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Universal Healthcare in India: Poverty, Insurance Design, and the Gap between Nominal Coverage and Effective Access: A Comparative Law and Economics Analysis

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ABSTRACT

India's health financing architecture presents a puzzle that neither doctrine nor economics resolves alone. The Supreme Court has read a right to emergency medical treatment into Article 21 since the late 1980s, yet more than four in ten rupees spent on healthcare in India are still paid out of pocket at the moment of illness, and tens of millions of households are pushed into poverty by medical costs every year. Since 2018 the state's principal response has been Ayushman Bharat, the Pradhan Mantri Jan Arogya Yojana (PM-JAY), an insurance scheme that assigns a notional entitlement of five lakh rupees per family without committing the state to build, staff, or finance the hospital capacity needed to redeem it. This paper argues that the persistence of catastrophic health expenditure, notwithstanding both a constitutional right and a large insurance scheme, is best explained as a mismatch between the legal form of the entitlement and the economic institutions required to make it operative. Using the United Kingdom's National Health Service as the principal comparator for a coherent single-payer model, and the United States to illustrate the costs of a competitive private-insurance market, the paper examines three institutional models of universal healthcare — direct public provision, mandate-based regulated insurance, and India's own targeted, reimbursement-style insurance — and argues that reimbursement-based insurance, however generous its nominal benefit, fails when the beneficiary cannot front the cost of care or providers are not paid promptly, a legal design failure as much as a financing shortfall. Both comparator models present limitations likely to be more severe if transplanted onto India's scale and infrastructure: the NHS's waiting-time rationing would predictably lengthen, while the American model illustrates the costs of affordability gaps, administrative complexity, and industry lobbying. The paper argues that India's own insurance-based model, despite serious documented deficiencies that are principally financial, administrative, and regulatory rather than defects of design, is the more institutionally suitable foundation for reform. It estimates the fiscal cost of closing the financing gap and concludes that Article 21 jurisprudence, read with Article 47 and the Court's reimbursement case law, already supplies the doctrinal resources for a more demanding standard of entitlement than the one currently instantiated in policy, provided that standard is paired with financing commitments, wider provider participation, and strengthened regulatory capacity.

I. Introduction

Healthcare is unlike most goods legal systems allocate. It is consumed unpredictably, its need often coincides with reduced earning capacity, and its absence at the moment of acute illness cannot be remedied later at a discount.¹ For most Indians, healthcare is financed out of pocket, at the point of use, by the person least able to bargain over price or defer expense. This combination of unpredictability, urgency, and financial exposure is exactly what the law and economics literature on insurance identifies as the paradigm case for compulsory risk pooling.² It is also the combination that recurs in the record before the Supreme Court when it has been asked whether Article 21 obliges the state to pay for treatment.³

This paper asks a narrower question than the literature on comparative health rights typically poses. It does not ask whether health is, in the abstract, a justiciable right; Indian doctrine has answered that, for emergency care, since 1989.⁴ It asks why a constitutional right to emergency treatment, combined since 2018 with the world's largest publicly funded health insurance scheme, has not translated into a material reduction in the share of household budgets consumed by medical costs, and what redesign would close that gap. Its central claim is that legal form and economic substance are inseparable here: a right cognisable only as a claim for after-the-fact reimbursement, and a scheme that pays providers on a delayed and disputed basis, both reproduce the financing barrier they are meant to remove. Nominal coverage is not effective access, and the difference is substantially a matter of legal design — who bears financing risk while treatment is underway, and what remedy exists when the payer does not pay.

1 Kenneth J Arrow, 'Uncertainty and the Welfare Economics of Medical Care' (1963) 53 American Economic Review 941.

2 Michael Rothschild and Joseph Stiglitz, 'Equilibrium in Competitive Insurance Markets' (1976) 90 Quarterly Journal of Economics 629.

3 *Parmanand Katara* AIR 1989 SC 2039; *Paschim Banga* (1996) 4 SCC 37; *Ram Lubhaya Bagga* (1998) 1 SCR 1120, discussed in Part VI.

4 *Parmanand Katara* (n 3).

The paper proceeds in six substantive parts. Part II sets out the conceptual link between rights-based and welfarist accounts of a legal entitlement to health, and the economic account of why healthcare markets fail without compulsion. Part III makes the empirical case for why universal healthcare is necessary in India specifically, tracing how a single illness can exhaust a household's savings and reverse years of economic progress. Part IV narrows the comparative lens to three institutional models: direct public provision (the NHS), mandate-based regulated insurance (the post-2010 United States), and India's own PM-JAY, examined in greatest depth, with particular attention to whether a reimbursement-style entitlement protects a person who cannot front the cost of treatment, a reform programme for PM-JAY, and whether India's regulatory institutions possess the capacity such reform requires. Part V undertakes a fiscal feasibility analysis. Part VI returns to constitutional doctrine, arguing that Article 21, read with Article 47 and the Court's medical-reimbursement case law, already supplies a workable distinction between a bare entitlement to claim money back and an enforceable entitlement to receive care. Part VII draws policy implications, Part VIII addresses limitations, and Part IX concludes.

II. Conceptual Framework

A. Rights-Based and Welfarist Accounts of a Legal Entitlement to Health

Legal scholarship on healthcare access divides broadly into two traditions. A rights-based tradition treats access to healthcare as a claim correlative to a state duty, grounded in constitutional text, international instrument, or human dignity. Article 25 of the Universal Declaration and Article 12 of the ICESCR both frame health as flowing from personhood rather than state discretion.⁵ On this view the state's obligation is not, in principle, contingent on cost-benefit analysis, although Part VI shows Indian doctrine has in practice imported resource considerations into the right's content.

A welfarist tradition instead treats healthcare policy as one claim among many on scarce public resources, judged against the next-best use of the same funds — a tradition associated methodologically with Coase and Posner.⁶ The two traditions are not, in practice, as far apart as they first appear: the Indian Supreme Court's own doctrine occupies a middle position, treating an emergency claim as close to absolute while an ongoing or non-emergency claim is treated as substantially conditioned by what the state has actually budgeted and built.⁷

B. The Economic Case for Compulsion

The canonical economic justification for public intervention in healthcare markets originates in Kenneth Arrow's 1963 analysis of uncertainty in medical care, which identified features separating healthcare from an ordinary competitive market.⁸ Demand is irregular and unpredictable at the individual level, which is why insurance rather than direct purchase is the efficient mode of finance. There is severe information asymmetry between patient and physician. Voluntary insurance markets are vulnerable to adverse selection, in which healthier people exit the pool and premiums rise for those who remain, and to moral hazard, in which insured individuals over-consume care. Healthcare also generates positive externalities, most obviously through infectious-disease control, so unregulated private markets under-provide it relative to the social optimum.

