HEALTH CARE ACCESS AND LEGAL RIGHTS: ADDRESSING THE INVERSE CARE LAW IN INDIA FROM A LEGAL PERSPECTIVE

Dissertation submitted to the National University of Advanced Legal Studies, Kochi, in partial fulfilment of the requirements for the award of Master of Laws in Public Health Law

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CERTIFICATE

This is to certify that **Mr. David Varghese Thomas**, Reg No: **LM0324003** has submitted his Dissertation titled – " **Healthcare Access and Legal Rights: Addressing the Inverse Care Law in India- from a legal perspective**" in partial fulfilment of the requirement for the award of Degree in Master of Laws in Public Health Law to the National University of Advanced Legal Studies, Kochi under my guidance and supervision. It is also affirmed that the dissertation submitted by him is original, bona fide and genuine.

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DECLARATION

I, **David Varghese Thomas**, do hereby declare that this dissertation work titled "**Healthcare Access and Legal Rights: Addressing the Inverse Care Law in India from a Legal Perspective**" researched and submitted by me to the National University of Advanced Legal Studies in partial fulfilment of the requirement for the award of degree of master of laws in Public Health Law under the guidance and supervision of **Dr. Athira P S**, Assistant Professor, The National University of Advanced Legal studies is an Original, Bonafide and Legitimate work. It has been pursued for an academic interest. This work or any type thereof has not been submitted by me or anyone else for the award of another degree of either this university or any other university.

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I hereby acknowledge that I have made sincere and sustained efforts in completing my dissertation titled *"Healthcare Access and Legal Rights: Addressing the Inverse Care Law in India from a Legal Perspective."* This journey has been both intellectually enriching and personally transformative, and I remain deeply grateful to everyone who has contributed to its completion.

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PREFACE

The seeds of this dissertation were sown long before I formally began my academic exploration of health law. Growing up, I was a witness to the quiet yet powerful work of my father, a surgeon in the Regional Cancer Centre, Tvm, who dedicated his professional life to providing care to those who are most often left behind by the system. Through his daily encounters with the underserved and his reflections on the structural inequalities embedded within the healthcare system, I came to understand the harsh reality of what later I would recognise as the *Inverse Care Law*: that those who need medical care the most are often the ones who receive it the least.

This early exposure, coupled with my own formative experience during my early legal career, gave clarity to a question that has guided this work: How can the law be mobilised to correct the systematic denial of healthcare to the disadvantaged? It is this question that eventually crystallised into the subject of this dissertation: *Healthcare Access and Legal Rights: Addressing the Inverse Care Law in India from a Legal Perspective.*

The journey of writing this dissertation has been intellectually rewarding and, at times, deeply challenging. The Inverse Care Law is not merely a medical or policy concern—it is an analytical lens through which one must examine vast and interrelated dimensions of inequity, including legal doctrine, resource allocation, health infrastructure, and social justice. One of the most difficult aspects of this research was the need to resist the temptation to explore every facet of this expansive problem. Striking a balance between breadth and depth required continuous re-evaluation and restraint. In this sense, the process of delimiting the scope of inquiry was as significant as the research itself.

I remain deeply grateful to the National University of Advanced Legal Studies (NUALS), Kochi, for providing a rigorous academic environment where such a subject could be pursued meaningfully. My heartfelt thanks go to my guide, Dr. Athira P. S., whose patience, intellectual clarity, and steadfast encouragement allowed me to stay committed to this topic, especially during moments when I questioned its academic manageability. Her support was instrumental in shaping the final structure and focus of this dissertation.

Above all, I dedicate this work to my father, whose integrity and compassion have been a lifelong inspiration.

This dissertation also represents a small but sincere contribution to the larger discourse on healthcare equity in India. It is my earnest belief that the law has a transformative role to play in correcting historical wrongs and enabling access to healthcare as a matter of right, not privilege. I hope to carry forward these insights into my professional life and to remain engaged with the effort to make healthcare access more equitable, just, and responsive to the needs of those whom the system too often forgets.

LIST OF ABBREVIATIONS

ABDM	Ayushman Bharat Digital Mission
ABHA	Ayushman Bharat Health Account
ABHIM	Ayushman Bharat Health Infrastructure Mission
AIDS	Acquired Immunodeficiency Syndrome
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homoeopathy
BPL	Below Poverty Line
CAG	Comptroller and Auditor General
CBM	Community-Based Monitoring
CEA	Clinical Establishments Act
CESCR	Committee on Economic, Social and Cultural Rights
DPSPs	Directive Principles of State Policy
ECG	Electrocardiogram
GDP	Gross Domestic Product
GINI	Gini Coefficient (income inequality measure)
GP	General Practitioner
GSDP	Gross State Domestic Product
HIV	Human Immunodeficiency Virus
ICL	Inverse Care Law
ICESCR	International Covenant on Economic, Social and Cultural Rights
IVR	Interactive Voice Response
JAY	Jan Arogya Yojana (from PM-JAY)
MBBS	Bachelor of Medicine, Bachelor of Surgery
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NHP	National Health Policy
NHRC	National Human Rights Commission
NHS	National Health Service
NHSRC	National Health Systems Resource Centre
NITI	National Institution for Transforming India
OECD	Organisation for Economic Co-operation and Development
PIL	Public Interest Litigation
PM-JAY	Pradhan Mantri Jan Arogya Yojana
RAWP	Resource Allocation Working Party
SMS	Short Message Service
SUS	Sistema Único de Saúde (Brazil)
TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization

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1.	Paschim Banga Khet Mazdoor Samity v. State of West Bengal, (1996) 4 SCC 37
2.	Consumer Education & Research Centre v. Union of India, (1995) 3 SCC 42
3.	State of Punjab v. Mohinder Singh Chawla, (1997) 2 SCC 83
4.	Parmanand Katara v. Union of India, (1989) 4 SCC 286
5.	Minister of Health v. Treatment Action Campaign, 2002 (5) SA 721 (CC) (South Africa)
6.	Francis Coralie Mullin v. Union Territory of Delhi, (1981) 1 SCC 608
7.	Bandhua Mukti Morcha v. Union of India, (1984) 3 SCC 161
8.	Navtej Singh Johar v. Union of India, (2018) 10 SCC 1
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CHAPTER 1

INTRODUCTION

1.1. BACKGROUND AND CONTEXT

A good state of health is a fundamental requirement for the well-being of human beings and is of critical importance to the growth and development of a nation. Health is a prerequisite for the exercise of other basic rights. The philosopher René Descartes wrote in his *Discours de la méthode "the preservation of health… is without doubt the first good and the foundation of all other goods in this life"*[1] Health is widely perceived as essential to human prosperity because it enables a person to pursue the various goals and projects in life that they have reason to value.
The World Health Organization (WHO) has provided a definition of "health" that is widely accepted in the preamble of its constitution. According to the World Health Organization, "health is a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity."[2] With this definition, the World Health Organization (WHO) has contributed to the expansion of the concept of health beyond a narrow, pathological, and biomedical-based perspective and frames it in terms of overall well-being. It highlights that health is not simply the lack of illness but a positive condition of wellness in multiple dimensions, which is essential to human flourishing. Consistent with this understanding, international human rights instruments have long affirmed health as a fundamental right. For example, the Universal Declaration of Human Rights (1948) proclaims everyone's right to "*a standard of living adequate for the health and well-being" of oneself and one's family, including medical care and necessary social services*[3]. Likewise, the International Covenant on Economic, Social and Cultural Rights (ICESCR), to which India is a party, obligates states to recognise

[1] René Descartes, *Discourse on the Method*, pt. VI (1637), in 1 The Philosophical Works of Descartes 111 (Elizabeth S. Haldane & G.R.T. Ross trans., *Cambridge Univ. Press* 1973) (original work published 1637).
[2] Constitution of the World Health Organization pmbl. (1946) (defining "health"); see also World Health Organization, *Constitution*, July 22, 1946, 62 Stat. 2679, 14 U.N.T.S. 185 (entered into force Apr. 7, 1948).
[3] Universal Declaration of Human Rights, art. 25, G.A. Res. 217A (III), U.N. Doc. A/810 (Dec. 10, 1948).

the right of everyone to the highest attainable standard of physical and mental health and to take steps towards its realisation on the basis of equity and non-discrimination[4]. These global commitments establish health as a core aspect of human dignity and social justice.

