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Medical Inflation and its Impact on Access to Healthcare in India: A Socio-Legal Analysis

Ms. Anisha Bano[1], Mr. Rahul D Chouhan[2]

[1]Advocate, LL.M (P), Chanderprabhu Jain College of Higher Studies & School of Law, New Delhi
[2]Research Scholar, Rama University, Kanpur

Abstract

Medical inflation, broadly defined as the annual rise in the cost of healthcare goods and services, has emerged as one of the most pressing challenges within India's healthcare landscape. Unlike general inflation, medical inflation often escalates at a significantly higher rate, driven by an increasingly privatized healthcare sector, rising pharmaceutical costs, advanced diagnostic technologies, and regulatory inadequacies. This relentless surge in medical expenses has critical implications on the accessibility, affordability, and equity of healthcare, particularly for economically and socially marginalized populations. India's constitutional framework, while not expressly recognizing the Right to Health as a fundamental right, has seen judicial expansion of Article 21 of the Constitution to include the Right to Health and medical care as essential to the right to life and human dignity. Despite this judicial recognition, legislative and policy frameworks have not kept pace with the economic realities of rising medical costs. Public healthcare infrastructure remains underfunded and underutilized, while private sector dominance and insufficient regulation have left patients vulnerable to exploitative pricing and inequitable service delivery. This research article undertakes a socio-legal analysis of medical inflation in India by exploring its root causes, economic consequences, and legal ramifications. It critically evaluates constitutional directives, judicial precedents, and public policy initiatives aimed at mitigating the adverse impact of medical inflation. The paper further draws comparative insights from global models such as Thailand's Universal Coverage Scheme and Brazil's Unified Health System to identify feasible strategies for India.

Through this multidisciplinary approach, the article argues for the urgent need to codify the Right to Health as a fundamental and enforceable legal right, supported by robust regulatory mechanisms and inclusive health financing systems. The study concludes with policy recommendations to promote affordable, accessible, and equitable healthcare in alignment with India's constitutional values of justice, equality, and human dignity.

Keywords: Medical Inflation, Right to Health, Article 21, Healthcare Costs, Socio-Legal Analysis, Access to Healthcare, Indian Constitution, Health Policy, Judicial Interpretation, Healthcare Inequality, Public Health Law, Universal Health Coverage, Health Justice, Health Rights, Healthcare Financing.

1. Introduction

India's journey toward the realization of universal healthcare has been long, complex, and riddled with a host of structural, economic, and policy-level challenges.[1] Despite significant strides in medical science, technology, and healthcare delivery systems, equitable access to healthcare remains a distant goal for la-

rge sections of the Indian population. While the Constitution of India does not explicitly guarantee the Right to Health, the Supreme Court has, through a series of landmark judgments, interpreted Article 21—guaranteeing the Right to Life and Personal Liberty—to include the Right to Health as a critical and inseparable component of a dignified life.[1] This judicial interpretation has laid a strong moral and legal foundation for public health obligations; however, it has not been sufficient to shield the public from the financial burden imposed by the rising cost of medical services.

Over the past two decades, India has witnessed a concerning trend of medical inflation, far exceeding the rate of general inflation. Medical inflation encompasses the year-on-year escalation in the cost of healthcare services, including hospital charges, diagnostic tests, surgical procedures, pharmaceuticals, and health insurance premiums. Factors contributing to this phenomenon include rapid privatization of healthcare, insufficient regulatory oversight, expensive medical technologies, and growing demand for specialized treatment. The dominance of the private sector—responsible for over 70% of healthcare delivery—has turned healthcare into a profit-driven enterprise, leaving the underfunded public health system unable to provide quality care to all.[2]

The consequence of this inflationary trend is the systematic exclusion of economically vulnerable groups from the healthcare system. Out-of-pocket expenditures remain alarmingly high, often leading to financial catastrophe or avoidance of medical care altogether. This situation contradicts the ideals of social justice and the constitutional vision of a welfare state. While schemes like Ayushman Bharat aim to provide financial protection to the poor, their limited coverage, exclusions, and implementation gaps raise concerns about effectiveness.

This article critically explores the issue of medical inflation through a socio-legal lens. It seeks to understand how rising costs infringe upon constitutionally recognized rights, examines the effectiveness of current legislative and policy measures, and highlights the gaps in governance and regulation. It also considers global best practices from countries that have successfully managed healthcare costs while ensuring accessibility and affordability for all.

2. Understanding Medical Inflation

Medical inflation refers to the year-on-year increase in the cost of healthcare goods and services, including hospital treatment, diagnostics, pharmaceuticals, surgeries, medical consultations, and insurance premiums. Unlike general inflation—which impacts prices across sectors—medical inflation tends to rise at a steeper rate, significantly affecting individuals and families.[3] In India, this trend has emerged as a serious impediment to achieving universal health coverage, especially for economically weaker and marginalized sections of society.

