UNIVERSAL HEALTHCARE

THE INDIAN QUANDARY

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India, the most populous country in the world but with a questionable healthcare system which ranks as low as 66 out of 195 countries in 2021 global healthcare security index with an overall index score of 42.8 and along with a change of -0.8 from 2019. India was ranked 111 out of 167 countries in 2021 health and health systems ranking index. In 2023, the Global Burden of Disease Study Report ranked India 154 out of 195 in "healthcare access and quality". India is ranked 39th in Global Innovation Index, 116th on Global Peace Index, 105th on Global Hunger Index, 14th on Global Terrorism Index, and 130th on Human Development Index with low-income inequality of 25.5 on Gini Index in 2022 by the World Bank.

Universal Health Coverage (UHC) addresses that all people have complete access to quality healthcare services that are needed for prevention, treatment and rehabilitation, without any financial hardships. The main pillars are covering entire population, provision of comprehensive range of services, and offering financial protection to prevent any out-of-pocket expenses. The key component to achieve UN's Sustainable Development Goals is to fulfil UHC goals. UHC is designed and developed on the principles of equity and the right to health making sure that it is a fundamental right of all the citizens across the globe. It remains the driving force behind sustainable development goals such as ending poverty, zero hunger, and good health and well-being. It ensures accessibility to necessary care and raises the minimum standard of healthcare, improving overall health and well-being of the population.

India has set UHC as a national goal aiming to provide equitable, affordable, and quality healthcare to all its citizens. Key initiatives such as Ayushman Bharat scheme which includes the largest government-funded health insurance program (PMJAY) and the transformation of primary health centers into health and wellness centers (WHO, 2025). While challenges remain quite large, the progress pace is slow, such as financing, human resources, and improving service delivery in all regions of the country to fully achieving comprehensive coverage. Key initiatives for India for implementation of UHC are,

• **Ayushman Bharat (AB):** launched in 2018, this flagship programme for India's UHC has two components: 1) Pradhan-Mantri Jan Arogya Yojana (PMJAY): it is aimed to provide costless secondary and tertiary healthcare to poorest 40% of the citizens with an annual insurance cover of up to ₹5 lakh per family, and 2) Ayushman Arogya Mandirs (AAMs): Originally Health and Wellness Centres (HWCs), these are sub-centres and primary health centres being upgraded to provide comprehensive primary healthcare services closer to people's homes.

• **2017 National Health Policy:** it focuses on increasing the public health expenditure to 2.5% of GDP by 2025 for laying the foundation of UHC in India. India's status remains as it identifies more than 42 crore people for Ayushman Bharat and issuing them ID cards to make healthcare more affordable for vulnerable families (PIB, 2025).

Despite the Hon'ble Supreme Court of India interpreting the access to healthcare as a fundamental right vis-à-vis the right to life and personal liberty under Article 21 of the Constitution of India, which means the right to health includes the right to medical care and encompasses the protection and improvement of health for a meaningful and dignified life, India faces some critically acclaimed challenges such as,

• **Implementation gaps:** There are significant gaps in healthcare infrastructure, service delivery, and the availability of skilled health personnel, especially in rural and underserved areas.

• **Financing:** Inadequate budgetary allocation and the high cost of healthcare remain major hurdles, making it difficult to achieve financial protection for all, says the Annals of National Academy of Medical Sciences.

• **Insurance gaps:** Approximately 400 million Indians remain uninsured, highlighting the need for greater insurance coverage.

• **Quality and access:** Ensuring both the quality of care and equitable access across different states and regions is an ongoing challenge. For example,

some southern states have higher UHC coverage than those in central, eastern, and northeastern India, notes the US's National Institutes of Health.

• **Regulation and governance:** Weak governance structures and policy inconsistencies between the centre and states have been hindering progress.

• **Out-of-Pocket Expenditure (OoPE):** Households still bear large portion of healthcare costs, with OoPE accounting for 2.3% of GDP and causing financial stress.

• **Urban-Rural Disparity:** Access to essential services remains a challenge in rural areas, where the doctor-population ratio is often significantly lower (rural ratio is 1:11,082) than the WHO recommended of 1:1000. This remains due to disproportionate distribution of doctors between rural and urban areas, a shortage of specialists, and the need for more infrastructure and resources in rural health facilities.

• **Shortage of Medical and Healthcare Professionals:** The extremely high tuition fees and ad-hoc cost of MBBS/PG degree programmes is one of the major reasons for declining interest of potential students from becoming either medical doctor or healthcare professionals. Candidates have started to reconsider their career choices from nursing degree programmes too. To fulfil their dreams of being doctors and other healthcare professionals, students consider moving abroad for degree and training purposes which proves them to be cheaper than the private medical universities and colleges.

• **Fragmented quality of care:** Fragmentation leads to higher healthcare costs, increased hospital readmissions, more emergency visits, inefficiency, and a greater risk of complications for patients, especially those with chronic or complex conditions.