These failures supply the standard rationale for compulsory risk pooling, community rating, and public subsidy — instruments that require legal compulsion, because a voluntary insurance market cannot solve its own adverse-selection problem. This is where law and economics become inseparable: the economic case for universal coverage terminates in a demand for a legal instrument, whether a tax-financed entitlement, a purchase mandate, or an automatic-enrolment default. As Part IV shows, the choice among these instruments substantially determines whether a nominal entitlement converts into care actually received.

III. The Case for Universal Healthcare: Poverty, Illness, and Catastrophic Cost in India

A. The Poverty-Illness-Cost Cycle

The economic argument for universal healthcare in a high-income country is typically framed around efficiency. In India a second, more urgent argument applies: the absence of financial protection against illness is itself a significant driver of poverty, through a mechanism well documented in Indian survey data.

A poor or near-poor household typically has little liquid saving and limited access to affordable formal credit.⁹ When a member falls seriously ill, the household chooses between forgoing treatment — a choice a substantial share of households in fact make — and financing treatment by running down savings, selling productive assets such as livestock or land, or borrowing at high informal rates.¹⁰ Each response is corrosive: forgone treatment converts a treatable illness into a chronic or fatal one, often ending the earning capacity of the household's principal earner; depleted savings remove the buffer for education or resilience against the next shock; distress sale of land or livestock is frequently irreversible; high-interest informal borrowing can trap a

5 ICESCR (1966) 993 UNTS 3, art 12(1); Universal Declaration of Human Rights (1948) art 25(1).

6 Ronald H Coase, 'The Problem of Social Cost' (1960) 3 *Journal of Law and Economics* 1; Richard A Posner, *Economic Analysis of Law* (9th edn, 2014).

7 See Part VI.A-B below.

8 Arrow (n 1).

9 Reserve Bank of India, *Report of the Household Finance Committee* (2017).

10 Anamika Pandey and others, 'Trends in Catastrophic Health Expenditure in India: 1993 to 2014' (2018) 96 *Bulletin of the World Health Organization* 18.

household in debt servicing for years. The empirical literature describes this collectively as “distress financing,” finding its incidence rose rather than fell between 1993 and 2014, particularly among poorer and older households.¹¹

Critically, this mechanism does not require a catastrophic diagnosis to operate. A single hospitalisation of a household’s primary earner, even for a condition neither rare nor exotic, can consume in weeks what would otherwise have taken years of careful saving. Where that saving was the household’s principal buffer against poverty, a single illness can reverse several years of economic progress in one hospital admission — the specific sense in which healthcare access in India functions not merely as a welfare good but as a determinant of whether a household remains above or falls below the poverty line.

B. The Empirical Scale of the Problem

The scale of this phenomenon is large by any comparative standard. Out-of-pocket expenditure (OOPE) accounted for 43.4 per cent of India’s total health expenditure in 2022-23 according to the tenth National Health Accounts estimates, a figure that had fallen steadily from 64.2 per cent in 2013-14 before rising again as government health spending growth slowed post-pandemic.¹² Even at its lowest recorded point, India’s out-of-pocket share remained more than double the 18.1 per cent global average reported by the World Bank for 2019.¹³

The measured consequence is that a substantial share of households experience catastrophic health expenditure, defined as out-of-pocket spending equal to or exceeding ten per cent of total household consumption.¹⁴ A WHO assessment published in March 2022 found that more than seventeen per cent of Indian households incur catastrophic health expenditure annually.¹⁵ A national survey series spanning 1993–2014 found the incidence of catastrophic expenditure rose from 11.1 per cent of households in 1995-96 to 24.9 per cent in 2014, concentrated disproportionately among the poorest households.¹⁶

Translated into headcounts, a study using repeated National Sample Survey rounds between 1994 and 2014 estimated that healthcare costs push approximately fifty-five million Indians into poverty in a typical year, some thirty-eight million because of spending on medicines alone.¹⁷ Other studies, using different survey rounds and poverty lines, produce comparable estimates generally between thirty and sixty million people annually.¹⁸ The consistency of this finding across independent methodologies is itself evidence that the underlying mechanism — healthcare costs as a driver, not merely a symptom, of poverty — is real rather than an artefact of any single dataset. These are not estimates of people who are both poor and sick; they are estimates of people pushed below the poverty line specifically by healthcare spending.¹⁹

C. From Necessity to Institutional Design

None of this establishes, without further argument, which institutional response suits the Indian case; that is Part IV’s question. It does establish the paper’s threshold claim: the absence of financial protection against illness in India is not a marginal welfare concern but a first-order driver of poverty and an obstacle to broader poverty reduction.²⁰ Comparative literature modelled on high-income countries, which frames the case for reform primarily around efficiency, understates the urgency of the Indian case: the central argument here is not merely that a badly designed financing system is wasteful, though it is, but that it is actively impoverishing tens of millions of people every year.

IV. Comparative Models of Universal Healthcare: Legal and Economic Logic and Their Limits

This Part narrows the comparative lens deliberately, selecting the NHS as the principal comparator because it represents the most fully realised legally and economically coherent single-payer system,²¹ drawing on the United States only to illustrate what happens when the legal instrument needed to prevent adverse selection is withdrawn, and turning in greatest depth to India’s own model because that is the model India has actually adopted.

A. Direct Public Provision: The United Kingdom’s National Health Service

11 *ibid*, finding the proportion incurring catastrophic expenditure rose from 11.1 per cent (1995-96) to 24.9 per cent (2014), a 2.24-fold increase concentrated among poorer households.

12 Government of India, National Health Authority, *National Health Accounts Estimates for India 2022-23* (10th edn, 2026); reporting OOPE at 43.4 per cent of total health expenditure in 2022-23, up from 39.4 per cent the previous year.

13 World Bank, *World Development Indicators: Out-of-Pocket Expenditure* (2021).

14 World Health Organization and World Bank, *Global Monitoring Report on Financial Protection in Health 2021* (WHO 2022).

15 *ibid*, reporting that out-of-pocket spending impoverishes approximately fifty-five million Indians annually.

16 Pandey and others (n 10).

17 Sakthivel Selvaraj, Habib Hasan Farooqui and Anup Karan, ‘Quantifying the Financial Burden of Households’ Out-of-Pocket Payments on Medicines in India’ (2018) 8 *BMJ Open* e018020.

18 Meenakshi Nanda and Ramna Thakur, ‘A Comprehensive Examination of the Economic Impact of Out-of-Pocket Health Expenditures in India’ (2023) 38 *Health Policy and Planning* 926; One Health Trust (2022) estimate of approximately 63 million.

19 See Fahimuddin Ahmad and Pratap Chandra Mohanty on incidence and intensity of catastrophic expenditure and impoverishment.

20 See generally Selvaraj and others (n 17); Karan and others, ‘Multimorbidity, Healthcare Use and Catastrophic Health Expenditure’ (2022) 22 *BMC Health Services Research* 1151.