Against this conceptual backdrop, persistent disparities in healthcare access have been observed worldwide, giving rise to a critical principle known as the **Inverse Care Law**. First articulated by Dr. Julian Tudor Hart in 1971, the Inverse Care Law posits that "*the availability of good medical care tends to vary inversely with the need for it in the population served*"[5]. In other words, those populations most in need of healthcare, typically the poor, marginalised, or sick, are often the least likely to receive it, whereas those with the least need (often more affluent or healthier groups) tend to consume more and better-quality healthcare services. Hart noted that this inequitable phenomenon is most pronounced in healthcare systems driven by market forces and profit, and less severe in systems with strong public provision or regulation[6]. His insight emerged from observing Britain's National Health Service and noticing that even in a State-funded system, ostensibly committed to universal care, socio-economically disadvantaged areas suffered relative neglect in service availability and access. Over the past five decades, Hart's thesis has become a cornerstone in the study of health inequalities. Empirical research has repeatedly confirmed the pattern in various contexts: communities with greater burdens of illness frequently have fewer doctors, clinics, and resources, while well-served communities tend to be those with comparatively lower needs. This inverse relationship between need and care perpetuates worse health outcomes for vulnerable groups, entrenching a cycle of inequality.

The relevance of the Inverse Care Law is global. A recent international study re-examining Hart's thesis found that an inverse care dynamic persists in almost all low- and middle-income countries in the present day: socially disadvantaged people consistently receive less, and lower-quality, health care than more advantaged people,

[4] See *International Covenant on Economic, Social and Cultural Rights* art. 12, Dec. 16, 1966, 993 U.N.T.S. 3 (recognizing "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"); *U.N. Committee on Economic, Social & Cultural Rights*, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), ¶ 12, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).
[5] Julian T. Hart, *The Inverse Care Law*, 1 *Lancet* 405, 405 (1971)
[6] Id.

despite having higher disease burdens[7]. The problem is not confined to poorer nations; even high-income countries continue to grapple with internal disparities in healthcare access along lines of class, geography, and race, revealing that structural inequities can undermine even national health systems that strive for universal coverage. As health scholar Michael Marmot has argued, merely providing universal health coverage is not enough to achieve equitable health outcomes; policies must follow the principle of "proportionate universalism," meaning that interventions should be universal but allocated in proportion to need, so that more disadvantaged groups are supported more intensely[8]. The lasting significance of the Inverse Care Law shows that health inequities are fundamentally issues of social justice and necessitate systemic solutions.

In the context of India, the Inverse Care Law is clearly reflected in the country's healthcare landscape, highlighting a pressing issue. India experiences a dual reality: on one hand, it upholds constitutional ideals and policies that promote health for all; on the other hand, significant disparities in access to healthcare and health outcomes exist among various segments of the population. About two-thirds of India's 1.4 billion people live in rural areas, yet healthcare resources are heavily concentrated in urban centres. Approximately 75% of the country's health infrastructure and medical personnel are found in these urban areas, which only account for about 25 to 30% of the population[9]. This disparity between urban and rural healthcare means that millions of people in rural areas must travel long distances to access even the most basic medical care, and even when they reach healthcare facilities, they often find them understaffed or lacking essential supplies. Similarly, socio-economic status significantly impacts access to healthcare. Wealthier individuals in urban areas can afford private hospitals and better services, while poorer individuals often depend on an overstretched public sector or forgo care altogether due to high costs. India's health financing structure worsens these disparities. Historically, public expenditure on health in India has been very low, around 1-1.5% of GDP. As a result, out-of-pocket spending accounts for

[7] Richard Cookson et al., *The Inverse Care Law Re-Examined: A Global Perspective*, 397 *Lancet* 828, 829 (2021)
[8] Michael Marmot, *Fair Society, Healthy Lives: The Marmot Review* 15–16 (2010)
[9] Jacob Player, Healthcare Access in Rural Communities in India, *Ballard Brief* (2021), https://ballardbrief.byu.edu/issue-briefs/healthcare-access-in-rural-communities-in-india.

approximately half of total health expenditures[10]. This reliance on out-of-pocket payments disproportionately affects the poor, often leading to "catastrophic" health expenses that can push families into poverty. In fact, high medical costs and inadequate public services mean that those least able to pay are often the most likely to be denied or delayed treatment, highlighting a clear pattern of inverse care.

The consequences of structural imbalances in healthcare are evident in key health indicators. Marginalised communities, defined by factors such as geography, income, caste, and more, typically experience higher rates of infant and maternal mortality, malnutrition, and preventable diseases. They also have lower life expectancies and immunisation rates compared to more privileged groups[11]. For instance, a child born into a poor rural household or an urban slum is statistically more likely to die before the age of five than a child born to a wealthy urban family. This stark reality highlights the intersection of poverty and lack of access to healthcare.

These disparities emphasise that health in India is not just a medical issue, but also a significant legal and ethical concern. The unequal distribution of healthcare resources and outcomes raises questions of equality, rights, and the state's responsibilities to its citizens. Against this backdrop of global principles and national realities, the current study is positioned.

We begin with the premise that health is a fundamental human interest and explore how law and policy in India have addressed the challenges presented by the Inverse Care Law. The following sections will outline the rationale, research questions, scope, methodology, and original contributions of this dissertation, framing an inquiry into how India's legal system can address and rectify the inverse care dynamics in healthcare.

[10] Fahimuddin Ahmad & Pratap C. Mohanty, *Incidence and Intensity of Catastrophic Health Expenditure and Impoverishment among the Elderly: An Empirical Evidence from India*, 14 Sci. Rep. 15908, at 2 (2024)
[11] Kanhaiya Tripathi et al., Social Determinants of Health in India: Reimagining of Dr. B.R. Ambedkar's Vision in the Light of Marginalized Communities, 14 Soc. Sci. 1 (2025), https://doi.org/10.3390/socsci14010001.

1.2. RATIONALE AND SIGNIFICANCE OF THE STUDY

The rationale for this study arises from a critical observation: despite India's formal commitments to equitable development and a solid framework of fundamental rights, the Inverse Care Law remains highly relevant today, as it highlights systemic inequalities in healthcare access. In recent years, the urgency of addressing health equity has increased, particularly following the COVID-19 pandemic, which exposed significant disparities in health infrastructure across different regions and social groups. Now more than ever, there is a recognition that a country's legal and policy frameworks must proactively address these disparities. This dissertation argues that the Inverse Care Law provides a valuable framework for understanding and addressing the structural inequities in India's healthcare system from a legal perspective.