• **Centre-State cooperation:** In 2021-22, the Union Government accounted for 41.8% of the total government health expenditure, while state governments contribute 58.2%. Despite this, the right to health places an obligation on the state to ensure access to healthcare including free or low-cost services at government facilities. The government is constitutionally obligated to provide health services. This has been challenging for most of the states other than Kerala and Delhi.

Recommendations

• **Expenditure to be 3% of GDP by 2030:** India's Public Health Budget stands at 1.9% of the total GDP of the country for FY 23-24 which is well below the target of 2.5% per National Health Policy. This needs to be revised and new target of 3% should be set for achieving it by 2030.

• **To improve the Urban-Rural divide**: Though the government has increased the number of medical colleges and MBBS/PG seats to address the shortage, while COVID-19 was drastic for medical professionals and doctors, the willingness to serve in rural areas remains a major question despite benefits and special allowances provision by the government. Thus, remains beyond any statistical computation. The Government of India needs to consider setting strict target of doctor-population ratio to 1:500 (currently 1:836). Thus, a minimum of 3 million (30 lakh) doctors, which should be easily achievable based on the number of candidates registered for National Eligibility Entrance Test (NEET) per year and the population of India. This opens up question of fixing the population density and migration issues and further doctor density based on district in order to address this at micro-levels.

• **Out-of-Pocket Expenditure (OoPE):** Though the share of OoPE reduced from 62.6% (FY15) to 39.4% (FY21-22), the target needs to be less than 10% by FY2030 for complete financial protection of households (PIB, 2025).

• **Government Health Expenditure:** Despite significant increase in the public health expenditure of India, reaching ₹4,34,163 crore in 2021-22, the per capita expenditure remains extremely low (PIB, 2025). Though, many studies in the Lancet and reports by WHO have found US $249 - $271 per capita as a target to achieve SDGs related to health under different scenarios, whereas NIH has reported in a study for low-income countries to have at least US $86 per capita expenditure for health. As for India, based on the

mid-year population in 2021 viz., 141.42 crores, the per capita expenditure turns out to be INR ₹3,070 (= US $41; $1 = ₹75). The Central government's minimum wage rate (as of October 1, 2024) for highly skilled worker is ₹26,910 per month and for unskilled worker is ₹20,358 per month with 26 working days. With such a minimum structure and current inflationary healthcare, the set minimum wages would not suffice to appropriate health care of the worker, if so needed. Both per capita and minimum wages need revision inclusive economic and health growth aiming for Viksit Bharat @ 2047 (Trnsl. Developed India @ 2047). The minimum wages should be ₹39,000 per month for unskilled workers and ₹65,00 per month for highly skilled workers, while setting a strict target of ₹10,000 per capita health expenditure. Strong targets set the tone of development for a country while raising the standard of living and quality of life for its citizens.

• **Aam Adami Mohalla Clinics:** The Delhi Government's model of Aam Adami Mohalla Clinics (trnsl. Common Man's Neighbourhood Clinics) is one such good model for implementation for treatment at the primary health care stage. This model provides accessible and quality health care services through primary, secondary and tertiary facilities, wherein primary care delivered through dispensaries, secondary health care delivered through multi-speciality hospitals and tertiary health care services delivered through super-speciality hospitals. The core concept was to increase the primary healthcare system and its delivery reducing the burden on secondary and tertiary systems. Increasing the access of primary healthcare to poor and vulnerable population having no/limited access to primary care services within their reach. The new model defined Aam Adami Mohalla Clinics for primary healthcare, Multi-Speciality Poly Clinics for secondary healthcare vis-à-vis OPD consultations & others (earlier primary healthcare), Multi-Speciality Hospitals for IPD care (earlier secondary healthcare), and Super-Speciality Hospitals for quaternary healthcare (earlier tertiary healthcare). This model in Delhi has been deemed successful by the people of the Delhi and has served as a pilot project for its implementation at national level and relies for future administration for its futuristic implementation.

Conclusion

India's hard-to-accept global health rankings specifically in "healthcare access and quality" present a stark contrast to its status as the world's most populous nation. The goal of the UHC is not a policy target but a constitutional and moral obligation, interpreted by the Hon'ble Supreme Court of India as fundamental to the right to life. The current system, despite flagship efforts like Ayushman Bharat (PM-JAY and Ayushman Arogya Mandirs/AAMs), suffers from significant implementation gaps, inadequate financing, and deep urban-rural disparity.

To achieve equitable and quality healthcare by Viksit Bharat @ 2047, India must adopt bold, measurable reforms. Critically, public health expenditure must be increased to a strict target of 3% of GDP by 2030 to reduce the burdensome Out-of-Pocket Expenditure (OoPE) from nearly 40% to under 10%. Furthermore, per capita health spending must be significantly boosted to ₹10,000, necessitating a proportional rise in minimum wages to ensure affordability.

Addressing the doctor shortage requires setting a clear 1:500 doctor-population ratio target and incentivizing service in rural areas. Scaling up successful primary care models, like the Aam Adami Mohalla Clinics, is essential to improve accessibility and reduce the strain on higher-level facilities. By making these decisive, financially protected, and equity-focused policy choices, India can transform its health system and secure a meaningful, dignified life for all its citizens.

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