Anusandhanvallari
Vol 2024, No.1
December 2024
ISSN 2229-3388

Healthcare at a Cost: Examining Out-Of-Pocket Expenditure and the Right to Health in India and Beyond

[1]Saket Kumar, [2]Dr. Anchal Mittal Aggarwal

[1]Ph.D. Scholar, Faculty of Law, SGT University, Gurugram.

[2]Associate Professor, Faculty of Law, SGT University, Gurugram.

Abstract

The right to health, a fundamental component of human dignity, is implicitly protected by the Indian constitution. Despite this, a sizable proportion of India's population is in financial trouble as a result of excessive out-of-pocket (OOP) medical costs. This study investigates the constitutional basis of the Right to Health, assesses the impact of out-of-pocket expenses, and evaluates the legislative and regulatory framework for managing healthcare costs. It also offers a comparative review of foreign healthcare systems and emphasises judicial precedents. The study concludes with recommendations for reducing the financial burden of healthcare while guaranteeing fair access and protecting fundamental rights.

Key Words: Healthcare, Out-Of-Pocket, Right to Health, Article 21, Ayushman Bharat (PM-JAY).

I. Introduction

The Right to Health includes healthcare services that are available, accessible, acceptable, and of high quality. While India has made achievements in healthcare, nearly 63 million Indians are forced into poverty every year due to OOP charges, which include costs for consultations, tests, prescriptions, and hospitalisations (National Health Accounts, 2021).

India's healthcare system has substantial discrepancies. Government healthcare facilities, while economical, are frequently unavailable due to inadequate infrastructure and geographic limits. As a result, the private healthcare sector dominates, accounting for more than 70% of all service providers and frequently demanding exorbitant costs. This study explores the relationship between the Right to Health and the financial constraints provided by out-of-pocket payments, examining constitutional provisions, judicial interpretations, and international best practices.

II. Constitutional Perspective On The Right To Health

The Indian Constitution protects fundamental rights and outlines the state's responsibility to promote social welfare. The Right to Health, while not officially mentioned, is derived from multiple constitutional provisions:

Right To Life Enshrined Under Article 21

The Indian Constitution, while not directly recognising the Right to Health as a basic right, does so implicitly through numerous articles, most notably Article 21 pertaining to Right to Life and Personal Liberty. It is regarded as the heart of fundamental rights, including crucial rights.

The Supreme Court of India regarded the right to health as an integral component of the right to life, requiring the state to ensure access to sufficient healthcare. Despite these constitutional safeguards, out-of-pocket (OOP)

medical expenses continue to be a considerable hardship for the vast majority of Indians, limiting access to adequate healthcare services.

A significant facet of Right to Life under Article 21 of the Constitution of India is Right to health and medical facilities according to Consumer Education and Research Centre v. Union of India. This case concerned the health rights of workers exposed to harmful conditions in asbestos industries. In *Bandhua Mukti Morcha v. Union of India*, the Apex Court of India addressed the abuse of bonded labourers in hazardous industries and indorsed their fundamental rights, particularly Right to Life under Article 21 of India's Constitution. The NGO Bandhua Mukti Morcha filed the Public Interest Litigation (PIL) to highlight the harsh working conditions of labourers in Madhya Pradesh's stone quarries. According to the Court, the right to health and humane working circumstances is an essential component of the right to life and dignity guaranteed by Article 21. The State's constitutional obligations under Articles 39, 41, and 42 to protect workers' health and ensure just and humane working conditions was also emphasised. The decision paved the way for a broader interpretation of the right to life that includes socioeconomic rights, notably for marginalised people. This historic judgement reinforced the state's responsibility to ensure labourers' well-being, laying the groundwork for subsequent decisions on the Right to Health as a basic right. The Supreme Court opined that occupational health is an essential component of the Right to Life, and that the state must provide safe working conditions and medical services for workers.

According to Article 47 of the Constitution, the state's primary obligation is to maintain public health as per the case of *Vincent Panikurlangara v. Union of India*. The Supreme Court ruled that public health is critical to a decent existence, and that the state must take the appropriate steps to prevent health hazards, control medications, and provide proper healthcare.

Further, the Delhi High Court, took suo motu cognizance of a public interest litigation filed to addressed the issue of a destitute woman who died on a busy street after giving birth, emphasising the necessity for proper medical services and shelter for homeless pregnant women. The court directed the state government to create shelters with the appropriate medical facilities to prevent similar events in the future. the Delhi High Court ordered the government to improve healthcare facilities in state-run hospitals and assure the availability of critical medications and equipment in Delhi High Court in *Court on Its Own Motion v. UOI*. Proper facilities and infrastructure to be provided in Government hospitals.