One key reason the Inverse Care Law is significant in India is its implicit yet powerful acknowledgment of health as a fundamental right under the Indian Constitution. Although the Constitution does not explicitly list the right to health as a fundamental right, the Supreme Court of India has interpreted such a right as being included in the guarantee of life and personal liberty under Article 21. Article 21 states: "No person shall be deprived of his life or personal liberty except according to the procedure established by law."[12]. The judiciary has broadly interpreted the term "life" in this context to mean a life characterised by human dignity and quality, rather than mere survival or animal existence[13]. Over a series of landmark cases, the Supreme Court has affirmed that the right to life encompasses the right to live with good health and access to basic medical care. For example, in the case of *Consumer Education & Research Centre v. Union of India (1995)*, which addressed occupational health hazards faced by workers, the Court firmly stated that the maintenance of health is a crucial aspect of living with dignity. The judgment declared that "the right to health and medical care is a fundamental right… necessary for making the life of the worker meaningful and purposeful with dignity"[14]. In this ruling, the Court emphasised that without health, other rights and freedoms cannot be fully enjoyed, thereby implicitly recognising

[12] INDIA CONST. art. 21.
[13] Francis Coralie Mullin v. Union Territory of Delhi, (1981) 2 S.C.R. 516, 518 (India)
[14] Consumer Educ. & Research Ctr. v. Union of India, (1995) 3 S.C.C. 42, 53 (India)

healthcare as essential to Article 21. In another pivotal case, *Paschim Banga Khet Mazdoor Samity v. State of West Bengal (1996),* the Supreme Court addressed a situation where a seriously injured labourer, who was in dire financial circumstances, was denied admission by multiple government hospitals due to a lack of beds and adequate facilities. The Court ruled that this denial of timely treatment violated the patient's right to life under Article 21 of the Constitution. It emphasised that the State has an affirmative constitutional obligation to provide sufficient emergency medical facilities[15]. Importantly, the Court dismissed the State's argument regarding resource constraints, stating that budgetary limitations cannot justify the violation of fundamental rights. The ruling not only awarded compensation to the victim but also mandated systemic improvements. The Court instructed the government to increase health budget allocations, expand medical facilities, and ensure that no patient is turned away in emergencies. These precedents are significant, as they demonstrate that the apex court in India recognises health-related deprivations as justiciable issues under the right to life. Moreover, that the Court is willing to require the State to take positive action to address inequalities.

Moreover, beyond Article 21, the Directive Principles of State Policy—particularly Articles 47, 38, 39(e), and 41[16]—Highlight the State's obligation to prioritise public health and social welfare. Although these principles are non-justiciable, they inform the interpretation of Article 21 and have played a significant role in the implicit constitutional recognition of the right to health. Consequently, India's legal framework acknowledges access to healthcare as a duty of the State and a constitutional entitlement, rather than merely a policy discretion.

The ongoing impact of the Inverse Care Law in India, where those most in need, such as the rural poor, scheduled castes and tribes, women, and other marginalised groups, often have the least access to quality care, demonstrates a gap between constitutional ideals and the reality on the ground. There is an urgent need to examine why existing laws and policies have not succeeded in eliminating, or even substantially reducing, these inequities. The significance of this dissertation becomes pertinent in that aspect because it addresses this need through the analytical lens of the Inverse Care Law,

[15] Paschim Banga Khet Mazdoor Samity v. State of W*.B.*, (1996) 4 S.C.C. 37, 43–45 (India)
[16] INDIA CONST. art. 47, 38, 39(e), and 41

questioning whether India's legal framework is adequately equipped to fulfil the promise of health equity. By framing the issue in terms of the Inverse Care Law, the study emphasises systemic and structural factors, such as resource allocation, healthcare financing, and institutional design, rather than viewing health disparities as isolated failures or merely administrative issues.

Legal research plays a vital role in addressing healthcare inequities. Laws and rights can serve as tools for social change, they can establish standards, redistribute resources, and hold authorities accountable. In healthcare, the law can help ensure that the distribution of services does not favour the affluent over the less fortunate; rather, it should align with principles of justice and equality. This study examines how legal doctrines, constitutional mandates, and judicial enforcement can be used to counteract the Inverse Care Law in India. It poses the question: How can the law help ensure that those with the greatest health needs receive proportionately greater care and protection?

The importance of this inquiry is heightened by ongoing developments: India is striving to achieve Universal Health Coverage and has initiated ambitious programs like Ayushman Bharat. However, without a clear understanding of the legal foundations necessary to prioritise the most disadvantaged, such initiatives may not effectively resolve inequities.

By engaging with the Inverse Care Law framework, this dissertation aims to contribute to a more robust legal discourse on how to operationalise the right to health in a way that reaches the most underserved populations. This discourse is both timely and essential for India's journey toward achieving health justice.

1.3. STATEMENT OF PROBLEM

In India, persistent disparities in healthcare access highlight the reality of the Inverse Care Law. Despite legal frameworks that recognise healthcare as a fundamental right, marginalised groups continue to experience significant obstacles, including socio-economic disparities, inadequate healthcare infrastructure, and limited awareness of their legal rights. These challenges impede equitable healthcare access and contribute to ongoing health inequities.

1.4. SCOPE OF STUDY

This dissertation examines the legal and policy dimensions of healthcare access and inequity in India through the analytical lens of the Inverse Care Law. Its primary focus is doctrinal and analytical, concentrating on constitutional provisions—particularly Article 21 and the Directive Principles, such as Article 47—alongside statutory laws, national health policies, and judicial interpretations that shape the healthcare framework.

The Inverse Care Law serves as a crucial framework for evaluating whether India's legal and policy regimes effectively address disparities in healthcare access, especially among poor, rural, and marginalized populations. The study also adopts a comparative and international perspective; Chapter 3 explores how other jurisdictions, such as the United Kingdom, and international norms like the ICESCR and WHO guidelines, inform or contrast with India's approach.

In addition to assessing the current legal landscape, this study takes a forward-looking stance, proposing legal and policy reforms aimed at achieving more equitable healthcare delivery. These proposals include enacting a Right to Health law, enhancing public health financing, improving legal enforcement mechanisms, and promoting accountability and community participation in health governance.

1.5. RESEARCH QUESTIONS

- In what ways does the Inverse Care Law manifest in India, and what causes sustain its persistence?
- What are the advantages and disadvantages of existing Indian laws and policies concerning healthcare access?
- In what ways do socio-economic gaps affect the implementation of legal rights to healthcare across different Indian states?
- What are the legal frameworks for enhanced healthcare access in India?

- What legal reforms are essential to enhance healthcare access and guarantee equitable allocation of healthcare resources in India?

1.6. HYPOTHESIS

1. The Inverse Care Law markedly intensifies health inequities in India, resulting in marginalised populations suffering poorer health outcomes relative to more affluent groups.
2. The current legal framework in India is insufficient in tackling the obstacles to healthcare access, resulting in exacerbating disparities in service availability and quality.

1.7. RESEARCH METHODOLOGY

The research approach employed in this study is a doctrinal research method. This legal research technique is a systematic approach that emphasises the examination and analysis of existing legal principles, legislation, judicial decisions, and other scholarly commentaries relevant to healthcare access and the Inverse Care law in India. It derives conclusions and ideas from reputable legal authorities and sources.

1.8. SCHEME OF CHAPTERS

1.8.1. Chapter 1: Introduction

The first chapter generally introduces the subject of the dissertation. This chapter includes the scope of the study, research objectives, research problems, hypothesis, and the limitations of the study.

1.8.2. Chapter 2: – Inverse Care Law as a Doctrine in Healthcare- An Analysis

This chapter explores the Inverse Care Law as a Doctrine in healthcare, tracing its origin and evolution. It provides a detailed discussion of Julian Tudor Hart's formulation from 1971 and examines the conceptual foundations of healthcare inequalities. The chapter analyzes theoretical concepts such as the social determinants of health and the principle of distributive justice in healthcare.

Additionally, it reviews how health inequities have been recognised in various international "soft law" instruments and by constitutional principles in multiple countries. By the end of Chapter 2, readers will have a comprehensive understanding of the Inverse Care Law and its usefulness as a framework for analysing health rights in India and beyond.

