bisexual, transgender and non-binary or gender-non-conforming people).[131]

This points to the need to investigate the underlying reasons for disparities, which partly involve marginalisation, structural oppression and racism, and calls for access to health care to be evaluated from the perspective of health equity.[132] Health equity is 'the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically'.[133] Structural barriers to health equity include limited access to health services because of the uneven distribution of health professionals,[134] and gaps in insurance coverage, which exacerbate inequitable access to care.[135]

Specific evidence of the disparities caused by these barriers can be seen across the access spectrum. In the United States, people in racially and ethnically marginalised groups are more likely to be uninsured: 14 per cent of Black, 25 per cent of Hispanic and 24 per cent of American Indian and Alaska Native (AI/AN) adults are uninsured, compared with only 8 per cent of White adults.[136] White adults with mental illness were more likely to receive mental health treatment in 2021, with 52 per cent receiving such care, than their Black (39 per cent), Hispanic (36 per cent) and Asian (25 per cent) counterparts. Minoritised groups are also more likely than Whites to report not seeking care because of cost (18 per cent of Hispanic, 15 per cent of AI/AN and 14 per cent of Black adults, compared with 9 per cent of Whites).[137] This, along with other access inequities, has led to the accumulation of health inequities.[138]

It is equally true that responsive systems must take into account the health literacy, knowledge and beliefs of the populations they aim to serve. While health literacy is trending positively at the population level, disparities remain for certain subpopulations, such as minoritised

[131] Lisa Bowleg, *The Problem with the Phrase Women and Minorities: Intersectionality, an Important Theoretical Framework for Public Health*, 102 AM. J. PUB. HEALTH 1267 (2012), https://doi.org/10.2105/AJPH.2012.300750.
[132] Gilbert C. Gee & Chandra L. Ford, *Structural Racism and Health Inequities: Old Issues, New Directions*, 8 DU BOIS REV. 115 (2011), https://doi.org/10.1017/S1742058X11000130.
[133] CENTERS FOR DISEASE CONTROL & PREVENTION, *What Is Health Equity?* (2022), https://www.cdc.gov/nchhstp/healthequity/index.html#print.
[134] Sanjay Basu et al., *Association of Primary Care Physician Supply with Population Mortality in the United States, 2005–2015*, 179 JAMA INTERNAL MED. 506 (2019), https://doi.org/10.1001/jamainternmed.2018.7624.
[135] Jie Chen et al., *Racial and Ethnic Disparities in Health Care Access and Utilization Under the Affordable Care Act*, 54 MED. CARE 140 (2016), https://doi.org/10.1097/MLR.0000000000000467.
[136] Samantha Artiga, Latoya Hill & Anthony Damico, *Health Coverage by Race and Ethnicity, 2010–2021* (KFF 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/.
[137] Latoya Hill, Nambi Ndugga & Samantha Artiga, *Key Data on Health and Health Care by Race and Ethnicity* (KFF 2023), https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/.
[138] U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, *Report of the Secretary's Task Force on Black & Minority Health* (Margaret M. Heckler, Secretary, 1985), http://resource.nlm.nih.gov/8602912.

populations and those living in rural areas.[139] Most current research on health literacy examines samples that already have contact with the health system; this pre-existing relationship prevents such studies from showing how low health literacy affects a person's ability to make contact with the system when he or she has limited or no contact with it. Patients with low health literacy are more likely to delay care and to have trouble contacting providers than patients with adequate health literacy.[140]

It is vital to reach proactively those groups that are difficult to access before they need to reach out to the health system.[141] In order to promote health equity and reduce disparities, social efforts to improve health literacy must be connected to the underlying, multifaceted predictors of a person's capacity to recognise the need for care before seeking it, and then to identify, comprehend and apply health information.[142] Trust in health care has declined over the past fifty years and is even lower in many racial minority communities, principally Black communities in the United States, which have faced long-standing obstacles to accessing health care, disparate outcomes and overt racism in the delivery of care.[143]

XII. LEGAL AND POLICY FRAMEWORK GOVERNING UNIVERSAL HEALTH COVERAGE IN INDIA

Across the world, an increasing number of nations are willing to adopt universal health coverage. UHC is one of the principles of the global health agenda; it seeks to ensure health care on the basis of equality of access regardless of a person's income from work, and the idea has been incorporated into the otherwise comprehensive and unifying global development plan.[144] Through the 2030 Agenda (United Nations, 2015), countries have in effect already committed themselves to UHC, and they reaffirmed that commitment at the high-level meetings

[139] Devlon N. Jackson, Neha Trivedi & Cynthia Baur, *Re-Prioritizing Digital Health and Health Literacy in Healthy People 2030 to Affect Health Equity*, 36 HEALTH COMMC'N 1155 (2021), https://doi.org/10.1080/10410236.2020.1748828.