In a notable ruling of the Apex Court, the court determined that no hospital to reject treatment in emergency medical care since it is a fundamental right.

Role of Directive Principles of State Policy in Healthcare

The DPSPs impose a constitutional obligation on the state to work towards a welfare-based healthcare system. These provisions, while not legally enforceable, serve as a moral and political mandate for the government to pursue policies that assure universal, high-quality and inexpensive healthcare for all citizens.

Article 38 directs the state to promote people's wellbeing by minimising inequities, making it a key article for healthcare policy formulation. Equitable healthcare is an important aspect of this obligation.

With the Supreme Court of India, the constitution emphasises that the state must protect workers' health by ensuring that working conditions do not affect their well-being, under Article 39(e). Even in cases of sickness, incapacity, and old age it is the state's obligation to give public. It is state's duty to improve public health, nutrition, and living standards. It also advocates for the prohibition of intoxicating substances in order to preserve public health, according to Article 47.

In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, 1996 It was determined that the lack of free medical treatment at government facilities breaches Article 21, strengthening DPSP healthcare mandates.

The Court directed the government to offer free life-saving treatment to destitute patients, highlighting the DPSP commitment under Articles 38 and 47 in the case of *Mohd. Ahmed (Minor) v. Union of India.*

The Directive Principles of State Policy (DPSPs) emphasise the state's responsibility to provide egalitarian healthcare, yet the reality of out-of-pocket medical spending in India demonstrates a disconnect between constitutional principles and policy implementation. Despite numerous government initiatives aimed at universal health coverage, a sizable section of the population continues to rely on personal funds for healthcare, driving many into poverty.

Fundamental Duty under Article 51A: Public Health, Out-of-Pocket Medical Expenses, and the Right to Health in India

The Right to Health in India is primarily based on Article 21 (Right to Life) and is supported by Directive Principles of State Policy (DPSPs). However, maintaining healthcare access is not only the government's responsibility, but also people' fundamental duty under Article 51A of the Indian Constitution.

Residents are required to maintain and promote the natural environment, which includes public health under Article 51A(g) and citizens to foster scientific temper and modify regressive health-related behaviours under Article 51A(i).

In the context of out-of-pocket (OOP) medical expenses, citizens are encouraged to practise preventive healthcare and avoid health-damaging activities, thereby minimising the overall financial burden on individuals and the healthcare system.

III. Out-Of-Pocket Medical Expenses In India

Out-of-pocket (OOP) medical expenses are payments that individuals directly pay for healthcare services that are not covered by insurance or government subsidies. The expenses include consultation, hospitalization costs, diagnostic, medication costs, medical devices, emergency care, ambulance charges, traditional and alternative treatments, such as ayurveda and homeopathy, etc.

According to the World Health Organization (WHO) out-of-pocket expenses are '*Direct payments made by individuals to healthcare providers at the time-of-service use, excluding pre-paid payments such as taxes or health insurance*'

Out-of-pocket medical expenses have a direct impact on a country's healthcare accessibility and financial stability, particularly in low-income areas where exorbitant healthcare prices have driven millions into poverty. Out-of-pocket payments has not only discouraged individuals to seek medical treatment but accelerated health problems, ultimately decreases productivity.

India has got various laws and regulatory frameworks to handle out-of-pocket medical expenses, however, significant concerns persist such as, gaps in implementation, enforcement, and insufficient financial protection. The initiatives include:

- The 2017 National Health Policy (NHP) intends to deliver universal health coverage-UHC while also reducing out-of-pocket medical expenses to provide affordable healthcare access. This policy acknowledges the significant financial load on individuals and provides mechanisms like, to increase public health spending by 2025

to 2.5% of GDP, prevent & strengthen primary healthcare and health services, encourage the penetration of health insurance among vulnerable populations, to promote public-private partnerships (PPPs) for better and effective healthcare delivery.

Despite its broad scope of 2017 NHP, it lacks strong legal processes and does not place strict requirements on governments to undertake reforms. Furthermore, fiscal restrictions have hampered its goal of reducing OOP healthcare expenditure, resulting in a mismatch between policy aspirations and ground reality.