One of the primary drivers of medical inflation in India is the increasing privatization of healthcare. Over 70% of healthcare services in the country are delivered by the private sector. These institutions often operate on a profit-maximization model, charging significantly more for medical consultations, procedures, and medications than public health facilities. This profit-driven orientation, compounded by the absence of effective price regulation, has resulted in healthcare becoming a commercial commodity rather than a public good.

[1] *Paschim Banga Khet Mazdoor Samity v. State of W.B.*, (1996) 4 S.C.C. 37 (India)
[2] A. Mills, Health Care Systems in Low- and Middle-Income Countries, 370 *New Eng. J. Med.* 552 (2014), https://doi.org/10.1056/NEJMra1110897.
[3] National Health Authority, *Ayushman Bharat PM-JAY: Annual Report 2022–2023*, Govt. of India, https://pmjay.gov.in.

Another significant factor contributing to medical inflation is the reliance on advanced medical technology. While technological advancement enhances diagnostic accuracy and treatment efficiency, it also raises the cost of care. Hospitals invest heavily in imported equipment and high-end medical infrastructure, and these expenses are passed on to patients.[4] In many cases, unnecessary tests and procedures are recommended, driven by commercial incentives rather than medical necessity.

The role of health insurance companies also influences medical inflation. The "third-party payer" model—where patients pay through insurance rather than directly—has led to inflated billing practices, known as "moral hazard." Hospitals may charge more when they know the patient is insured, and insurance companies, in turn, increase premium rates to compensate for higher payouts. This cycle of cost escalation adversely affects both insured and uninsured populations.

Additionally, there is a glaring lack of effective regulatory oversight in the Indian healthcare system. Unlike sectors such as telecommunications or education, there is no single, unified authority regulating the prices of healthcare services across the country. While the National Pharmaceutical Pricing Authority (NPPA) controls the price of certain essential drugs, medical devices and services largely remain unregulated. The absence of cost transparency, especially in private hospitals, has led to arbitrary pricing, making it difficult for patients to make informed decisions.

The burden of medical inflation disproportionately falls on low-income and rural households. According to the National Health Accounts (2020), over 60% of health expenses in India are met through out-of-pocket expenditure. This often results in catastrophic financial consequences, forcing families to deplete savings, sell assets, or fall into debt. In many cases, patients choose to delay or avoid treatment altogether due to the unaffordability of care, further exacerbating health inequalities.[5]

In sum, medical inflation is not just an economic phenomenon—it is a socio-legal issue that threatens the constitutional promise of equal access to healthcare. Addressing it requires comprehensive reforms, including regulatory mechanisms, increased public investment in health infrastructure, rational pricing policies, and legal frameworks that guarantee health as a fundamental right. Without these interventions, the dream of equitable and affordable healthcare for all remains elusive.

3. Socio-Economic Impact of Medical Inflation

Healthcare affordability lies at the heart of the discourse on health equity. When medical services become financially inaccessible, the principle of health as a basic human right is compromised. In the Indian context, the persistent rise in healthcare costs—driven by medical inflation—has created a formidable barrier to equitable access, especially for low-income and vulnerable populations. This affordability crisis has far-reaching socio-economic implications that undermine public health, economic productivity, and the country's commitment to social justice as envisioned under the Constitution.

One of the most immediate and observable consequences of healthcare unaffordability is the postponement or complete avoidance of medical treatment. Rising costs deter individuals from seeking timely healthcare, particularly in cases of chronic diseases, maternal health, and preventive care. This not only leads to the worsening of health conditions but also increases long-term healthcare expenditure due to delayed diagnosis and treatment. Preventable illnesses thus escalate into critical health issues, placing a heavier financial burden on individuals and the healthcare system.

[4] *What Will It Take to Ease Medical Inflation?*, Econ. Times (Jan. 15, 2025), https://economictimes.indiatimes.com.
[5] World Health Organization, *Health Systems Financing: The Path to Universal Coverage*, World Health Report (2010), https://www.who.int/whr/2010/en/.

Rural populations are among the worst affected by the lack of affordable healthcare. Public health infrastructure in rural areas remains grossly inadequate in terms of both quality and reach. In the absence of nearby functional government facilities, rural residents are often forced to rely on private clinics or travel long distances to urban centers, incurring high travel and treatment costs. This geographic inequity in access, when coupled with financial barriers, results in health neglect and untreated conditions becoming normalized.