1.8.3. Chapter 3: - Exploration of relevance of Inverse Care Law in Healthcare systems- Comparative perspective

Chapter 3 examines the relevance of the Inverse Care Law across various healthcare systems worldwide, providing a comparative analysis. It looks at case studies from specific jurisdictions, including the United Kingdom's National Health Service (contextualised within Hart's study), the United States' market-driven healthcare model, and other countries like Brazil and South Africa, which have established the right to health in their laws. It also considers nations that experience the least healthcare inequity and those countries that share economic similarities with India. The chapter highlights how each healthcare system either exacerbates or mitigates the inverse care phenomenon. It draws lessons on how policy choices, such as the level of public funding, universal coverage schemes, and community health networks, can help reduce disparities. These comparative insights pave the way for reflecting on India's situation by illustrating what has worked or failed in other contexts to bridge healthcare gaps.

1.8.4. Chapter 4 – The Inverse Care Law in India: Legal Frameworks, Challenges, and Prospects:

This chapter serves as the core analytical section focusing on India. It delves into the existing legal frameworks related to healthcare access, including constitutional provisions and national health laws such as the Clinical Establishments Act and various public health acts. It also examines initiatives like Ayushman Bharat and relevant judicial decisions.

The chapter evaluates how these frameworks cater to the needs of the poor and marginalized, highlighting both progress and ongoing challenges. Key issues discussed include the urban-rural divide in healthcare infrastructure, the shortage of healthcare professionals in rural areas, the role and regulation of the

private sector, and the impact of insurance schemes on equity.Using the lens of the Inverse Care Law, this chapter critically assesses whether India's legal and policy measures effectively address the "inverse" distribution of care. The latter part of the chapter looks ahead, analyzing ongoing initiatives and proposals, such as recent moves to recognize a right to health at the state level, and evaluates their potential to address the dynamics of inverse care. Overall, this chapter paints a comprehensive picture of the legal landscape of Indian healthcare and examines how it aligns with or falls short of the demands for equity.

1.8.5. Chapter 5: Research Findings, Conclusions, And Suggestions:

The final chapter synthesizes the findings of the dissertation and provides concluding reflections. It reiterates the key insights gained regarding the gap between constitutional ideals and the reality of healthcare under the Inverse Care Law in India. Importantly, this chapter proposes specific recommendations for legal and policy reform that directly address the research questions. These recommendations aim to strengthen India's laws to ensure that the right to health is made more explicit, justiciable, and effective for those most in need. The proposals may include drafting and enacting a constitutional amendment or legislation to recognize health as a fundamental right, increasing budgetary allocations to healthcare guided by equity (potentially through statutory minimums or the establishment of monitoring bodies), improving accountability through health commissions or ombudspersons, and fostering community participation in health governance to amplify the voices of marginalized populations. The chapter concludes with reflections on the broader implications of this research, emphasizing that addressing the Inverse Care Law is essential not only for improving healthcare outcomes but also for fulfilling India's constitutional vision of justice and equality. In closing, the dissertation highlights potential avenues for future research, such as conducting deeper empirical studies on health inequities or evaluating the impact of any new health rights legislation, underscoring that the pursuit of health equity through law is an ongoing journey.

1.9. LIMITATIONS OF THE STUDY

1) **Primary Empirical Data Collection Not Undertaken:** This research does not involve new empirical fieldwork, such as surveys, statistical analysis, or clinical data collection. Instead, it relies on existing data, reports, and studies to provide evidence of healthcare disparities. The approach taken is legal-doctrinal and qualitative; quantitative public health analyses, such as detailed epidemiological or econometric modeling of healthcare utilization, are beyond the scope of this study. Consequently, the conclusions about the extent of inequality are drawn from secondary sources, such as the National Family Health Survey data and WHO reports, rather than original data collected by the author.

2) **Scope of Healthcare Issues:** The dissertation provides a broad overview of healthcare access and does not extensively explore specialized sub-fields within health, such as mental health law, reproductive rights, or pharmaceutical regulation, except where they serve to demonstrate the general inverse care problem. The focus is primarily on general healthcare delivery systems and basic medical services. Specific disease-oriented programs or vertical initiatives, such as those addressing HIV or tuberculosis, are not individually assessed, but are mentioned as examples to highlight broader legal themes.

3) **Geographical Focus:** The primary focus of this dissertation is at the national level, examining Union (central) laws, constitutional mandates, and nationwide policies. Although state governments in India also legislate and implement health measures—since health is a subject that falls under both Union and State authority—the dissertation does not conduct a state-by-state legal analysis. It does consider state-level innovations and challenges and uses inter-state comparisons to highlight disparities. However, detailed examinations of each Indian state's health laws or performance are beyond the scope of this study. Instead, it employs representative examples and aggregated comparisons to illustrate its points, with an emphasis on structural issues affecting India as a whole.

4) **Comparative Analysis-Bounded:** The comparative perspective presented in Chapter 3 aims to draw lessons and place India's situation in context. However, it is not a comprehensive study of any single country's healthcare system. Only select

countries or global examples are discussed based on their relevance to the Inverse Care Law. The limitation of this chapter is that it highlights key contrasts and norms, such as how the UK, in Hart's context, addressed inequities, or how certain other countries constitutionally guarantee health rights, without attempting to cover every possible comparison. The goal is to enhance the Indian discourse rather than to thoroughly review foreign healthcare systems.

5) **Time Frame:** The legal analysis is current as of 2024 and does not include developments that occurred after this period, such as new court judgments or legislative changes. While historical context is provided, including the evolution of laws and policies since independence, the primary focus is on the contemporary situation and the recent decades, particularly the economic changes following the 1990s and the rise of public interest litigation related to health..

6) **Normative Focus:** It is important to note that this work focuses on normative and legal-ethical analysis. It evaluates what the law should do to ensure justice in healthcare, in addition to describing the current legal landscape. The dissertation does not engage in a cost-benefit analysis of specific health policies or conduct an implementation science study. Instead, it critically assesses existing legal structures and proposes reforms based on constitutional values. This perspective brings some limitations: while issues of political feasibility and the detailed execution of proposed legal reforms are discussed, they are not the main focus. The primary aim is to provide a legal framework and justification for these reforms, acknowledging that actual implementation will require further policy development and political support.

CHAPTER 2

INVERSE CARE LAW AS A DOCTRINE IN HEALTHCARE – AN ANALYSIS

2.1 ORIGIN AND EVOLUTION OF THE INVERSE CARE LAW

The Inverse Care Law as a doctrinal principle of healthcare equity was formulated by Julian Tudor Hart in 1971 in a seminal article in *The Lancet*. In his much-quoted thesis, Hart saw that "*the availability of good medical care tends to vary inversely with the need for it in the population served*" and contended that this negative correlation functions most perfectly in those situations where the provision of medical services is open to market forces, and least in situations where such susceptibility is alleviated[17]. This contention was formulated as a critical observation of the healthcare system in the United Kingdom, particularly under the post-war National Health Service (NHS), and has since become foundational in the field of the study of inequalities in health[18].

Hart's theory needs to be understood as part of the general background of post-Second World War welfare state growth in Europe, and specifically in the UK. The advent of the NHS in 1948 marked a dramatic turn towards overall health coverage, founded on the ethos of socialism as a basis for equal access[19]. Even in this state-funded model, however, Hart discovered inequalities in healthcare accessibility, particularly in those socioeconomically disadvantaged areas[20]. He saw that, at the same time as affluent populations tended to enjoy advances in medical provision, those populations with a greater disease burden—usually those of the working class, from poor backgrounds—

[17] Julian Tudor Hart, The Inverse Care Law, *297 Lancet 405*, 405 (1971).
[18] S.W. Mercer et al., The Inverse Care Law and the Potential of Primary Care in Deprived Areas, *397 Lancet 775* (2021),
[19] John Appleby & Chris Deeming, The Inverse Care Law, King's Fund (June 21, 2001), *Socialist Health Association*, https://sochealth.co.uk/national-health-service/public-health-and-wellbeing/poverty-and-inequality/the-inverse-care-law/(last visited May 24, 2025).
[20] Richard Cookson et al., The Inverse Care Law Re-Examined: A Global Perspective, *397 Lancet 828*, 828–29 (2021).

tended to be systemically neglected. This discontinuity pointed towards how structural inequality could be sustained in seemingly egalitarian healthcare systems.