- Under Pradhan Mantri Jan Arogya Yojana, the Ayushman Bharat Yojana is instrumental in reducing Out of Pocket expenditure. This initiative was introduced in 2018 to provide five lakh insurance cover to each family on yearly basis which are economically vulnerable. It offers cashless treatment at empanelled hospital pan India to such families with the objective to reduce financial burden on them. Benefits includes pre-hospitalization of three days and post-hospitalization of fifteen days.[1] To provide PPP i.e. services dealing with primary care, preventive and promotive for free Ayushman Bharat has Health & Wellness Centers under it. The key motive being to reduce spent on treatments by early detection of diseases.

Since, OOPE is a global issue, not just in India. According to a recent study of WHO published in the British Medical Journal (BMJ), it is observed that Europe and Central Asia are witnessing a rise in the number of people spending more on healthcare that they do not have enough money for their other essential needs. These expenses that occur when a family's out-of-pocket payment exceeds a certain level of paying capacity are known as *Catastrophic health expenditure*, which are becoming increasingly common.[2]

- Clinical Establishments (Registration and Regulation) Act of 2010: To ensure quality, uniformity and transparency in cost in healthcare clinical establishments. Hospital, dispensary, nursing home, maternity home, clinic, sanatorium or an institution by offering services, facilities requiring diagnosis, treatment or care. The main aims of the Act are related to mandatory registration, standardization of treatment costs, transparency in healthcare services and curbing malpractices. This act seeks to regulate private healthcare providers but faces challenges due to weak enforcement in many states. This piece of legislation is critical tool reduce out of pocket expenditure however, challenges exist.

Public Health Legislation in India lacks comprehensive public health legislation to address the financial protection of citizens comprehensively.

IV. Comparative Analysis With Other Countries

In 1948, United Kingdom established the National Health Service that offers free healthcare system at the point of service, funded through taxation, generally. It provides limited to prescription charges and certain dental services because patients bear minimal OOP costs. The chief objective of this initiative is to ensures universal health coverage (UHC) for all individuals. This makes healthcare in the UK notably different from systems where patients incur hefty out-of-pocket costs (OOP). This establishes the NHS as a global norm for publicly funded healthcare that reduces financial hardship while promoting universal access to care. Despite its success in limiting OOP expenditure, NHS is not free from challenges such as long waiting times, funding constraints, workforce shortages, private healthcare growth.

[1] https://amkresourceinfo.com/ayushman-bharat-pradhan-mantri-jan-arogya-yojana-pm-jay-a-comprehensive-guide/, 13.02.2025.
[2] 1991 reforms shifted burden of healthcare costs from govt to people. PM-JAY reversed it, *available at* 1991 reforms shifted burden of healthcare costs from govt to people. PM-JAY reversed it, 13.02.225.

Similarly, in Canada their healthcare system known as Medicare is based on Canada Health Act (CHA), 1984. It guarantees that all Canadian citizens and permanent residents have access to medically required services free of charge at the point of care. Healthcare is mostly supported by general taxes, resulting in much lower out-of-pocket (OOP) payments for people. Canada's Medicare system greatly reduces out-of-pocket costs by providing free access to critical healthcare services such as hospitalisations, doctor visits, and diagnostic tests. However, gaps exist in areas such as prescription medicines, dentistry, vision, and mental health care, resulting in some out-of-pocket expenses. While Canada's approach covers catastrophic health costs, expanding coverage in these areas could help individuals save even more money.

V. Conclusion

The AB- Pradhan Mantri Jan Arogya Yojana, has achieved broad population coverage, but despite four years of implementation with an evidence-based rise in hospital payment fees, it has had little impact on enhancing usage, quality, or financial protection. The contracted private hospitals under the system continued to overcharge patients, and purchasing proved ineffectual in regulating provider behaviour. More research is needed to evaluate the effect of publicly supported health insurance plans on financial protection in other low- and middle-income nations.[3]

The healthcare systems in the United Kingdom, Canada, and India show notable differences in terms of out-of-pocket (OOP) expenses. A universal, publicly funded model is followed by the United Kingdom's National Health Service (NHS), where healthcare services are free at the point of delivery, supported primarily by tax revenues. Consequently, the UK has one of the lowest OOP expenditures worldwide, accounting for approximately 15% of total health costs. Core services such as hospital care, GP consultations, and emergency treatments are covered without direct charges. However, services like dental care, vision treatments, and prescriptions are not entirely free in England, though residents of Scotland, Wales, and Northern Ireland benefit from free prescriptions. Although the NHS minimizes financial strain, lengthy waiting periods for non-urgent procedures sometimes drive patients to seek private healthcare, leading to higher OOP costs for faster access.