The gendered impact of medical inflation is another critical concern. Women, especially in rural and conservative households, often face restricted access to healthcare due to intra-household resource allocation biases. As the cost of medical services rises, families tend to prioritize the health needs of earning members—usually men—over those of women and children. This exacerbates maternal mortality, malnutrition, and untreated reproductive health issues, reinforcing gender-based health disparities.

Marginalized communities, including Scheduled Castes, Scheduled Tribes, and Other Backward Classes, are doubly disadvantaged. These communities often reside in areas with poor healthcare infrastructure and have limited financial means to afford private care. The intersection of caste, class, and location amplifies the barriers they face, perpetuating cycles of poor health outcomes and economic deprivation. This not only violates the right to health but also infringes upon the principles of equality and dignity under Articles 14 and 21 of the Constitution.

The heavy reliance on out-of-pocket expenditure (OOPE) further compounds the affordability crisis. According to the National Health Accounts Estimates (2020), over 60% of healthcare financing in India comes directly from individuals, with little or no insurance coverage. This makes Indian households highly vulnerable to health-related financial shocks. A single episode of hospitalization can wipe out a family's savings, push them into long-term debt, or force them to sell assets. Studies have shown that millions of Indians fall below the poverty line every year due to high medical expenses.

Moreover, informal workers, who constitute a large portion of India's labor force, are typically excluded from employer-sponsored insurance or government health schemes. They are left to navigate an unregulated and expensive private healthcare market without any financial safety net. This lack of social protection not only endangers their health but also destabilizes their economic productivity and well-being.

The socio-economic impact of medical inflation is, therefore, not merely a matter of individual hardship but a structural issue with profound implications for national development, public health, and constitutional governance. It necessitates a multi-pronged approach involving legal recognition of the right to health, expansion of health insurance, investment in public healthcare infrastructure, and robust regulatory reforms aimed at curbing exploitative pricing. Without addressing affordability, healthcare cannot be universal, nor can it be just.

4. Legal Framework: Constitutional and Judicial Perspectives

Indian courts have played a crucial role in interpreting and expanding the scope of the Right to Health. Through various landmark judgments, the judiciary has held the State accountable for its health-related obligations and has provided clarity on the contours of this right under Article 21. These decisions have established that access to affordable and quality healthcare is not merely a policy matter but a constitutional imperative.

One of the earliest and most influential cases is **Consumer Education and Research Centre v. Union of India** [(1995) 3 SCC 42]. In this case, the Supreme Court dealt with the health rights of workers employed in hazardous industries. The Court held that the Right to Health and medical care is a fundamental right under Article 21.[6] It declared:

"The right to health and medical care is a fundamental right under Article 21 of the Constitution since it is essential for making the life of the workman meaningful and purposeful with dignity of person."

This judgment established a clear link between human dignity and access to healthcare, laying a foundation for future interpretations of the Right to Health. The Court emphasized that socio-economic rights like health could no longer be viewed merely as directive principles but must be treated as enforceable components of the right to life.

In **Paschim Banga Khet Mazdoor Samity v. State of West Bengal** [(1996) 4 SCC 37],[7] the Supreme Court addressed the issue of denial of emergency medical treatment due to lack of facilities. A labourer suffering from a head injury was turned away by multiple government hospitals on the grounds of inadequate infrastructure.[8] The Court held that such denial amounted to a violation of Article 21 and ruled that it is the responsibility of the State to provide timely medical treatment to every person.

"Failure on the part of a government hospital to provide timely medical treatment to a person in need results in violation of his Right to Life guaranteed under Article 21."

This case reinforced the idea that healthcare is not a charity but a right enforceable against the State. The Court directed governments to ensure availability of minimum standards in public hospitals and to evolve policies ensuring accessibility of emergency healthcare services for all.

In **State of Punjab v. Mohinder Singh Chawla** [(1997) 2 SCC 83][9], the Supreme Court went a step further by holding that the State is obliged to bear the expenses of medical treatment for its employees, even if that treatment has to be taken in private hospitals due to non-availability of government facilities. This judgment was pivotal in recognizing the financial dimension of the Right to Health and State responsibility in bearing medical costs.

Another important judgment is **Paramanand Katara v. Union of India** [(1989) 4 SCC 286][10], where the Court emphasized that no person should be denied emergency medical aid merely because of procedural or administrative issues. The ruling made it mandatory for hospitals to admit accident victims and provide first aid without waiting for legal formalities like FIR registration.

These judicial pronouncements have helped crystallize the idea that the Right to Health is not only substantive but also actionable. The jurisprudence has grown to reflect an understanding that health is integral to a dignified life and that the State must play a proactive role in ensuring its realization.

However, despite progressive jurisprudence, challenges remain. The judiciary can only interpret and enforce rights—it cannot legislate or implement policy. While courts have provided valuable directions, systemic issues such as medical inflation, regulatory failure, and underfunded public health services continue to undermine the Right to Health. The disconnect between constitutional ideals and ground realities becomes even more pronounced when viewed through the lens of rising healthcare costs.