Tudor Hart's life experiences helped shape his formulation of the Inverse Care Law. Trained at elite academic centers of learning, at least in his initial positions he was formally involved in research postings, eventually moving on into general practice at a mining village called Glyncorrwg in South Wales.[21] It was in this blue-collar environment that Hart saw in person the gradients of socioeconomic status in terms of health as well as healthcare. His practice featured continuity of care, epidemiological awareness, and population-based practice, setting his clinical practice apart from the dominant episodic as well as specialist-oriented care.[22] His practice reflected a paradigm of social medicine that countered the commercialization of healthcare and prioritized closeness to community needs.

The Inverse Care Law resonated with nascent critiques of healthcare inequality in the UK and other high-income countries. Later empirical work confirmed Hart's observations, demonstrating how patients living in disadvantaged locations suffered not only from greater burdens of illness but also poorer access to diagnostic and therapeutic services.[23] nascent critiques of healthcare inequality in the UK and other high-income countries. Later empirical work confirmed Hart's observations, demonstrating how patients living in disadvantaged locations suffered not only from greater burdens of illness but also poorer access to diagnostic and therapeutic services.[24]

The concept of *proportionate universalism*, developed by Michael Marmot, further elaborates on the original findings of the Inverse Care Law. Marmot posits that interventions to curb the inequality of health must be universal in nature but graduated in intensity in proportion to the degree of disadvantage.[25] This model resonates with Hart's vision but adds a sophisticated understanding of implementation allowance for diverse social determinants. According to Marmot, the fact that the Inverse Care Law continues to be applicable today demonstrates a failure not just of market regulation but

[21] Penny Warren, Julian Tudor Hart: Visionary General Practitioner Who Introduced the Concept of the "Inverse Care Law," 362 *BMJ* (July 9–15, 2018)
[22] Julian Tudor Hart, Commentary: Three Decades of the Inverse Care Law, 320 *BMJ* 18, 18 (Jan. 1, 2000)
[23] Stewart W. Mercer & Graham C. M. Watt, The Inverse Care Law: Clinical Primary Care Encounters in Deprived and Affluent Areas of Scotland, 5 Annals Fam. Med. 503, 503–04 (2007).
[24] Graham Watt, The Inverse Care Law Today, 360 *Lancet* 252, 252–53 (2002).
[25] Michael Marmot, An Inverse Care Law for Our Time, 362 *BMJ* (July 30–Aug. 5, 2018)

of political will to reform healthcare delivery systems in accordance with social gradients.[26]

Thus, the Inverse Care Law continues to be a powerful doctrinal tool to probe the maldistribution of healthcare, grounded in Hart's critical practice as well as reflective of evolving structural inequities. Although originally developed in the context of the British NHS, its applicability is far broader, including countries such as India, where the dynamic interplay between disease-related poverty, market-driven medicine, and under-resourced public healthcare facilities dramatically demonstrates its continued pertinence. In India, regardless of constitutional social justice promises and the Directive Principles' priority on public health through Article 47 of the Constitution[27], healthcare coverage remains highly differentiated. The preeminence of private healthcare—frequently beyond the reach of broad sectors of the population—worsens disparities, especially in rural and underserved districts. The Inverse Care Law thus offers a theoretical prism according to which the Indian healthcare scene can be critically evaluated, emphasizing the imperative of structural reform inspired by equity and proportion. Its legacy continues to shape global as well as Indian discourses on healthcare justice, invoking system realignments that prioritize need over profit and access over exclusion.

2.2 CONCEPTUAL FOUNDATIONS AND THEORETICAL UNDERPINNINGS

The Inverse Care Law, which was first defined by Julian Tudor Hart by means of empirical observations, has important moral, legal, as well as policy implications. At its nucleus, this principle identifies a systemic issue i.e. the most in need of healthcare most commonly receives the least good and accessible care.[28] This structural phenomenon questions broad issues of justice, equality, as well as legal accountability. In turn, the Inverse Care Law is not only a descriptive phenomenon but also a critical framework for analysis of healthcare inequities in legal as well as governance spheres.

2.2.1. The Moral and Legal Dimensions of the Inverse Care Law

[26] Id.
[27] India Const. art. 47.
[28] Hart, supra note 1,

Morally, the Inverse Care Law is a violation of the principles of basic fairness as well as distributive justice. When healthcare systems fail to respond proportionately to the needs of the most disadvantaged, the result is a morally indefensible status quo. The legal dimension is particularly salient in welfare states like India, where constitutional provisions; especially Article 21 (Right to Life) and Directive Principles such as Article 47 (Duty of the State to raise the level of nutrition and standard of living and to improve public health); infuse the obligation to ensure access to healthcare as a component of fundamental rights.[29] Still, the continued existence of structural hurdles highlights the gaps between constitutional guarantees and their enforcement in real life.

Moreover, international human rights law affirms health as a justiciable right. The International Covenant on Economic, Social and Cultural Rights (ICESCR), to which India is a party, obliges states to ensure the highest attainable standard of physical and mental health free from discrimination.[30] Within such legal framework, the Inverse Care Law can be understood as a normative violation of domestic as well as international legal standards.

2.2.2. Theoretical Lenses for Understanding the Inverse Care Law

Various interdisciplinary models have been used to interpret the mechanisms of, and reasons behind, the Inverse Care Law to provide a deeper conceptual understanding. These broadly include social epidemiology, critical theory, development economics, and legal philosophy.

i. Social Determinants of Health *by Michael Marmot***:**

Marmot's thesis on social gradients in health states that outcomes of health are deeply conditioned by non-health factors including income, education, housing, and social exclusion.[31] These determinants result in tiered outcomes regardless of healthcare provision. Marmot believes that equitable healthcare needs to be responsive to such determinants and informed by the principle of "proportionate universalism"—interventions are universal but proportionate to degree of disadvantage.[32] The Inverse

[29] India Const. art. 21; art. 47.
[30] International Covenant on Economic, Social and Cultural Rights, art. 12, Dec. 16, 1966, 993 U.N.T.S. 3.
[31] Michael Marmot & Richard Wilkinson, eds., *Social Determinants of Health: The Solid Facts* (2d ed. 2003).
[32] Marmot, supra note 7

Care Law is a manifestation of a failure to apply this principle, especially in those societies in which market forces supersede equity-planning.

ii. Structural Violence *by Paul Farmer***:**

Farmer introduced the conceptual framework of structural violence as a means of describing how political, economic, and institutional configurations systematically cause harm to marginalized populations.[33] Health inequities are not a matter of chance but are the predictable consequence of social structures that value particular populations over others. The framework of Farmer highlights the invisibility of suffering brought about by policy inertia, legal exclusion, or bureaucratic indifference—conditions that are highly consonant with the logic of the Inverse Care Law.[34] According to this analysis, the Inverse Care Law is not just a matter of healthcare but a result of deeper structural injustices.

iii. Capabilities Approach *by Amartya Sen***:**

Sen's capabilities approach redescribes health, not as the absence of disease, but as a constitutive element of one's freedom to lead a life of dignity.[35] Health, within this framework, encompasses both functioning—meaning an individual's actual state of well-being—and capability, which refers to the real and effective chance to achieve good health. The Inverse Care Law acts as a constraint on capabilities as it limits individual agency in health-seeking behavior by systemically withholding resources and opportunities systemically. This perspective is especially important for legal theory, as it strengthens rights-based claims to entitlements and promotes the concept of substantive equality.

iv. Eco-Social Theory *by Nancy Krieger***:**

Krieger's eco-social framework offers a multi-level analysis of how inequality becomes embodied biologically.[36] It weaves macro determinants (e.g., policy, law, history) with micro-outcomes (e.g., disease prevalence) to provide a holistic framework for

[33] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* 40–45 (2003).
[34] Iccha Basnyat, Structural Violence in Health Care: Lived Experience of Street-Based Female Commercial Sex Workers in Kathmandu, *Qual. Health Res.* 1, 4–7 (2015).
[35] Amartya Sen, Development as Freedom 3–6 (1999).
[36] Nancy Krieger, Methods for the Scientific Study of Discrimination and Health: An Ecosocial Approach, 102 *Am. J. Pub. Health* 936, 937 (2012).

understanding how the Inverse Care Law manifests itself in lived disparities. Its insistence on embodiment, social injustice's biological trace, enhances the legal conceptualisation of the Inverse Care Law by linking law, policy, and health at the population level[37].