Canada's Medicare system is yet again a publicly funded, single-payer healthcare model that ensures universal access to essential hospital and physician services. Similar to the UK, the country maintains a relatively low out-of-pocket (OOP) expenditure of around 15%, as primary care and hospital treatments are available free of cost at the point of service. However, prescription medications, dental care, vision services, and mental health treatments are not included under the standard coverage, leading to higher private spending in these areas. Many individuals rely on provincial drug programs or employer-sponsored insurance to manage these costs, but those without coverage often experience financial difficulties when accessing necessary treatments. Additionally, Canada's lengthy waiting periods for elective procedures push some patients to opt for private care or seek medical treatment abroad, further increasing their OOP expenditures.

India has one of the highest out-of-pocket (OOP) healthcare expenditures globally, accounting for approximately 50-55% of total health spending. Unlike the publicly funded systems in the UK and Canada, India follows a mixed healthcare model, where government hospitals offer free medical services, but the private sector dominates and often imposes high treatment costs. Although initiatives like Ayushman Bharat (PM-JAY) aim to provide free healthcare coverage for economically disadvantaged families, gaps in execution and limited support for outpatient

[3] The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) after four years of implementation – is it making an impact on quality of inpatient care and financial protection in India?, *available at* https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-024-11393-2, 13.02.225.

services and medication expenses leave many individuals facing significant OOP costs. Expenses related to prescription drugs, dental care, vision treatment, and mental health services are primarily self-financed, making medical care a financial burden for millions. Consequently, catastrophic health expenditure (CHE) is widespread, with over 60 million people pushed into poverty every year due to healthcare-related costs.

Although the healthcare systems in the UK and Canada offer substantial financial protection against excessive medical costs, India faces ongoing challenges with high out-of-pocket (OOP) expenses due to its limited public healthcare infrastructure and heavy dependence on private providers. Enhancing universal health coverage, implementing strict cost regulations, and reinforcing health insurance schemes could alleviate India's financial healthcare burden and make medical services more affordable for its population.

To lower out-of-pocket (OOP) healthcare costs in India, the legal framework should focus on regulating prices for essential medical services, prescription drugs, and diagnostic tests to prevent overcharging. Expanding universal health coverage by widening the scope of Ayushman Bharat (PM-JAY) to include outpatient care, medications, and preventive treatments can help reduce financial strain on patients. Strict enforcement of the Clinical Establishments (Registration and Regulation) Act, 2010 is necessary to ensure transparent pricing and fair billing by private hospitals. Strengthening health insurance laws to provide affordable, comprehensive coverage across all income groups, with government subsidies for low-income families, can improve access to care. Additionally, setting up a national grievance redressal system to handle unfair medical billing and overpricing issues would enhance legal protection and accountability in the healthcare sector.

References:

[1] National Health Policy, 2017 – Ministry of Health and Family Welfare, Government of India. Available at: https://www.nhp.gov.in/national-health-policy-2017_pg.

[2] Pradhan Mantri Jan Arogya Yojana (PM-JAY) – Ayushman Bharat, National Health Authority. Available at: https://pmjay.gov.in.

[3] Clinical Establishments (Registration and Regulation) Act, 2010 – Ministry of Health and Family Welfare. Available at: https://main.mohfw.gov.in.

[4] Out-of-Pocket Expenditure on Health in India – National Sample Survey (NSS) 75th Round. Available at: http://mospi.nic.in.

[5] World Health Organization (WHO) – Universal Health Coverage and India's Progress. Available at: https://www.who.int.

[6] Divya Parmar, Christoph Strupat, Swati Srivastava, Stephan Brenner, Diletta Parisi, Susanne Ziegler, Rupak Neogi, Caitlin Walsh & Manuela De Allegri (2023) Effects of the Indian National Health Insurance Scheme (PM-JAY) on Hospitalizations, Out-of-pocket Expenditures and Catastrophic Expenditures, Health Systems & Reform, 9:1, 2227430, DOI: 10.1080/23288604.2023.2227430.

[7] https://mohfw.gov.in/sites/default/files/MoHFW%20Booklet%20on%20UHC%20as%20on%20September%202019%2032%20MB.pdf?utm_source=chatgpt.com

[8] https://cdn.visionias.in/infographics/National-Health-Policy-2017.pdf