[6] R. Gaitonde et al., "Right to Health: Strengthening Legal Frameworks for Public Health in India," 13 *Indian J. Public Health* 321 (2019).
[7] **Paschim Banga Khet Mazdoor Samity v. State of West Bengal** [(1996) 4 SCC 37],
[8] P. Swaminathan, *Right to Health in India: A Constitutional Perspective*, 42 *Indian Bar Rev.* 134 (2015).
[9] **State of Punjab v. Mohinder Singh Chawla** [(1997) 2 SCC 83],
[10] **Paramanand Katara v. Union of India** [(1989) 4 SCC 286],

In light of this, the article argues for a more aggressive legislative and administrative response. Codifying the Right to Health through a central legislation, regulating healthcare pricing, and increasing public spending on health are essential steps. These measures would not only give effect to judicial directives but also fulfil the constitutional promise of a welfare state committed to social and economic justice.

5. Policy Framework and State Interventions

5.1. Ayushman Bharat Scheme: Promise and Pitfalls

The **Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY)**, launched in 2018, is a flagship healthcare initiative aimed at achieving universal health coverage in India. Touted as the world's largest government-funded health insurance program, PM-JAY was designed to address critical issues of healthcare accessibility and affordability for economically disadvantaged populations. It seeks to offer health insurance coverage of ₹5 lakh per family per year for secondary and tertiary hospitalization to over 10 crore poor and vulnerable families, thereby benefiting around 50 crore individuals.

The scheme marks a significant shift in India's healthcare policy, moving from a fragmented and vertical approach to a more integrated and comprehensive one. It has two components: (1) **Health and Wellness Centres (HWCs)**, which aim to provide comprehensive primary care including non-communicable disease prevention and maternal-child health services; and (2) **PM-JAY**, which covers hospitalization expenses.

While the scheme's intent and scale are commendable, it faces several challenges that hinder its effective implementation and its potential to mitigate the effects of medical inflation. First and foremost, **limited participation of private hospitals** has emerged as a serious concern. Given the dominance of the private sector in secondary and tertiary care in India, the success of PM-JAY hinges on meaningful engagement with private healthcare providers. However, low reimbursement rates under the scheme, administrative delays, and inadequate package pricing have deterred many reputed private hospitals from joining the network. Consequently, beneficiaries often find it difficult to access quality care, particularly in urban areas where public hospitals are overburdened and private hospitals remain out of reach.

Secondly, the scheme **largely excludes outpatient care**, which accounts for a substantial portion of health-related expenditure for Indian households. Most routine and chronic treatments, such as diabetes or hypertension management, require regular consultations, diagnostics, and medication—none of which are covered under PM-JAY. This exclusion limits the scheme's ability to meaningfully reduce out-of-pocket expenditure, which continues to exceed 60% of total healthcare spending in India. Thus, while the scheme addresses catastrophic hospitalization costs to an extent, it leaves routine but essential care largely unaddressed.

Thirdly, there exists a **lack of awareness and digital literacy** among beneficiaries, particularly in rural and semi-urban areas. Despite being eligible, many families are either unaware of the scheme or unsure of how to access benefits. This information gap, coupled with technological hurdles related to digital verification and claim processing, prevents effective utilization of services. Field studies and surveys have found that a significant percentage of targeted households either do not possess the PM-JAY card or have never used it, reflecting gaps in outreach and enrolment mechanisms.

Moreover, the scheme has been criticized for adopting a **top-down approach**, with insufficient attention paid to strengthening the public health system infrastructure. The reliance on an insurance-based model to achieve universal health coverage may not be sustainable in the long run unless accompanied by investment in public hospitals, training of healthcare professionals, and infrastructural development.

Despite these limitations, Ayushman Bharat has laid an important foundation. As of 2023, over 4.5 crore hospitalizations have been reported under PM-JAY, and the scheme has helped to reduce the financial burden for many families. Going forward, however, it must evolve to address systemic bottlenecks and align more closely with the constitutional and ethical vision of the Right to Health.

5.2. Other Government Health Insurance Schemes: Fragmentation and Gaps

In addition to Ayushman Bharat, India has a range of other public health insurance and welfare schemes catering to specific populations. Among the most prominent are the **Employees' State Insurance Scheme (ESIS)**, the **Central Government Health Scheme (CGHS)**, and various **state-level health insurance initiatives** such as Rajiv Aarogyasri in Andhra Pradesh, Mukhyamantri Amrutam Yojana in Gujarat, and Chief Minister's Comprehensive Health Insurance Scheme in Tamil Nadu.