2.2.3. Inequality versus Inequity: A Conceptual Clarification

A key distinction needs to be made between inequality and inequity in health. The former implies quantifiable differences in health status or in the availability of care; such differences can be caused by age, by heredity, or by place. The latter implies avoidable, unjust differences caused by social, economic, or legal structures.[38] Inequity is, therefore, by nature, a value judgment calling for redress. The Inverse Care Law, by definition, is a form of inequity: it is a preventable, structurally grounded injustice in the distribution of healthcare resources.[39]

2.2.4. Placing the Inverse Care Law as a Socio-Legal Doctrine

Through scrutiny of the theories and conceptual tools developed above, we can see that the Inverse Care Law can not only be considered a sociological observation but can be a socio-legal doctrine that is capable of directing just policy reform. It is a legal challenge to the status quo, a normative standard for legislative intervention and policy action to correct health injustices. By applying the Inverse Care Law in the interpretation of constitutions, in public health law, and in the adjudication of rights, we can turn it from a descriptive truism into a governing principle of justice in health regulation.

2.3 LEGAL RECOGNITION OF HEALTH INEQUITIES: SOFT LAW AND CONSTITUTIONALISM

International human rights law provides a foundational recognition of health as a human right and addresses health inequities through both binding treaties as well as soft law interpretations. This principle was first pronounced in Article 25(1) of the Universal Declaration of Human Rights (UDHR) which states that "*Everyone has the right to a*

[37] Id.
[38] Inequity and Inequality in Health, *Global Health Europe* (Aug. 24, 2009)
[39] Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, World Health Organization (2008).

standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.[40]." Though the UDHR (1948) is not a binding treaty, the expansive guarantee of Article 25 pertains to an adequate standard of living which includes *healthcare*, reflects a global consensus that access to healthcare and the conditions necessary for health are indeed fundamental rights, this establishes a standard ideal to address and reduce disparities when it comes to access to health care. This standard tends to conceptually address the issue of Inverse Care Law – the observed phenomenon that those who are most in need of care often receive the least amount of it[41] by establishing a right for everyone, most specifically the vulnerable populations, to basic health and well-being without any discrimination.

The International Covenant on Economic, Social and Cultural Rights (ICESCR) builds upon the UDHR's principles with a binding treaty obligation. The Article 12 of the ICESCR explicitly recognises *"the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*[42]. This article requires the States Parties to take specific measures to fully realize the right to health. These measures include taking proper steps to decrease infant mortality, improve environmental and industrial hygiene, prevent and control diseases, and ensure medical care is available to everyone in the case of an illness[43]. The said steps make it clear that the Covenant not only establishes health care as a basic human right but also attacks the underlying causes of inequities in health, such as infant mortality, sanitation, and control of epidemics. This promotes the commitment of resources to public health and preventive care.

As per the Article 2(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), States are to work toward these goals through "progressive realization," utilizing the maximum resources which are available[44]. Importantly,

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Comm. on Econ., Soc. & Cultural Rts**.,** General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), ¶ 2, GLOBAL HEALTH & HUMAN RIGHTS DATABASE (Aug. 11, 2000),https://www.globalhealthrights.org/instrument/cescr-general-comment-no-14-the-right-to-health.

[41] The Lancet Global Health**,** *Breaking the Inverse Care Law*, 9 LANCET GLOBAL HEALTH e218 (2021)

[42] Comm. on Econ., Soc. & Cultural Rts., *supra* note 21

[43] International Covenant on Economic, Social and Cultural Rights art. 12, Dec.16, 1966, 993 U.N.T.S. 3

[44] International Covenant on Economic, Social and Cultural Rights art. 2(1), Dec.16, 1966, 993 U.N.T.S. 3.

Article 2(2) prohibits discrimination in the enjoyment of Covenant rights. This implies that as States progressively work towards establishing their own health systems, they are under a non-derogable obligation to provide access to healthcare facilities and the determinants of good health free from discrimination. This serves as a direct legal countermeasure to the inverse care law, which often results in the poorest and most vulnerable populations being left behind[45].

One of the most important interpretive tools for understanding Article 12 is the General Comment No. 14 (2000) from the U.N. Committee on Economic, Social and Cultural Rights (CESCR). The General Comment offers a "soft law" guidance that establishes the key elements of the right to health. It provides the definitive "AAAQ" structure—availability, accessibility, acceptability, and quality, as standards for assessing if the structure and services of facilities are in conformity with the requirements enunciated in the Covenant[46].

The General Comment 14 states that several requirements must be met by the health facilities, services, and products: they must be accessible to all (which entails non-discrimination, accessibility in form, economic accessibility, and information availability), acceptable (culturally suitable and respectful medically) as well as of good quality (medically and scientifically appropriate)[47]. Specifically, the CESCR stresses that *accessibility* entails non-discrimination and special consideration to the needs of vulnerable or marginalised populations in law and fact[48].

The General Comment insists that states pay particular heed to the issue of equity of care distribution: *"equality of access to health care and health services has to be emphasized"*, and states have a *"special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities"*[49], preventing any discrimination in the providing of care. General Comment 14 makes an important observation: de facto discrimination may be caused by improper distribution of resources for care. For example, the state must avoid overinvestment in highly costly

[45] Comm. on Econ., Soc. & Cultural Rts., *supra* note 21, ¶ 18&19
[46] Benjamin Mason Meier et al., Rights-Based Approaches to Public Health Systems, in *Advancing the Human Right to Health* 72 (José M. Zuniga et al. eds., 2013), https://bmeier.web.unc.edu/wp-content/uploads/sites/700/2015/07/2010-Meier-et-al-Rights-Based-Approaches-to-Public-Health-Systems-Ch.4.pdf.
[47] Comm. on Econ., Soc. & Cultural Rts., *supra* note 21, ¶ 12
[48] *Id.*
[49] *Id.*¶ 19.

tertiary care that is accessible only to a privileged elite at the expense of primary as well as preventive care for the masses.[50]. This guidance directly addresses the problem of *inverse care law* – it demands turning over policy priorities to the basic primary care of disadvantaged groups, thus challenging states to overcome the inverse care law by ensuring *"equal and timely access to basic preventive, curative, rehabilitative health services…preferably at the community level"* [51]. Overall, international instruments attempt to overcome health inequities by calling for health as a right for everyone and by insisting on states making broad coverage a priority, as well as considering equity in the provision of healthcare. By Article 25 of the UDHR, Article 12 of the ICESCR, and the General Comment 14 of the CESCR, international law creates a legal as well as moral framework requiring states to ensure the reduction of disparities in the availability of healthcare, in essence, requiring states to do whatever it takes to *"break the inverse care law"* by ensuring "*equally accessible, quality care for all*."[52].