21 OECD, *Health at a Glance 2023* (OECD 2023).

The NHS, created by the National Health Service Act 1946 on the recommendation of the 1942 Beveridge Report, provides comprehensive care financed almost entirely from general taxation and free at the point of use.²² A single national payer that directly employs or contracts most providers gives it substantial monopsony purchasing power over wages, prices, and pharmaceutical procurement. UK health spending has historically run below the OECD average despite near-universal coverage, reaching approximately 9.3 per cent of GDP in 2022, markedly lower than the 16-17 per cent the United States spends without achieving universal coverage.²³ Because payer and provider are largely the same entity, there is no extensive billing and adjudication infrastructure, and no possibility that a patient is treated and then denied payment. The legal guarantee of access and the economic mechanism of cost control are, in this sense, the same institutional choice viewed from two angles.

The acknowledged cost is rationing by waiting time rather than price. As of late 2025 England's referral-to-treatment waiting list stood at approximately 7.3 million pathways, with roughly one in six patients waiting longer than the eighteen-week standard.²⁴ This is the clearest illustration that no financing mechanism is costless: a system eliminating financial barriers must ration by some other means. The comparative point for India is instructive nonetheless: even a chronically underfunded single-payer system that misses its own targets does not expose patients to denial of care or bankruptcy at the point of treatment. The failure mode of underfunded direct provision is delay; the failure mode of underfunded reimbursement-based insurance, as Part IV.C shows, can be denial of care altogether.

Institutional Transferability

None of this denies the NHS's value as a comparator; the point that follows goes to institutional suitability rather than intrinsic merit. Even a well-resourced single-payer system, built over nearly eighty years in a wealthy, comparatively small country, currently misses its own waiting-time standard, and there is good reason to think the same design, transplanted onto India's scale and infrastructure, would produce a materially worse failure.

Scale is the first difficulty: the UK's population is approximately 68 million against India's 1.45 billion, more than twenty times larger.²⁵ A national health service model requires the state to be, in substance, direct employer of most clinicians and owner of most hospital capacity — replicating that role at twenty times the population is not a matter of scaling a budget line proportionally.

India's existing infrastructure compounds the problem. India has approximately 0.79 government hospital beds per 1,000 population against the National Health Policy's own target of 2 and a global average of 2.7; meeting even the government's modest target would require more than doubling the existing bed stock, a shortfall estimated at 2.4 million beds.²⁶ Government estimates place India's doctor-population ratio at approximately 1:834, better than the WHO benchmark of 1:1,000, but this aggregates registered practitioners nationally, including AYUSH practitioners, and conceals large urban-rural and inter-state disparities.²⁷ If a system with a materially larger base of beds and staff, in a country of 68 million, cannot meet an eighteen-week standard, there is no basis for assuming an equivalent entitlement extended over twenty times the population from under half the recommended bed density would produce anything other than substantially longer waits.

This is not merely a projection: a partial version of exactly this dynamic is already visible in India's government tertiary care. AIIMS Delhi records an average outpatient footfall of some 14,000-15,000 patients a day, with reports as recent as September 2026 describing waits for some specialities stretching to five years, patients queuing overnight for a token number, and a dedicated overnight shelter established to accommodate them.²⁸ Other central government hospitals in Delhi have reported non-emergency surgical waits of six months to two years for want of beds, staff, and equipment.²⁹ These are failures of the existing, more limited government hospital system, not of an NHS-style entitlement India has not adopted; the concern is that extending a legal entitlement to direct public provision nationally risks converting today's documented queues into the ordinary condition of the system as a whole. This concern about transferability, rather than doubt about the NHS's coherence, informs this paper's ultimate preference for reforming India's own insurance-based architecture.

B. Mandate-Based Regulated Insurance: The Cautionary Lesson of the United States

The United States illustrates a different failure mode: a coverage expansion pursued through insurance-market regulation rather than direct provision, in which the legal instrument needed to prevent adverse selection proves politically fragile. The Affordable Care Act of 2010 required most individuals to maintain insurance or pay a penalty — the compulsory purchase mandate economic theory identifies as necessary to prevent a voluntary pool from unravelling.³⁰ In *NFIB v Sebelius* the Supreme Court held the mandate could not rest on the Commerce Clause but upheld it as a valid exercise of the taxing power.³¹ Congress reduced the penalty to zero in 2017 while retaining guaranteed-issue and community-rating rules — an almost laboratory-clean

22 National Health Service Act 1946, 9 & 10 Geo 6, c 81 (UK); Beveridge, *Social Insurance and Allied Services* (Cmd 6404, 1942).

23 OECD (n 21).

24 NHS England referral-to-treatment statistics, late 2025.

25 UK and Indian census/population estimates, 2025-26.

26 National Health Policy 2017 target; parliamentary disclosure on government hospital bed density.

27 Government doctor-population ratio estimates; WHO benchmark of 1:1,000.

28 AIIMS Delhi outpatient and waiting-time reporting, September 2026.

29 Reporting on central government hospital waiting periods in Delhi.

30 Patient Protection and Affordable Care Act, Pub L No 111-148, 124 Stat 119 (2010).

31 *National Federation of Independent Business v Sebelius* 567 US 519 (2012).

natural experiment in withdrawing legal compulsion while keeping the rest of the apparatus intact, with the predictable consequence of a less healthy, more expensive risk pool.³²

The lesson is not that mandate-based private insurance is inherently unworkable; several European systems combine competing insurers with compulsory participation successfully.³³ The lesson is narrower: an insurance-based coverage guarantee is only as durable as the legal mechanism keeping a broad, solvent risk pool intact, and that mechanism is a legal choice, not an automatic feature of insurance markets. The US also illustrates that expenditure is a poor proxy for legal universality: despite the highest per-capita health spending among high-income countries, the absence of a uniform legal entitlement has produced persistent access gaps, particularly for low-income households in states that declined to expand Medicaid.³⁴

Even where a mandate survives, nominal coverage does not translate reliably into effective protection. The Commonwealth Fund's 2024 survey found the uninsured rate had fallen to about eight per cent, yet 23 per cent of continuously insured working-age adults were underinsured, meaning their costs were high enough relative to income that they could not reliably afford care.³⁵ More than half of underinsured respondents reported avoiding needed care on cost grounds, and roughly half of those with medical debt owed \$2,000 or more, most commonly traced to a single hospital stay.³⁶ A further gap persists in the ten states that declined Medicaid expansion, where an estimated 1.5 million of the poorest residents remain wholly uncovered.³⁷

Medical bankruptcy illustrates the same point from a different angle, and the literature is genuinely contested. A 2019 Consumer Bankruptcy Project study found medical problems contributed to an estimated 66.5 per cent of bankruptcies between 2013 and 2016, statistically indistinguishable from the pre-ACA period and not differing significantly by Medicaid-expansion status.³⁸ Other researchers, using panel-data methods on state-level filings between 2008 and 2017, found Medicaid expansion associated with a modest but significant reduction in overall bankruptcy rates.³⁹ The findings are not strictly incompatible, but their coexistence counsels caution against any simple claim that coverage expansion resolves the risk of medical financial catastrophe.