[140] Helen Levy & Alex Janke, *Health Literacy and Access to Care*, 21 J. HEALTH COMMC'N (Supp. 1) 43 (2016), https://doi.org/10.1080/10810730.2015.1131776.

[141] Tricia Keesee & M.J. Johnson, *Two Case Examples of Reaching the Hard-to-Reach: Low-Income Minority and LGBT Individuals*, 10 J. HEALTH DISPARITIES RSCH. & PRAC. 11 (2017), https://digitalscholarship.unlv.edu/jhdrp/vol10/iss3/11.

[142] Cynthia A. Gómez et al., *Addressing Health Equity and Social Determinants of Health Through Healthy People 2030*, 27 J. PUB. HEALTH MGMT. & PRAC. (Supp. 6) S249 (2021), https://doi.org/10.1097/PHH.0000000000001297.

[143] Liz Hamel et al., *Race, Health, and COVID-19: The Views and Experiences of Black Americans* (KFF 2020), https://files.kff.org/attachment/Report-Race-Health-and-COVID-19-The-Views-and-Experiences-of-Black-Americans.pdf.

[144] WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR AFRICA, *Universal Health Coverage* (2019), https://www.afro.who.int/health-topics/universal-health-coverage.

on UHC in 2019 and 2023.[145] Each country's journey to UHC will vary in shape and form and will be influenced by such factors as health-system structure, resource availability, political systems and governance.[146]

Analytical frameworks for UHC have been designed to be useful in evaluating health policies in countries where UHC cannot be taken for granted because of political, economic and structural constraints. In developing such frameworks, researchers have been guided by existing definitions of UHC and by relevant reports such as the World Bank's 'Universal Health Coverage in Africa: A Framework for Action' and the 2030 Agenda for Sustainable Development.[147] Population coverage under UHC refers to the population covered for a defined set of health services.[148]

Adequate and sustainable financing is one of the 'building blocks' of UHC. The economies of many countries, particularly low- and middle-income countries, are so strained, however, that raising finance for health systems is relatively hard for governments.[149] Considerable leadership and strategic governance are needed for progress towards UHC, which requires political will and the implementation of health-system reforms. A useful framework therefore considers to what extent UHC policies articulate goals and objectives and whether they specify indicators to monitor progress over time. Progress towards UHC is a process that requires political commitment, the mobilisation of key players, and the development of steering groups and systems for the transparent monitoring of progress.[150]

Health promotion should be carried out through effective community involvement in identifying needs and in planning, agreeing and implementing actions and strategies to meet those needs so as to achieve better health. Effective provision of health services can only be guaranteed if such participation is guaranteed by states.[151] Participation in health is generally placed among the fundamental rights of the people and is the mainstay of successful development activity; it treats people as partners rather than as recipients of developmental benefits, thus establishing an

[145] G.A. Res. 74/2, Political Declaration of the High-Level Meeting on Universal Health Coverage (Oct. 10, 2019); G.A. Res. 78/4, Political Declaration of the High-Level Meeting on Universal Health Coverage (Oct. 5, 2023).
[146] Martin McKee et al., *Universal Health Coverage: A Quest for All Countries but Under Threat in Some*, 16 VALUE HEALTH S39 (2013), https://doi.org/10.1016/j.jval.2012.10.001.
[147] WORLD BANK, *UHC in Africa: A Framework for Action* (2016).
[148] Minoo Alipouri Sakha, Najmeh Bahmanziari & Amirhossein Takian, *Population Coverage to Reach Universal Health Coverage in Selected Nations: A Synthesis of Global Strategies*, 48 IRANIAN J. PUB. HEALTH 1155 (2019), https://doi.org/10.18502/ijph.v48i6.2930.
[149] A.G. Olalere, *Public Financing for Health in Africa: 15% of an Elephant Is Not 15% of a Chicken*, AFRICA RENEWAL (United Nations 2020).
[150] David Stuckler et al., *The Political Economy of Universal Health Coverage* (Background Paper, First Global Symposium on Health Systems Research, 2010).
[151] U.N. Comm. on Econ., Soc. & Cultural Rts., General Comment No. 14, *supra* note 16, ¶ 54.