Constitutional Recognition of Health Inequities in India

At the domestic level, the Indian Constitution and judiciary have taken great strides in recognising the right to health, in conformity with international standards through the lens of constitutionalism. While the Constitution of India does not explicitly lay down a separate fundamental right to health, the Supreme Court of India has interpreted Article 21, which guarantees the right to life and personal liberty, to encompass the right to health and access to healthcare. This interpretation implies that the right to health is an integral component of existing life with human dignity. Article 21's right to life has been understood to mean more than mere animal existence; rather, it encompasses a life with human dignity and decency from which the protection of health is derived[53]. Significantly, the Court has explicitly held that *"the right to health and medical care is a fundamental right under Article 21 since health is essential for making the life of workmen meaningful and purposeful and compatible with personal dignity."* [54]. Through this way, the Indian judiciary involves the principle of constitutional morality and welfare to construe and interpret socio-economic rights in the broader

[50] *Id*.
[51] Meier et al., *supra* note 26, at 107.
[52] *The Lancet Global Health, supra* note 22, at e218.
[53] UJA Legal, *Right to Health in India – Constitutional Perspective*, UJA BLOG (Nov. 23, 2022), https://uja.in/blog/legal-chronicle/right-to-health-in-india-constitutional-perspective.
[54] *Consumer Educ. & Research Ctr. v. Union of India*, (1995) 3 S.C.C. 42 (India).

framework of Article 21. This approach is supplemented by Article 51(c) of the Constitution, which calls for respect for international law and treaty obligations. In fact, the Supreme Court has emphasised that domestic fundamental rights must be interpreted in consonance with international human rights law[55]. On various occasions, the Court has invoked instruments such as UDHR's Article 25 and ICESCR provisions in order to affirm a citizen's right to health [56], thereby incorporating the afore-mentioned *soft law* norms into Indian constitutional jurisprudence.

Further, the Directive Principles of State Policy (DPSPs) of Part IV of the Constitution specifically charge the State with the responsibility of alleviating health inequalities and promoting public health. Though these principles are not law, Article 37 says that they are "*fundamental in the governance of the country*" and serve as a guide to interpretation of fundamental rights. Some DPSPs specifically dealt with health-related problems. For instance, Article 39(e) requires the State to make sure that "the health and strength of workers, men and women, and the tender age of children, are not abused.", thereby requiring protection of workers and children from working conditions that would compromise their health[57]. This demonstrates a constitutional concern for vulnerable workers and minors, emphasising the urgent need to address the disparities faced by these groups. Article 41 imposes a duty on the State to "*make effective provision for securing the right to public assistance in cases of unemployment, old age, sickness, and disablement*,"[58] within its economic capacity. This, therefore, essentially obliges the government to provide support to individuals who are unable to work or afford care due to illness or disability. This provision constitutes a social security for individuals in sickness or disablement with a view to catering to the inequities which confront persons who are in extremely health-related adversities. To be specific, Article 47 lays down that it is the primary responsibility of the State to enhance "*the level of nutrition and the standard of living of its people and to improve public health*". Article 47 thus enhances the improvement of public health and nutrition, which are the key underlying determinants of health, to a constitutional obligation. This means that policies will need to put the population's health on the top, especially for socio-

[55] Biraj Patnaik, *The Fundamental Right to Health Care*, INDIAN J. MED. ETHICS, Jan.–Mar. 2012, https://ijme.in/articles/the-fundamental-right-to-health-care/?galley=print.
[56] *Id.*
[57] India Const. art. 39(e).
[58] India Const**.** art. 41.

economically disadvantaged groups. Together, Articles 39(e), 41, and 47 collectively establish a constitutional scheme that acknowledges health inequities, whether stemming from poverty, hazardous conditions of work, or lack of resources, and calls upon the State to address these issues. The Supreme Court has, on various instances, relied on these Directive Principles of State Policy (DPSPs) to form its interpretation of Article 21. It has been observed that the "*right to live with human dignity*" enshrined in Article 21 is deeply linked to the Directive Principles, including those which are related to health. Therefore, the government's constitutional obligations under Article 21 must thus be interpreted by reference to Articles 39(e), 41, 47, and others.

The Indian judiciary has greatly influenced the right to health and the significance of equity through landmark judgments that deal with and address health inequalities. In the case of ***Consumer Education and Research Centre v. Union of India*** (1995) 3 S.C.C. 42, which dealt with the occupational health risks faced by workers in the asbestos industry, the Supreme Court reiterated that the right to health is a fundamental aspect of the right to life under Article 21[59]. The Court held that maintenance of health is an indispensable aspect to the worker's right to live with dignity, and explained that *"the right to health and medical care [is] a fundamental right…necessary for making the life of the workman meaningful and purposeful with dignity"*[60]. This judicial enunciation specifically met the health disparities between industrial workers, who tend to be poor and are under hazardous conditions, and other members of society. It forced employers and the State to act positively to safeguard workers' health and safety. In *Consumer Education & Research Centre*, the Supreme Court not only included the right to healthcare in Article 21, but also enforced it by ordering measures like medical surveillance of workers and compensation for workers suffering from occupational diseases. [61]. The ruling focused on the fact that withholding healthcare or exposing workers to workplace hazards contravenes the essential rights of the most vulnerable workers. This ensures social justice in the understanding of the Constitution. By affirming the rights to health of disadvantaged workers, the Court illustrated how rights under the Constitution can be utilised to respond to the inverse care law prevalent in

[59] Indian Law Watch, *Right to Health Linked with Right to Life and Right to Live with Dignity*, INDIAN LAW WATCH (Nov. 29, 2022), https://indianlawwatch.com/right-to-health-linked-with-right-to-life-and-rightto-live-with-dignity.
[60] Consumer Educ. & Research Ctr., supra note 33.
[61] Indian Law Watch, supra note 39.

society. Here, it made sure that poor workers were not exposed to disproportionate health hazards without proper care or redressals.

Similarly, in the case of ***Paschim Banga Khet Mazdoor Samity v. State of West Bengal***[62], the Supreme Court clarified the disparity in terms of access to emergency medical care for a poor victim of a train accident. The case involved a labourer named Hakim Sheikh, who had suffered serious injuries from a train accident and was denied admission to multiple government hospitals in Kolkata due to a lack of beds and facilities.[63] The Court considered this situation to be a significant failure of the public healthcare system and also a violation of Article 21 of the Constitution. The Supreme Court concluded that the right to life under Article 21 encompasses the right to timely and adequate medical treatment in government hospitals. It reiterated that the State has a constitutional duty to provide emergency medical care and that failure to give timely treatment on the part of a government hospital to a patient in need constitutes a violation of the patient's right to life[64].

Interestingly, the State government claimed lack of resources as an excuse for refusing life-saving treatment, but this was rejected by the Court. The ruling declared that the obligation of the government to provide health care under Article 21 cannot be sacrificed at the altar of fiscal constraints. This precept conforms to the position of the Committee on Economic, Social and Cultural Rights (CESCR), which prioritizes that even during instances of scarcity of resources, vulnerable persons need to be safeguarded[65]. The Supreme Court, apart from ordering compensation to the victim for violation of their rights, also ordered reforms at the system level. It ordered the State of West Bengal to enhance budgetary allocations for public health, to increase medical facilities, to set up emergency accident centers in hospitals, and to come out with a blueprint to ensure that such accidents do not recur in the future[66]. With these general remedial orders, Paschim Banga demonstrates the judiciary's recognition of a grave health inequality: urban government hospitals were poorly equipped to deliver

[62] Paschim Banga , supra note 14
[63] Paschim Banga Khet Mazdoor Samity v. State of West Bengal*: Affirmation of Article 21 Right to Immediate Medical Care in Government Hospitals*, CASEMINE (Apr. 30, 2020), https://www.casemine.com/commentary/in/paschim-banga-khet-mazdoor-samity-v.-state-of-west-bengal:-affirmation-of-article-21-right-to-immediate-medical-care-in-government-hospitals/view.
[64] Id.
[65] Comm. on Econ., Soc. & Cultural Rts., supra note 21, ¶ 18
[66] Paschim Banga , supra note 62

emergency care to the poor. This ruling illustrates the exercise of constitutional authority to induce the State to act to further more equitable access to healthcare. It has since been cited as a reaffirmation that the right to health, particularly in the context of emergency medical care, is an integral part of Article 21. Further, it clarified the principle that the State's obligation to protect life extends to positive action in the provision of healthcare services to all sections of society[67].