A further, India-relevant limitation is administrative complexity. The ACA marketplace requires an enrollee to compare plans across metal tiers, estimate future income to calculate a premium tax credit later reconciled against actual income, distinguish deductible from co-payment from coinsurance, and identify in-network providers, all within an annual window. Multiple surveys of insured American adults, mostly native English speakers with a literacy rate above 98 per cent, have found a majority cannot correctly define these basic terms: one survey found 77 per cent could not correctly define "coinsurance" and 46 per cent could not define "copayment"; only 4 per cent could correctly define every term tested.⁴⁰ A multi-year survey series similarly found fewer than a third could correctly define copay, deductible, and premium together.⁴¹

If this degree of confusion arises among a literate, English-speaking population navigating one national marketplace, unmodified transplantation to India would be considerably more precarious, and the burden would fall on exactly the population any scheme is meant to protect. India's literacy rate stands at 80.9 per cent for persons aged seven and above, but this conceals a rural rate of 77.5 per cent against an urban 88.9 per cent, and female literacy well below both in poorer states: rural female literacy stood at 61.8 per cent in Rajasthan, 65.0 per cent in Bihar, and 62.6 per cent in Madhya Pradesh.⁴² These are largely the same states and groups PM-JAY targets, since poorer, less literate, rural households are systematically over-represented among its beneficiaries. A design requiring beneficiaries to compare products, calculate subsidies, or contest denied claims imposes a burden correlating inversely with the characteristics that make a household eligible in the first place — a further reason to prefer the comparatively low-complexity design of a single cashless card over an ACA-style marketplace of consumer choice.

A related limitation concerns the difficulty of regulating a market of many competing private payers. The United States has several hundred licensed insurers operating primarily under state-based regulation under the McCarran-Ferguson Act, each separately negotiating rates and maintaining its own network and prior-authorisation rules.⁴³ The absence of a single point of price control, which the NHS's monopsony supplies as a matter of course, requires blunt instruments — network-adequacy standards, minimum medical-loss ratios, price-transparency rules — whose effectiveness remains contested and has not prevented the affordability problems above.⁴⁴ Germany manages a structurally similar multi-payer design but achieves more uniform

32 Tax Cuts and Jobs Act 2017, reducing the individual mandate penalty to zero.

33 Reinhard Busse and Miriam Blumel, 'Germany: Health System Review' (2014) 16(2) Health Systems in Transition 1.

34 *NFIB v Sebelius* (n 31), making Medicaid expansion optional for states.

35 Commonwealth Fund, *State of Health Insurance Coverage in the US: 2024 Biennial Survey* (2024).

36 *ibid.*

37 *ibid.*

38 David U Himmelstein, Robert M Lawless, Deborah Thorne, Pamela Foohey and Steffie Woolhandler, 'Medical Bankruptcy: Still Common Despite the Affordable Care Act' (2019) 109 American Journal of Public Health 431.

39 Maude Laberge and Kodjo-Maawuegnigan Djiffa, 'The Effect of the Affordable Care Act Medicaid Expansion on Consumer Bankruptcies' (2023) 75 Bulletin of Economic Research 1344.

40 Surveys of insured American adults on health-insurance literacy, cited in health-policy literature.

41 Multi-year insurance-literacy survey series by an insurance information provider.

42 Periodic Labour Force Survey 2023-24 (National Sample Survey Office).

43 McCarran-Ferguson Act 1945, 15 USC §§ 1011-1015.

44 See generally health-policy literature on network-adequacy and medical-loss-ratio regulation.

outcomes through centralised risk-adjustment and collectively negotiated fee schedules, a degree of centralisation the American system has not replicated.⁴⁵

A further limitation, material to the ceiling on cost containment achievable, is the pharmaceutical industry's demonstrated capacity to constrain price regulation through political influence. PhRMA and its members spent at least \$142.6 million lobbying in the first half of 2022 alone in an ultimately unsuccessful effort to prevent the Inflation Reduction Act's Medicare drug-price negotiation provisions.⁴⁶ Even as enacted, those provisions permit negotiation for only ten drugs from 2026, rising to sixty by 2029, out of thousands on the market, and do not extend to prices charged private insurers; 2025 legislation further narrowed the programme's scope.⁴⁷ The industry continued litigating against even this limited authority.⁴⁸ The result is that US prescription drug prices for identical products are estimated at roughly three times the OECD average, with the US alone accounting for between two-thirds and three-quarters of global pharmaceutical industry profits.⁴⁹ For India, the lesson is that political economy, not merely legal design, constrains what negotiated purchasing can achieve once a politically resourced industry has a direct stake — a point that recurs, in Indian register, in private hospital resistance to PM-JAY package rates below.

C. India's Model: Ayushman Bharat and the Limits of Reimbursement-Based Insurance

1. The Scheme's Design and Scale

Launched in September 2018, PM-JAY is the insurance component of Ayushman Bharat and, by enrolment, the largest publicly funded health assurance scheme in the world.⁵⁰ It provides an annual family-floater entitlement of five lakh rupees for secondary and tertiary hospitalisation, covering roughly 1,900-1,960 procedures across 27 specialities, for households identified as falling within the poorest forty per cent of the population, extended in 2024 to all citizens aged seventy and above regardless of income.⁵¹ As of December 2025, over 42 crore Ayushman cards had been issued and approximately 11 crore hospital admissions authorised, with claims exceeding one lakh crore rupees processed through over 36,000 empanelled hospitals; the government reports more than one lakh crore rupees in household expenditure averted.^{52,53} Legally, the National Health Authority, through State Health Agencies, either purchases insurance or self-administers a trust-based model, reimbursing empanelled hospitals directly on a package-rate basis, designed to be cashless at the point of use.⁵⁴

2. The Gap between Nominal Coverage and Effective Access

PM-JAY's economic logic is sound in basic structure: it pools risk, targets subsidy toward those least able to pay, and is nominally cashless so the beneficiary need not front the cost. In practice, a substantial body of evidence indicates the cashless design frequently breaks down at the patient-hospital-government interface.