The **Employees' State Insurance Scheme (ESIS)**, established under the Employees' State Insurance Act, 1948, is a social security scheme designed to provide medical and cash benefits to workers in the formal sector. It covers a wide range of medical services including hospitalization, maternity benefits, and disability compensation. However, the reach of ESIS remains limited, covering only a small fraction of the workforce, primarily those in the organized sector. Given that more than 80% of India's workforce is employed in the informal sector, a vast majority of workers are left without any coverage.

Further, the ESIS network suffers from **inadequate infrastructure and poor quality of care**, with many ESIS hospitals and dispensaries lacking essential equipment, medicines, and personnel. Delays in treatment, lack of accountability, and red tape have eroded public trust in the system. Beneficiaries often opt for private healthcare providers despite being entitled to free treatment under ESIS, thereby incurring out-of-pocket expenses.

The **Central Government Health Scheme (CGHS)**, launched in 1954, provides comprehensive medical care to central government employees, pensioners, Members of Parliament, and other eligible groups. The scheme operates through a network of CGHS wellness centres, empanelled hospitals, and diagnostic labs in major cities. While CGHS is relatively well-functioning, it caters to a **very limited demographic**—a privileged section of the population—thereby contributing little to broader health equity.

At the **state level**, various governments have launched their own health insurance programs, often tailored to the needs of the local population. These schemes, while innovative, tend to suffer from **lack of standardization**, **overlapping coverage**, and **inconsistent implementation**. Inter-state portability remains a challenge, limiting access for migrant workers and mobile populations. Moreover, the fragmentation of schemes across the country results in administrative inefficiencies, duplication of resources, and confusion among beneficiaries.

Common to most of these schemes are systemic limitations such as **stringent eligibility criteria**, **cumbersome documentation**, and **limited empanelment of hospitals**. These factors result in underutilization and uneven access. Moreover, many of these schemes do not effectively cover pre-existing conditions, outpatient care, or chronic diseases—some of the most significant sources of long-term medical expenditure. This leads to a situation where the most vulnerable are either excluded from the schemes or inadequately covered, defeating the very objective of universal healthcare.

It is also important to note the **lack of legal enforceability** of these schemes. Most are policy-driven and not anchored in a statutory framework guaranteeing the Right to Health. As a result, beneficiaries have limited legal recourse when services are denied or substandard. This absence of accountability mechanisms further weakens the public health safety net.

In conclusion, while India has made commendable efforts in rolling out multiple healthcare schemes, they often fall short in addressing the underlying issues of **medical inflation, coverage gaps, and systemic inequities**. There is an urgent need for harmonization of these schemes under a **comprehensive national health framework**, supported by adequate funding, robust regulatory oversight, and a rights-based approach. Only then can the vision of accessible, affordable, and equitable healthcare for all—enshrined in the Constitution and echoed in judicial pronouncements—be meaningfully realized.

6. Systemic Challenges to the Realization of the Right to Health in India

While the Indian judiciary has recognized the **Right to Health** as a part of the **Right to Life under Article 21** of the Constitution, the **absence of a codified, statutory Right to Health Act** remains a significant barrier to the effective and enforceable realization of this right. Without explicit legislative backing, the Right to Health remains largely aspirational, reliant on policy pronouncements and judicial interpretations rather than concrete legal entitlements. This gap undermines both the **accountability of the State** and the **ability of citizens to claim health as a justiciable right**, particularly in the face of growing medical inflation and privatization.

In many other countries, the Right to Health is recognized as a statutory or constitutional right with clearly defined obligations on the State. In India, however, health remains a **State subject under the Seventh Schedule**, and the lack of a uniform legal framework across the country leads to **uneven implementation and access**. While some states have introduced health insurance or welfare schemes, the absence of a national law results in fragmented coverage and gaps in protection, particularly for migrant workers, informal labourers, and marginalized groups.

One of the most critical challenges in the Indian healthcare system is the **weak regulation of the private healthcare sector**, which plays a dominant role in both outpatient and inpatient services. Over **70% of outpatient care** and nearly **60% of inpatient care** in India are delivered by private providers. Despite this overwhelming presence, **private healthcare remains inadequately regulated** in terms of pricing, quality standards, and ethical practices. This has led to widespread issues of **overcharging, unnecessary medical procedures, lack of transparency, and profiteering**, particularly in urban centers and during public health emergencies.

The **cost of pharmaceuticals and medical devices** is another major driver of medical inflation and a direct contributor to healthcare inaccessibility. Although India is known globally as the "pharmacy of the world" for producing affordable generic medicines, paradoxically, **medicines remain unaffordable for many Indians**. This is partly due to the **limited scope of price control mechanisms** and loopholes in drug regulation. The **National Pharmaceutical Pricing Authority (NPPA)**, tasked with controlling prices of essential medicines, regulates only a fraction of the thousands of drugs available in the market. Moreover, manufacturers often circumvent price caps through branding, packaging changes, and dosage modifications, rendering price controls ineffective.