egalitarian process.[152] A survey of health systems worldwide found that participation has positive effects on health outcomes, lessens information asymmetries, strengthens social capital and enhances the democratic process.[153]

XIII. REGULATORY CHALLENGES AND ACCOUNTABILITY MECHANISMS IN INDIA

According to the WHO, the regulation of health services is now part of everyday health care, ensuring standards, safety and access in the provision of care.[154] Health-services regulation comprises a broad system of laws, policies, standards and oversight mechanisms created by governmental and non-governmental organisations at multiple levels. One objective of regulation is to promote patient safety through the development and enforcement of clinical standards.[155] Through licensing, certification and accreditation, regulatory agencies ensure that healthcare providers and facilities comply with established standards of competence, responsibility and quality.[156] Administering health-services regulation is a key means of enhancing the quality of health services.[157] The rules on professional conduct, conflicts of interest, informed consent and patient confidentiality all help to sustain medical ethics and public confidence in the health service.[158]

It is also important that the regulation of health services enables the system to respond to emerging challenges and opportunities in healthcare delivery.[159] The creation of, and adherence to, quality standards and regulatory frameworks are vital to the pursuit of excellence in health care.[160] Accreditation is a process by which a profession establishes standards against which its

[152] Peter Oakley, *Community Involvement in Health Development: An Examination of the Critical Issues* (World Health Organization 1989), https://apps.who.int/iris/bitstream/handle/10665/39856/9241561262.pdf.
[153] PLANNING COMMISSION, GOVERNMENT OF INDIA, *High Level Expert Group Report on Universal Health Coverage for India* ch. 6 (2011), https://nhm.gov.in/images/pdf/publication/Planning_Commission/rep_uhc0812.pdf.
[154] WORLD HEALTH ORGANIZATION, ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT & WORLD BANK, *supra* note 6.
[155] Judith L. Clayton & Kimberly J. Miller, *Professional and Regulatory Infection Control Guidelines: Collaboration to Promote Patient Safety*, 106 AORN J. 201 (2017), https://doi.org/10.1016/j.aorn.2017.07.005.
[156] WORLD HEALTH ORGANIZATION, *Health Care Accreditation and Quality of Care: Exploring the Role of Accreditation and External Evaluation of Health Care Facilities and Organizations* (2022), https://www.who.int/publications/i/item/9789240055230. In India, see The Clinical Establishments (Registration and Regulation) Act, No. 23 of 2010, INDIA CODE (2010).
[157] Muhammet Usak et al., *Health Care Service Delivery Based on the Internet of Things: A Systematic and Comprehensive Study*, 33 INT'L J. COMMC'N SYS. e4179 (2020), https://doi.org/10.1002/dac.4179.
[158] Basil Varkey, *Principles of Clinical Ethics and Their Application to Practice*, 30 MED. PRINCIPLES & PRAC. 17 (2021), https://doi.org/10.1159/000509119.
[159] Debora J. Bell et al., *Health Service Psychology Education and Training in the Time of COVID-19: Challenges and Opportunities*, 75 AM. PSYCHOLOGIST 919 (2020), https://doi.org/10.1037/amp0000673.
[160] Cintia Lombardi et al., *Weak and Fragmented Regulatory Frameworks on the Accuracy of Blood Pressure-Measuring Devices Pose a Major Impediment for the Implementation of HEARTS in the Americas*, 22 J. CLINICAL HYPERTENSION 2184 (2020), https://doi.org/10.1111/jch.14058.

members can be evaluated as having achieved defined levels of professionalism, competence and knowledge in the field, and thereby makes a public declaration of their capability. It is an evaluation process which indicates, for example, that an organisation is up to date, meets and complies with recognised standards, and offers positive quality assurance.[161]

XIV. CONCLUSION

Alongside the push towards universal health coverage in every country, private healthcare services are becoming more widespread. The ethical questions raised by private healthcare systems are numerous: equity of access, competition with not-for-profit providers, the commercialisation of medicine, increased problems of doctor-patient communication, reduced quality of care, the devaluation of physician education, and the manipulation of health-related public policy. Private health care poses further challenges, including potentially serious equity issues and increased costs of care.

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[161] Mara Magri & Raquel Espada Martín, *The Accreditation Process*, in QUALITY MANAGEMENT AND ACCREDITATION IN HEMATOPOIETIC STEM CELL TRANSPLANTATION AND CELLULAR THERAPY 123 (Mahmoud Aljurf et al. eds., Springer 2021), https://doi.org/10.1007/978-3-030-64492-5_14.