Three failure modes recur. First, effective reach depends on hospitals continuing to find participation worthwhile; when a State Health Agency falls behind on reimbursement, hospitals have suspended services. In 2025, hundreds of private hospitals in Haryana and Jammu and Kashmir suspended cashless treatment over unpaid dues running into hundreds of crores, leaving cardholders to pay out of pocket or travel elsewhere.⁵⁵ As one health economist put it, delayed reimbursement "undermines" the very leverage the model depends on.⁵⁶ Second, package rates are often set well below actual treatment cost, particularly for complex tertiary procedures, creating an incentive to limit admissions, under-treat, or informally seek additional payment; one widely cited assessment found package rates covered less than thirty per cent of actual hospital charges for several procedure categories.⁵⁷ Third, the scheme's inpatient-only design excludes the outpatient diagnostic and medication costs that constitute a large share of overall out-of-pocket spending, leaving beneficiaries who are never admitted, or who need ongoing medication beyond the fifteen-day post-discharge window, unprotected.⁵⁸ Field research in weaker-capacity regions has documented additional barriers including informal payments demanded despite cashless design, claim rejections, documentation burdens, and physical inaccessibility of empanelled facilities.⁵⁹

These failure modes share a structural feature: each reintroduces, at one remove, the financing barrier the scheme exists to remove. A cardholder turned away because government has not paid its bills faces exactly the choice — forgo treatment or pay out of pocket — PM-JAY exists to eliminate. A patient

45 Busse and Blumel (n 33).

46 PhRMA lobbying disclosures, first half of 2022.

47 Inflation Reduction Act 2022, Medicare drug-price negotiation provisions; 2025 amending legislation.

48 PhRMA litigation against Medicare drug-price negotiation, 2023-2025.

49 OECD cross-country pharmaceutical price comparisons.

50 National Health Authority, PM-JAY programme documentation.

51 *ibid*; 2024 extension to citizens aged seventy and above.

52 National Health Authority enrolment and claims data, December 2025.

53 *ibid*, on household expenditure averted.

54 National Health Authority, *PM-JAY Operational Guidelines*.

55 Reporting on Haryana and Jammu and Kashmir hospital service suspensions, 2025.

56 Health economist quoted in reporting on PM-JAY payment delays (n 55).

57 Industry assessment of PM-JAY package rates relative to actual hospital charges.

58 PM-JAY benefit design excluding outpatient and extended post-discharge costs.

59 Field research on PM-JAY implementation barriers in Jammu and Kashmir.

asked to make up a shortfall between package rate and actual cost experiences a diminished but real version of the same barrier. A person needing outpatient care experiences the barrier undiminished, because the scheme was never designed to reach it.

3. Does Reimbursement-Based Insurance Protect Those Who Cannot Front the Cost of Treatment?

This is the central design question this paper addresses, and the honest answer is: only imperfectly, and only where the state reliably and promptly pays the provider. PM-JAY's cashless design is meant to avoid the classical reimbursement problem, in which a patient must pay first and claim later — a structure offering no protection to a household that cannot raise the money to pay first. Where PM-JAY functions as designed, it avoids this by shifting financing risk onto the hospital, which treats first and is reimbursed later. But this only relocates the risk. Where government is a slow or unreliable payer, hospitals rationally decline to bear that risk, pushing the burden back onto the patient as demanded upfront payment or refusal of service. A scheme cashless for the patient only for as long as the hospital extends unsecured credit to the government is not structurally different, from the beneficiary's point of view, from a conventional reimbursement scheme once that willingness runs out.

This is why the distinction between nominal coverage and effective access is legally and economically precise, not rhetorical. Nominal coverage is what a card or enrolment statistic records; effective access is what a person can obtain at a hospital counter at the moment of need, without producing cash they do not have. The gap is substantially a matter of whether the machinery connecting beneficiary, hospital, and payer functions reliably enough that the hospital is prepared to treat first and be paid later, every time. Part VI returns to this in constitutional terms.

4. Toward Institutional Fit: Reforming Rather Than Replacing PM-JAY

The preceding analysis, together with the NHS's transferability problems and the American alternative's limitations, points to a conclusion made explicit here: PM-JAY's basic design — a publicly administered, cashless, targeted insurance entitlement — is plausibly better suited to India's circumstances than wholesale conversion to either comparator model. This is not a claim that PM-JAY as implemented is adequate; the failures documented above are real. It is a claim about their character: principally procedural, administrative, and financial rather than defects of institutional logic, and therefore more remediable through incremental reform than a change of model.

Four reforms follow. First, financial coverage requires substantial upward revision to reflect actual treatment costs: industry assessments find package rates cover well under a third of actual private-hospital charges in several categories, a pricing structure the Association of Healthcare Providers of India says is a primary reason major chains have not empanelled.⁶⁰ A credible revision requires the rigorous, transparent costing study the National Health Authority's own chief executive has acknowledged has not yet been undertaken.⁶¹

Second, expanding the empanelled hospital network, including major chains that have so far participated only partially, is necessary if the cashless design is to reach patients wherever they present. Most empanelled private hospitals have fewer than fifty beds, and districts with fewer empanelled hospitals show lower utilisation.⁶² Apollo, Fortis, Max, Medanta, and Manipal have either not empanelled or done so only selectively, citing package rates and payment delay together; addressing only one is unlikely to secure broader participation.⁶³

Third, strict, enforceable regulation of hospital charges and payment timelines is required. India already has a working precedent in an adjacent area: the National Pharmaceutical Pricing Authority's 2017 ceiling-price orders for coronary stents and knee implants cut average prices by up to 85 and 70 per cent respectively.⁶⁴ This demonstrates the state's capacity to impose binding price discipline when it chooses to; extending a comparably rigorous approach to package rates and payment timeliness is institutionally plausible.

Fourth, effective enforcement against fraud is a precondition for any expansion. By mid-2026, government disclosures recorded over 2,000 hospitals de-empanelled or suspended for fraud, penalties exceeding Rs 328 crore, at least 29 FIRs, and an estimated Rs 676 crore in suspicious claims blocked through an AI-based National Anti-Fraud Unit flagging irregular billing within 24 hours.⁶⁵ The Gujarat case, in which a hospital chain allegedly ran fraudulent camps referring patients for unnecessary cardiac procedures resulting in over a hundred reported deaths, illustrates both the severity of unchecked fraud and that detection occurred only after patients had died, rather than through automated pre-payment checks.⁶⁶ The anti-fraud apparatus still functions substantially as an after-the-fact billing-pattern detector rather than a mechanism preventing inappropriate treatment before it occurs.

Together these describe a programme of institutional consolidation, better financing, wider and more reliable provider participation, firmer price discipline, and more rigorous fraud control within the existing framework, rather than a case for replacing it.

D. Public Provision versus Insurance-Based Purchasing: A Comparative Assessment

Setting the three models side by side yields a specific conclusion. Direct public provision avoids the reimbursement problem altogether by collapsing payer and provider into one entity accountable through ordinary public administration; its failure mode is rationing by delay, serious but comparatively visible and accountable. Mandate-based private insurance avoids the reimbursement problem for the insured population but depends on a legal mandate

60 Association of Healthcare Providers of India statements (n above); industry package-rate assessments.

61 National Health Authority chief executive, public statements on costing methodology.

62 Independent research on PM-JAY empanelment distribution and utilisation.

63 Reporting on major private hospital chains' PM-JAY participation, citing rates and payment delay.

64 National Pharmaceutical Pricing Authority ceiling-price orders for coronary stents (2017) and knee implants (2017).

65 Parliamentary disclosures on PM-JAY fraud enforcement, National Anti-Fraud Unit, mid-2026.

66 Reporting on the Gujarat unnecessary-cardiac-procedure investigation.

that has proved politically contestable and reversible, producing persistent coverage gaps. India's targeted, cashless, but reimbursement-financed model avoids requiring the poorest patients to pay and claim, a genuine improvement over pure reimbursement, but reintroduces financing risk at the hospital-government interface, currently borne by the patient rather than the state.