Similarly, the **Medical Devices Rules, 2017**, though a step forward, have yet to effectively regulate the cost and quality of critical devices like stents, implants, and diagnostic tools. The lack of pricing

transparency and variable costs across hospitals further complicates affordability for the common citizen.

The **health insurance sector**, expected to play a mitigating role in reducing out-of-pocket expenses, has also come under criticism for **frequent denial of claims, ambiguous policy terms, and lack of regulatory oversight**. In many cases, insurers reject claims on technical or procedural grounds, leaving patients financially burdened despite being covered. The **Insurance Regulatory and Development Authority of India (IRDAI)**, while issuing periodic guidelines, lacks the enforcement teeth to protect consumers effectively. Policyholders often find themselves in a complex and opaque system with little support or recourse. The **exclusion of pre-existing conditions, mental health services, and chronic disease management** from many insurance plans further narrows their effectiveness as financial safety nets.

The **public healthcare system**, on the other hand, is plagued by **chronic underfunding, infrastructure deficits, human resource shortages, and poor governance**. India spends only around **2% of its GDP on public health**, far below the global average and recommendations by the World Health Organization (WHO). Many government hospitals face overcrowding, lack of sanitation, outdated equipment, and long waiting times. These inadequacies deter citizens from availing public health services, pushing them towards expensive private providers.

To address these systemic flaws and realize the constitutional promise of health as a fundamental right, India urgently requires a **comprehensive and enforceable Right to Health legislation**. Such an act must lay down **minimum healthcare entitlements**, establish **standards of care**, ensure **regulation of both public and private providers**, and create a **robust grievance redressal framework**. It should also emphasize **financial protection**, with provisions for expanding **public financing of healthcare**, regulating **insurance practices**, and making **essential medicines and diagnostics affordable**.

The proposed **National Health Bill**, which has been in various drafts since 2009, aimed to address many of these concerns but has yet to be enacted. In its absence, India continues to rely on fragmented policies and judicial interventions that are insufficient to tackle the deep-rooted challenges posed by medical inflation and systemic dysfunction.

7. Comparative Jurisprudence: Learning from Global Models of Health as a Fundamental Right

As India grapples with the socio-legal challenges of medical inflation and inaccessible healthcare, lessons can be drawn from countries that have successfully recognized **health as a fundamental right** through legal enactments and implemented **universal healthcare systems** to address both equity and affordability. Countries such as **Thailand, Brazil, and Sri Lanka** present compelling models that demonstrate the transformative potential of **constitutional and legislative recognition of the right to health**, combined with robust public health systems and cost-containment mechanisms. These comparative experiences underscore the need for India to move beyond fragmented welfare schemes and judicial pronouncements towards a rights-based, legally enforceable framework.

7.1 Thailand: Universal Coverage Scheme and Legal Entitlement to Health

Thailand's **Universal Coverage Scheme (UCS)**, introduced in **2002**, is a hallmark of successful health reform grounded in the principle of equity. The UCS was preceded by a constitutional amendment in **1997**, which explicitly recognized health as a **legal right of all Thai citizens**. This constitutional foundation provided the legitimacy and enforceability required to implement a national health system that is **government-financed, rights-based, and inclusive of the poorest sections** of society.[11]

Under UCS, all citizens not already covered under other schemes (such as civil servant or social security schemes) are entitled to comprehensive healthcare services, including **outpatient care, inpatient care, maternity services, preventive health, and essential medicines**. What makes Thailand's model particularly effective is the **cost control mechanism**—patients can access services at registered public health facilities with **zero or minimal out-of-pocket payment**.

Moreover, Thailand introduced **global budgeting** for hospitals and **standardized medical packages**, ensuring predictable costs and financial sustainability. The **National Health Security Office (NHSO)** plays a central role in administering the scheme, maintaining quality standards, and ensuring accountability. Transparency, decentralization, and community involvement have also contributed to the scheme's credibility and success.

7.2 Brazil: Constitutional Mandate and Unified Health System (SUS)

Brazil provides another instructive example through its **Sistema Único de Saúde (SUS)** or Unified Health System, grounded in **Article 196 of the 1988 Brazilian Constitution**, which proclaims:

"Health is a right of all and a duty of the State."

This constitutional provision mandates the government to provide **universal and equal access to health services**, funded through general taxation. SUS is comprehensive in scope and includes **primary, secondary, and tertiary care**, as well as **preventive services, pharmaceuticals, and health promotion programs**.