None of this suggests India's model should be abandoned for wholesale replication of either comparator. Given the NHS's transferability problems, the ACA's limitations, and the considerable fiscal distance shown in Part V, India's own insurance-based model is plausibly the more suitable starting point — not because current performance is adequate, but because its deficiencies are principally financial, administrative, and procedural rather than defects in the underlying design choice. PM-JAY's success cannot be judged by enrolment or nominal benefit value alone; it must include the reliability of the payment chain between government and provider, which is what determines whether coverage is effective rather than merely nominal.

E. Regulatory Capacity and the Practical Accessibility of Insurance-Based Entitlements

The reform programme above depends on a premise requiring separate scrutiny: that a scheme of this complexity can be operated and policed effectively within India's existing capacity, and that the resulting entitlement is one an ordinary beneficiary can actually use. The legal availability of a remedy is not the same as the practical ability of a poor, rural, or low-literacy beneficiary to use it in time to matter.

The literacy and awareness constraints examined in Part IV.B apply, if anything, with greater force to PM-JAY. Field research in Jammu and Kashmir found a substantial share of cardholders faced documentation burdens, uncertainty about coverage, and confusion about pre-authorisation, attributed partly to limited beneficiary awareness.⁶⁷ An entitlement of this kind requires effective oversight along at least four dimensions: supervision of insurers and administering agencies for solvency and good-faith claims handling; transparent, time-bound claims procedures with a genuine appeal right; enforceable control of provider charges; and a credible investigatory authority over fraud.

The record here is uneven. IRDAI supplies general insurance oversight through its Bima Bharosa grievance portal and the insurance ombudsman system.⁶⁸ It processed over 2.5 lakh grievances in 2024-25, up roughly twenty per cent year on year, and its own annual report recorded 3.26 crore health claims nationally, 87 per cent settled and 8 per cent repudiated.⁶⁹ Yet asked in Parliament to disaggregate repudiation reasons by insurer, IRDAI stated such data were not available — a gap limiting its capacity to act against insurers with poor claims practices.⁷⁰ Bima Bharosa also requires a beneficiary first to lodge a complaint with the insurer and wait fifteen days before escalating, presupposing a level of procedural persistence Part IV.B's literacy data gives reason to doubt is evenly distributed.⁷¹

By contrast, the National Anti-Fraud Unit appears more operationally active within its domain: de-empanelment of over 2,000 hospitals and penalties exceeding Rs 328 crore by mid-2026 is more concrete than IRDAI's own acknowledged data gap.⁷² This asymmetry suggests institutional capacity is unevenly distributed rather than uniformly weak, and that reform built around the National Health Authority's own administering machinery may be more tractable than one depending on the general insurance regulator.

The Competition Commission of India illustrates the same point differently. It closed a 2016 cartelisation investigation without a finding of contravention, and in May 2026 concluded a near-decade inquiry into hospital "aftermarket" billing by rejecting that theory.⁷³ A decade-long inquiry closing without operative relief is not strong evidence that competition law reliably checks hospital pricing conduct; the NPPA's device-specific interventions have done more concrete work.

The Consumer Protection Act 2019 supplies a further formal avenue — the Supreme Court held in *Indian Medical Association v P P Shantha* that medical services are "service" within the Act.⁷⁴ Its practical accessibility to a poor PM-JAY beneficiary is doubtful: a 2026 assessment found ninety of India's 775 districts had no functioning consumer forum, average case-disposal time stood at 647 days, over five lakh cases were pending, and roughly half of state commissions lacked a president; the Chief Justice personally intervened in August 2026 after press reporting of a case unlisted for three years.⁷⁵ A remedy averaging close to two years, possibly unavailable in a beneficiary's own district, is a poor substitute for urgent, cashless treatment.

The overall picture is neither that India lacks capacity to regulate a scheme of this complexity, nor that such capacity is already adequate: it is uneven, strong within the National Health Authority's fraud-detection function and the NPPA's pricing role, markedly weaker within IRDAI's data infrastructure, competition-law enforcement, and consumer dispute resolution. This unevenness favours reforms implementable through the National Health Authority's own machinery over reforms depending on institutions not yet well placed to perform reliably.

67 Field research on PM-JAY cardholder awareness and documentation barriers, Jammu and Kashmir (n 59).

68 Insurance Ombudsman Rules 2017 (Notification GSR 413(E)).

69 IRDAI, *Annual Report 2024-25*; Bima Bharosa grievance-portal data.

70 Parliamentary questions on IRDAI claims-repudiation data disaggregation.

71 Bima Bharosa procedural requirements; PM-JAY trust/hybrid administrative models.

72 National Health Authority enforcement disclosures (n 65).

73 Competition Commission of India, 2016 order and 21 May 2026 order on hospital aftermarket pricing.

74 *Indian Medical Association v P P Shantha* (1995) 6 SCC 651.

75 India Justice Report, *Consumer Justice Report 2026*; reporting on Chief Justice intervention, August 2026.

V. Fiscal and Economic Feasibility of Universal Healthcare in India

A. The Current Expenditure Baseline

Total government health expenditure (GHE) rose from approximately 1.30 lakh crore rupees in 2013-14 to 3.85 lakh crore rupees in 2022-23, or from 1,042 to 2,786 rupees per capita.⁷⁶ As a share of GDP, GHE rose from 1.15 per cent to 1.43 per cent (1.48 per cent under the revised base-year series), briefly reaching 1.84 per cent in 2021-22 owing to pandemic spending, and as a share of general government expenditure from 3.78 to 4.89 per cent.⁷⁷ The National Health Policy 2017 set a target of 2.5 per cent of GDP by 2025, a target the country has not met and appears unlikely to meet on schedule.⁷⁹

B. Estimated Additional Cost of Universal Health Coverage

Three independent estimates converge, with meaningful variation, on the order of magnitude required. The High Level Expert Group on Universal Health Coverage recommended 2.5 per cent of GDP by 2017 and 3 per cent by 2022.⁸⁰ Ernst & Young estimated 3.75 to 4.5 per cent of GDP by 2022 was needed for comparable coverage.⁸¹ A peer-reviewed model-based estimate in *PLOS ONE* extrapolated a national requirement of approximately 3.8 per cent of GDP (95% CI 2.1-6.8 per cent).⁸² These figures rely on differing assumptions about benefit design and the public-private balance and should be read as illustrative rather than authoritative, but they agree directionally: closing the gap from India's current 1.4-1.5 per cent of GDP would require, conservatively, close to a doubling of that share, and on more demanding estimates a tripling or more — materially larger than the National Health Policy's own 2.5 per cent target.

C. Financing Options and Fiscal Sustainability

Additional revenue could be raised through several instruments with distinct incidence. General taxation offers the broadest risk pool and least direct link between an individual's consumption and contribution, at the cost of competing with other public priorities. Earmarked social-insurance contributions on formal-sector wages, as in several European systems, are limited by India's large informal-sector workforce, which would require either a large general-revenue subsidy or a coverage gap for exactly the population PM-JAY targets.⁸³ Targeted excise increases on tobacco and sugar-sweetened beverages can raise incremental revenue while reducing future disease burden, though the revenue realistically achievable is modest relative to the financing gap.⁸⁴

Any instrument carries an opportunity cost that must be stated honestly: rupees devoted to health financing are rupees not devoted to schools, roads, or debt reduction. The most defensible argument for treating health expenditure as partially self-financing rests on Part III's material: to the extent catastrophic expenditure currently pushes tens of millions below the poverty line, that cost is currently borne inefficiently through irreversible asset sales, high-interest borrowing, and forgone treatment producing costlier complications later, rather than through pooled financing spreading the cost more efficiently. Reducing catastrophic expenditure is plausibly welfare-improving before accounting for productivity gains from a healthier workforce — a claim about efficiency and distribution, not that expanded coverage is fiscally costless.

D. Distinguishing Existing Expenditure, Additional Requirement, and Projection

Three categories should be kept analytically distinct. First, existing expenditure: government health spending stood at approximately 1.43-1.48 per cent of GDP in 2022-23, alongside comparable or larger private out-of-pocket expenditure and a small, growing insurance share.⁸⁵ Second, the additional public expenditure to meet India's own stated target: reaching 2.5 per cent of GDP would require government health spending to rise roughly seventy to eighty per cent in relative terms — substantial but not unprecedented, given GHE has already more than tripled in absolute rupee terms over the preceding decade.⁸⁶ Third, illustrative long-run projections of 3 to 4.5 per cent of GDP across the HLEG, Ernst & Young, and *PLOS ONE* estimates indicate the order of magnitude of a longer-term aspiration rather than a costed near-term budget line. Conflating the second and third categories risks discrediting the case for incremental reform by attaching to it a figure neither necessary for meaningful near-term progress nor achievable in the relevant time frame.

VI. Constitutional and Legal Design: Article 21, State Obligation, and the Architecture of Entitlement

A. The Foundational Cases: An Absolute Duty in Emergencies

India's constitutional right to health has been read into Article 21's right to life rather than enacted as a freestanding textual right. In *Parmanand Katara v Union of India*, the Supreme Court held Article 21 obliges the state to preserve life, and every doctor, government or private, must extend medical aid

76 National Health Accounts Estimates for India 2022-23 (n 12).

77 *ibid*; reporting under the revised GDP base-year series.

78 *ibid*.

79 National Health Policy 2017 target of 2.5 per cent of GDP by 2025.

80 High Level Expert Group Report on Universal Health Coverage for India (2011).

81 Ernst & Young estimate, cited in Observer Research Foundation, 'The Road to Universal Health Coverage' (2023).

82 Shankar Prinja and others, 'The Cost of Universal Health Care in India: A Model Based Estimate' (2012) 7 *PLOS ONE* e30362.

83 Busse and Blumel (n 33), on wage-based social insurance preconditions.

84 World Health Organization, *WHO Technical Manual on Tobacco Tax Administration* (2021).

85 National Health Accounts Estimates for India 2022-23 (n 12).

86 *ibid*, noting GHE rose from approximately Rs 1.30 lakh crore (2013-14) to Rs 3.85 lakh crore (2022-23).

to preserve life without waiting for procedural formalities in an emergency.⁸⁷ The Court extended this in *Paschim Banga Khet Mazdoor Samity v State of West Bengal*, holding that a state's failure to provide timely treatment violates Article 21, and — critically — that the state cannot invoke financial constraints as a defence.⁸⁸ Together these establish an unusually demanding standard for denial of emergency treatment: the duty to preserve life in an emergency is close to absolute, unqualified by the “reasonableness within available resources” standard other jurisdictions, such as South Africa, apply to socio-economic rights more broadly.⁸⁹

B. The Qualified Cases: Reimbursement, Not Entitlement, for Non-Emergency and Ongoing Care

The doctrine looks different once the claim moves to an ongoing entitlement to reimbursement for non-emergency care. In *State of Punjab v Ram Lubhaya Bagga*, a government employee sought full reimbursement of cardiac surgery costs after the government capped reimbursement at AIIMS-comparable rates rather than the higher rate actually charged.⁹⁰ The Court held the state could place such a limit without violating Article 21 or 47, provided the capped rate itself represented a reasonable and adequate standard of care.⁹¹ The earlier *State of Punjab v Mahinder Singh Chawla* had established a right to timely treatment at state expense for government employees, but *Ram Lubhaya Bagga* clarifies this does not extend to unlimited reimbursement of whatever a private provider charges.⁹²

This case law establishes a distinction directly relevant to PM-JAY's design: Indian law already recognises a difference between an entitlement to receive adequate care, dischargeable through a capped, pre-negotiated rate, and an entitlement to unlimited reimbursement of actual cost, which the state need not provide. The legally significant variable is not the rate's generosity but whether the beneficiary can, at the point of treatment, actually obtain adequate care at that rate without first producing money they do not have. A capped-rate system is unobjectionable where the cap is genuinely adequate and treatment is available without upfront payment; it becomes constitutionally troubling, on *Paschim Banga*'s logic, where the cap is set so far below actual cost, or the payment chain so unreliable, that the practical effect is the same denial *Paschim Banga* held impermissible.

C. Article 47 and the Relationship between Directive Principle and Enforceable Right

Article 47, among the Directive Principles, directs the state to regard raising nutrition, living standards, and public health as among its primary duties.⁹³ Directive Principles are not, by Article 37's terms, judicially enforceable, but the Court has repeatedly read Part III rights, including Article 21, in light of Part IV principles.⁹⁴ Article 47 supplies the substantive policy content while Article 21, as interpreted above, supplies the enforceable mechanism. The practical significance is that a scheme implementing Article 47's goal, such as PM-JAY, does not become immune from Article 21 scrutiny merely because it is framed as directive-principle policy; where its design produces the same practical denial *Paschim Banga* addressed, that framing does not insulate implementation from Article 21's standard.

D. Designing Entitlement: Financing, Accountability, and Enforceability

An Article 21-consistent, economically coherent design would need at least four elements PM-JAY addresses only partially. First, entitlement should be defined in terms of care received rather than money reimbursed, following *Ram Lubhaya Bagga*'s logic; PM-JAY's cashless design already reflects this in principle, but its operation depends on a payment chain not itself legally guaranteed. Second, financing must be a legally enforceable feature of the entitlement rather than annual budgetary discretion, given that the state's own payment delay is the demonstrated failure mode; a statutory or ring-fenced financing mechanism, analogous to conditional-grant structures other federal systems use, would address this more directly than raising the nominal benefit ceiling.⁹⁵ Third, accountability requires State Health Agencies be subject to a transparent, time-bound, judicially cognisable duty to settle claims, so delayed payment becomes legally actionable rather than resolved only through ad hoc negotiation. Fourth, the doctrinal absolutism of *Paschim Banga* should be extended, as a matter of statutory design, to the situation where an empanelled hospital refuses treatment because government has not paid its dues — functionally indistinguishable, from the patient's perspective, from the denial *Paschim Banga* held impermissible, regardless of whether the denying institution is a government hospital or a private one invoking an unpaid government bill.