SUS operates on principles of **universality, equity, and decentralization**, with governance shared between federal, state, and municipal governments. A key innovation in Brazil has been the **Family Health Program**, which deploys multidisciplinary teams to provide home-based and community-based care, reducing dependence on tertiary care and lowering overall costs.

The Brazilian judiciary has played an active role in enforcing the right to health, with courts frequently directing the government to provide specific treatments or medicines under SUS. While this has led to debates about the role of judicial activism in resource allocation, it has undeniably strengthened **accountability and citizen empowerment**.[11]

Despite economic challenges, Brazil has significantly improved **life expectancy**, reduced **infant mortality**, and expanded **vaccination coverage** through its universal health system. Importantly, **public health spending accounts for over 45% of total health expenditure**, much higher than India's figure of less than 30%.

7.3 Sri Lanka: Public Healthcare Tradition and De Facto Right to Health

Although Sri Lanka does not have an explicit constitutional right to health, it has built a **strong public healthcare system** that effectively ensures **universal access to free medical care** at the point of delivery. The country's health policy is premised on **state responsibility for healthcare**, rooted in its post-independence welfare model.

Sri Lanka provides **free healthcare services through an extensive network of public hospitals and clinics**, covering **both curative and preventive care**. From childbirth to surgeries to mental health services, citizens are not charged fees for essential services. The government also subsidizes pharmaceuticals through public drug stores, further reducing the cost burden on individuals.

What sets Sri Lanka apart is its **investment in primary healthcare**, which has enabled it to achieve **low maternal and infant mortality rates**, **high immunization coverage**, and **better health indicators**

[11] World Bank, *Brazil's Unified Health System (SUS): Achievements and Challenges*, World Bank Reports (2020), https://documents.worldbank.org.

than many wealthier nations. Public confidence in the system remains high due to the **quality of services, wide reach, and absence of financial barriers**.[12]

7.4 Lessons for India

The comparative analysis of Thailand, Brazil, and Sri Lanka reveals common themes that are highly relevant for India:

Legal Recognition: Explicit constitutional or statutory recognition of the right to health is crucial. It provides a binding obligation on the State and legal recourse for citizens.

Universal Coverage: Schemes must be **universal, publicly funded, and inclusive** of outpatient, diagnostic, and preventive services. Targeted insurance schemes, like PM-JAY in India, though helpful, do not replace the need for universal systems.

Cost Controls: Regulating the price of medicines, treatments, and services is essential to prevent medical inflation. Thailand and Sri Lanka have demonstrated how public procurement and standard pricing can reduce costs.

Public Health Infrastructure: Strengthening public hospitals, primary care centres, and rural health facilities reduces dependence on the private sector and builds resilience.

Accountability: Establishing **independent regulatory authorities** and grievance redressal mechanisms, as seen in Thailand and Brazil, ensures transparency and citizen participation.

India, with its vast population and diverse health needs, must tailor these lessons to its context but cannot ignore their core principles. A **legislated Right to Health**, backed by **systemic reforms and public financing**, is not just a policy necessity—it is a constitutional imperative.

. Recommendations

The socio-legal analysis of medical inflation in India reveals deep-rooted systemic issues that obstruct equitable access to healthcare. The existing constitutional and policy framework, while aspirational, lacks enforceability and uniform implementation. To bridge the affordability gap, ensure justice in health delivery, and give concrete shape to the Right to Health as envisioned under Article 21, the following recommendations are proposed:

Enact a Comprehensive Right to Health Legislation

The foremost step towards realizing health justice in India is the enactment of a comprehensive and enforceable Right to Health Act. Such legislation must codify healthcare as a fundamental, justiciable right, accessible to every citizen regardless of socio-economic status, location, gender, or caste. The law should clearly outline:

- Minimum standards of care and essential health services to be provided free of cost by the State;
- Entitlements for vulnerable groups, including the elderly, women, children, and persons with disabilities;
- The obligations of both State and private health providers;
- Budgetary allocations, infrastructure development, and human resource policies to ensure quality delivery.

Drawing from the models of Brazil and Thailand, the legislation should be backed by adequate public financing and include mechanisms for enforcement and grievance redressal. It should also cover preventive, curative, palliative, and rehabilitative healthcare under a rights-based framework.

[12] S. Samarakoon, Health Policy and Reforms in Sri Lanka, in *Public Health in South Asia* 137–152 (Oxford Univ. Press, 2018).

Introduce Stringent Price Regulation on Healthcare Services and Pharmaceuticals

Unchecked medical inflation—driven by profiteering, market monopolies, and unregulated pricing—makes healthcare inaccessible. Therefore, there is a pressing need for stronger regulatory oversight of both public and private healthcare providers.