VII. Policy Implications and Recommendations

Several recommendations follow, framed as incremental strengthening of India's existing architecture rather than wholesale replacement, consistent with Part V's fiscal constraints.

First, PM-JAY's payment architecture should guarantee providers payment within a statutorily fixed period, with automatic escalation such as accruing interest penalties on default, since payment delay, not the nominal entitlement's level, is the proximate cause of the coverage failures documented above.

⁸⁷ *Parmanand Katara v Union of India* AIR 1989 SC 2039.

⁸⁸ *Paschim Banga Khet Mazdoor Samity v State of West Bengal* (1996) 4 SCC 37.

⁸⁹ cf *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC).

⁹⁰ *State of Punjab v Ram Lubhaya Bagga* (1998) 1 SCR 1120.

⁹¹ *ibid*; see also *Lt Col B S Dhanda v Union of India*.

⁹² *State of Punjab v Mahinder Singh Chawla* (1997) 2 SCC 83.

⁹³ Constitution of India 1950, art 47.

⁹⁴ Constitution of India 1950, art 37; see *Paschim Banga* (n 3) and *Parmanand Katara* (n 3).

⁹⁵ cf the conditional-grant structure of the Canada Health Act, RSC 1985, c C-6.

Second, the exclusion of outpatient diagnostic and post-discharge medication costs should be reconsidered given their large share of the expenditure the scheme is meant to prevent; a modest, means-tested outpatient benefit would close a gap the current design leaves entirely unaddressed.

Third, government health expenditure should rise toward the National Health Policy's own 2.5 per cent of GDP target as a near-term, achievable milestone, distinguished from the more demanding 3–4.5 per cent range; financing through general revenue reallocation and targeted tobacco and sugar-sweetened-beverage excise increases offers a defensible path.

Fourth, and most directly responsive to this paper's legal argument, future amendment of PM-JAY should draw explicitly on the *Ram Lubhaya Bagga/Paschim Banga* distinction, codifying a beneficiary's right to receive treatment without upfront payment as a directly enforceable statutory entitlement correlative to a State Health Agency's duty to keep providers current.

Fifth, package rates require revision through a rigorous, transparent, periodically updated costing methodology rather than government-hospital-derived rates, pursued together with the payment-timeliness reform above, since private hospitals cite both low rates and payment delay as reasons for non-participation.

Sixth, empanelment strategy should include a time-bound effort to bring major private chains into the scheme on a full-network basis; the common-empanelment and standardised-tariff mechanisms already under discussion in India's private insurance market suggest a comparable framework is institutionally realistic.

Seventh, hospital and device charges should be brought within a more systematic price-regulation framework, extending the NPPA's model beyond stents and implants to a wider set of consumables and, ultimately, to package-rate methodology itself.

Eighth, the National Anti-Fraud Unit should be expanded and better resourced, shifting its capability from after-the-fact billing-pattern analysis toward earlier, clinically informed screening of the kind that might have limited the harm in the Gujarat case.

Ninth, given regulatory capacity's uneven distribution, reform priority should favour strengthening institutions already showing operational capacity — the National Health Authority's own machinery and the NPPA's price-control function — over expecting the general insurance regulator, competition authority, or consumer-dispute system to close the same gaps in the near term; this is a claim about sequencing, not against improving those institutions in parallel over a longer horizon.

VIII. Discussion and Limitations

This paper's central claim invites several qualifications. First, it relies on a narrow set of comparators chosen for analytical focus; systems combining regulated multi-payer competition with compulsory participation, as in several European countries, may be more institutionally transferable to a federal system with a large informal-sector workforce than a fully unified single-payer model, a possibility a fuller comparative treatment would need to evaluate.

Second, the empirical estimates of catastrophic expenditure and impoverishment in Part III, while consistent in order of magnitude, vary with the poverty line, survey round, and threshold used, and should be read as a converging range rather than a precise figure; similarly the fiscal estimates in Part V span roughly 2.5 to 7 per cent of GDP at the extremes, and the paper's conclusion that meaningful progress requires roughly doubling current expenditure should be read as a defensible inference from that range rather than a claim to precision the data do not support.

Third, the central legal argument — that *Ram Lubhaya Bagga* and *Paschim Banga* together imply a judicially enforceable duty on State Health Agencies to keep PM-JAY providers current — has not been tested directly in this factual context in Indian courts, and remains a normative argument for how courts should rule rather than a description of settled law.

Fourth, the comparative-institutional-fit argument is itself a contestable normative judgment rather than an empirically settled one. It projects India's current infrastructure and literacy constraints forward using present-day data, without modelling how those constraints might change over a longer reform horizon through sustained investment or improved insurance literacy. Nor does the paper claim regulated multi-payer competition has been ruled out as a longer-term option; the argument is only that, on today's evidence, incremental reform of India's existing architecture is the more institutionally credible starting point, not the only model India could ever sustain.

IX. Conclusion

Universal healthcare in India cannot be understood as either a purely legal achievement, secured once a right to health is judicially recognised, or a purely economic one, secured once sufficient funds are appropriated. India already possesses both elements in some form: a constitutional right to emergency care enforced since 1989, and an insurance scheme that has issued Ayushman cards to a majority of the eligible population and financed over ten crore hospital admissions. Yet catastrophic, impoverishing health expenditure affecting tens of millions every year demonstrates that a right and a scheme are not, by themselves, sufficient. What is missing is the legal machinery connecting the two: a design treating the beneficiary's entitlement as a right to receive treatment without upfront payment, backed by a legally enforceable duty on the state to keep providers paid, rather than a right satisfied on paper while remaining contingent, at the moment of illness, on facts outside the beneficiary's control. The UK's direct-provision model and the cautionary American experience both point toward the same lesson, adapted to India's circumstances: a coverage guarantee is only as real as the mechanism making it unnecessary for a person to have money in hand before receiving care. Neither comparator offers a model to transplant wholesale: direct public

provision, extended over India's population from its current base, would trade financial denial for waiting-time rationing considerably worse than the UK's own difficulties, while a competitive private-insurance market, even nominally universal, can leave affordability, complexity, and industry influence over pricing substantially unresolved. The more institutionally credible path is reform of India's own insurance-based architecture: closing the gap will require a fiscal commitment considerably larger than the country has so far made, a wider and more reliably paid private hospital network, and regulatory capacity concentrated where it is already developing rather than dispersed across institutions not yet equal to the task. Neither the fiscal commitment nor the legal and regulatory redesign is sufficient without the other.

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