- The National Pharmaceutical Pricing Authority (NPPA) should be empowered to monitor and regulate the prices of not just essential medicines but also non-scheduled drugs, diagnostics, and medical devices.
- Hospitals, both private and public, must be mandated to display standardized treatment charges and adhere to a cap on high-cost procedures, especially during emergencies.
- Regulatory authorities should conduct regular audits and penalize practices like unnecessary diagnostics, inflated billing, and dual pricing.

Creating a Health Pricing Regulatory Commission could help standardize costs and eliminate regional disparities, thus restoring public trust and reducing the financial burden on patients.

Strengthen the Public Health Sector to Reduce Reliance on Private Providers

One of the root causes of rising healthcare costs in India is the over-reliance on private providers, driven by the poor quality and inaccessibility of government services. Strengthening the public health sector is, therefore, essential. This includes:

- Increased investment in public health infrastructure, particularly in rural and underserved regions;
- Upgradation of primary health centres (PHCs), community health centres (CHCs), and district hospitals with modern equipment and adequate staff;
- Hiring and training more doctors, nurses, and paramedical personnel;
- Ensuring the availability of free essential medicines and diagnostics in public facilities.

Public health must be prioritized in budgetary allocations, with a target of increasing health expenditure to at least 3% of GDP, as recommended by the National Health Policy. This would also help address disparities in access and improve the overall health index of the country.

Expand Insurance to Cover Outpatient and Preventive Care

Most health insurance schemes in India, including the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY), focus only on inpatient hospitalization, leaving out outpatient treatments, diagnostics, and preventive health check-ups—which account for the majority of healthcare expenses, especially among the poor.

To address this, insurance models need to be reformed to:

- Include comprehensive outpatient care, including consultations, medicines, and lab tests;
- Provide coverage for chronic illness management, mental health services, and reproductive health;
- Encourage prevention-based coverage that incentivizes healthy lifestyles and regular screenings.

State-sponsored insurance schemes must also ensure timely claim settlement, transparency in coverage, and greater participation from quality private providers, especially in Tier 2 and Tier 3 cities.

Establish Robust Grievance Redressal Mechanisms

Without effective legal remedies and administrative recourse, the right to health remains theoretical. India urgently needs an accessible, time-bound grievance redressal system at both state and national levels.

- A National Health Rights Commission (similar to the National Human Rights Commission) could be established to investigate complaints of denial, negligence, or overcharging.

- State-level tribunals or ombudsman offices should be set up to ensure real-time grievance handling in hospitals and insurance claims.
- There must be a legal obligation on public and private providers to inform patients of their rights, treatment protocols, and billing practices.

These mechanisms must be simple, free of cost, non-adversarial, and accessible even to illiterate and economically weaker individuals. They would act as important accountability tools and act as a check against arbitrary and unethical practices.

9. Conclusion

Medical inflation in India is not just an economic concern—it is a profound **human rights issue** that directly impedes the realization of the **Right to Health**, an integral part of the **Right to Life under Article 21 of the Constitution of India**. The increasing costs of healthcare, pharmaceuticals, diagnostics, and insurance premiums have created a structural barrier, disproportionately affecting the poor, marginalized, and vulnerable populations. This economic burden often compels individuals to either delay necessary treatments, seek substandard care, or fall into **poverty due to catastrophic health expenditures**. Despite constitutional guarantees and the judiciary's progressive interpretations, the **absence of a statutory Right to Health**, coupled with fragmented health policies, has hindered equitable access to healthcare.

The increasing privatization of healthcare, inadequate public investment, and poor regulatory oversight have allowed **market forces to dictate the cost of health services**, often at the expense of public welfare. While schemes like **Ayushman Bharat** represent steps in the right direction, their limitations in terms of coverage, awareness, and infrastructure reveal the need for a more **systemic and inclusive health policy**. Furthermore, **out-of-pocket expenditures**—still making up over 60% of total health spending—highlight the need for **cost regulation, public financing, and insurance expansion** to make healthcare financially accessible.

A **paradigm shift is essential**—one that moves from viewing healthcare as a commodity to recognizing it as a **public good and a legal right**. This entails not only enacting a **Right to Health law**, but also introducing **stringent price regulation, strengthening public healthcare infrastructure, expanding insurance coverage to include outpatient and preventive care**, and establishing **robust grievance redressal systems**. Simultaneously, the role of **public-private partnerships** must be reimagined through the lens of **accountability, transparency, and equity**.

Ultimately, health is not a privilege, but a **constitutional promise and a fundamental human right**. The challenges posed by medical inflation and systemic inequities cannot be overcome by judicial activism or piecemeal schemes alone. They require a **coherent national strategy** that integrates **law, policy, economics, and ethics**, driven by the commitment to **social justice**.

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