The Supreme Court's jurisprudence has consistently reiterated the duty of the State duty to mitigate health inequities. For instance, almost immediately after the ruling in *Paschim Banga,* the Court reaffirmed in *State of Punjab v. Mohinder Singh Chawla*[68] that "*the right to health is integral to the right to life,"* underlining the constitutional role of the government to ensure that health facilities were made available for the purpose of protecting that right[69]. Further, the Court has also stepped into the arena of Public Interest Litigations (PILs) to enjoin the medical treatment of downtrodden people. This involves offering life-saving drugs, enhancing facilities in government hospitals, and allocating free treatments to poor patients; all within the purview of Article 21, in accordance with the humanistic ethos of the Directive Principles of State Policy (DPSPs)[70].

Through judicial actions, Indian constitutional law has come to align more and more with the model of "availability, accessibility, acceptability, and quality[71]." Courts have called upon the State to make health facilities available and accessible, e.g., by opening primary health centres in rural settings. They have also required that services be made accessible without cost, imposing free or subsidized treatment on those who need it to provide economic accessibility. The courts have also pressed the significance of acceptable quality by denouncing negligence and below-par care and regulating essential medicines and private hospitals to guarantee proper quality[72].

Finally, the acknowledgment of health inequities is clear in international soft-law instruments as well as in India's constitution. On a global level, the right to health, as

[67] Id.
[68] 1997 (2) SCC 83
[69] Indian Law Watch, supra note 39.
[70] Biraj Patnaik, *supra* note 34.
[71] Kajal Bhardwaj & Veena Johari, COVID-19 Vaccines in India: Judicial Blind Spots in Upholding the Right to Health, 18 Socio-Legal Rev. 119 (2022), https://repository.nls.ac.in/slr/vol18/iss2/1/.
[72] Id.

articulated in the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), is further developed upon in the Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 14. This comment highlights the importance of equity by instituting the AAAQ criteria, which requires states to prioritise the health needs of the marginalized populations and abolish the discrimination that exists in the healthcare system.

At the national level, India's constitutional jurisprudence has interpreted Article 21 innovatively through the Directive Principles of State Policy (DPSPs), turning constitutional principles into actionable rights. This conversion forces the State to counteract the "inverse care" phenomenon that leaves the poorest and most vulnerable section of society with the weakest access to care. The Indian Supreme Court's acknowledgement of health as a fundamental right, and its insistence on equitable access, as seen in cases like Consumer Education & Research Centre and Paschim Banga, illustrates a constitutional commitment to social justice in healthcare.

This framework, blending elements of soft law and constitutional law, offers a legal foundation for requiring that the government tackle the health inequities that exist in society. This includes allocating resources, enacting policies, and ensuring services so that the right to health is realized for all segments of the population, more specifically those who have historically been underserved and disadvantaged. When viewed through these legal lenses, the inverse care law is not just identified as a societal problem, but rather, it is met with prescriptive obligations to correct the inequalities in healthcare access and outcomes.

2.4 OPERATIONALIZING THE INVERSE CARE LAW IN PUBLIC HEALTH GOVERNANCE

The *Inverse Care Law,* as we have already discussed, highlights a systemic injustice: those who need healthcare the most often have the least access to it, especially when care is distributed based on market forces rather than public needs[73]. Transforming this observation into an actionable governance principle requires integrating the *Inverse Care Law* into public health policy design, legislative mandates, and evaluation

[73] Julian Tudor Hart, *supra* note 1.

frameworks. Let's explore how the principles of the Inverse Care Law—such as need-based allocation, equity-weighted budgeting, and proportionate universalism—can be implemented through regulatory instruments, planning tools, and legal mandates while also acknowledging the practical limitations associated with applying these principles.

2.4.1. Translating the Inverse Care Law into Health Policy Design and Resource Allocation

The Inverse Care Law basically promotes redistributive justice in healthcare provision by urging the distribution of resources as per individual needs as opposed to equally to everyone. Thus, healthcare policy must be focused on targeting resources in accordance with those needs instead of pursuing a universal distribution strategy.

A good example of this concept in practice is the United Kingdom's National Health Service (NHS) where the Inverse Care Law was applied in policymaking. During the 1970s, the Resource Allocation Working Party (RAWP) and, subsequently, the Weighted Capitation Formula were used to redistribute funds according to particular healthcare needs in the population.

This included factors such as age demographics, deprivation indices, and morbidity burdens[74]. These efforts represent a conscious attempt to address and correct the unequal distribution of healthcare services.

A similar philosophy is reflected in Brazil's Sistema Único de Saúde (SUS), which adopts an equity-oriented approach in its health financing mechanisms. It emphasizes decentralization and prioritizes underserved regions[75]. Both models illustrate how the Inverse Care Law can shape funding structures to address systemic health inequities.

In India, the National Health Policy (NHP) 2017 formally acknowledges "reducing inequity" as a primary objective[76]. The policy envisions "*preventive and promotive*" healthcare with universal access, particularly for underprivileged and vulnerable groups. It proposes allocating at least two-thirds of government health expenditure to primary care and recommends an equity-based distribution of resources[77], thereby

[74] Sheila Leatherman & Kim Sutherland, *The Quest for Quality in the NHS: A Midterm Evaluation of the Ten-Year Quality Agenda*, The Commonwealth Fund (2008).
[75] SUS, Federal Constitution of Brazil, 1988, art. 196.
[76] NAT'L HEALTH POLICY, MINISTRY OF HEALTH & FAM. WELFARE, GOV'T OF INDIA (2017).
[77] Id. at 8.

operationalizing proportionate universalism, a principle propounded by Michael Marmot that requires universal services calibrated in intensity to levels of deprivation[78]. However, the India Health System Review (2021) notes that the implementation of these ideals has been inconsistent, with disparities remaining in per capita public health spending across different states and between urban and rural areas[79]. Despite these policy commitments, the Inverse Care Law continues to manifest within the nation, highlighting the need to integrate equity measures into budgeting processes.

The Ayushman Bharat program, particularly through the Health and Wellness Centres (AB-HWCs) initiative, contributes to the partial operationalisation of *Inverse Care Law* by improving primary care infrastructure in rural areas[80]. They have been designed so that comprehensive primary care would be delivered to underserved regions and populations and reduce out-of-pocket expenditures[81]. Notably, the conversion of Primary Health Centres as well as Sub-Health Centres into AB-HWCs is guided by need-based demographic and morbidity indicators that align with the Inverse Care Law principles on responsive provisioning[82]. Further, the governance framework under the PM-Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) includes equity-sensitive planning mechanisms for infrastructure distribution, particularly in rural and vulnerable districts[83]. However, studies warn that the insurance-based PM-JAY scheme may reinforce inequitable healthcare access, as it tends to benefit better-informed and urban populations who have easier access to hospitals, while neglecting the underlying factors that contribute to health inequity.[84]

2.4.2. Integrating Inverse Care Law into Public Health Planning Tools

Implementing the Inverse Care Law requires health planning processes to include equity-focused evaluation tools. Among these tools, Health Equity Audits (HEAs) and

[78] Florence Francis-Oliviero et al., Theoretical and Practical Challenges of Proportionate Universalism: A Review, 44 *Rev. Panam. Salud Pública* e110 (2020).
[79] WHO SEARO, *India Health System Review*, HEALTH SYST. IN TRANSITION (2021).
[80] Ayushman Bharat Programme, NAT'L HEALTH AUTH., GOV'T OF INDIA (2018).
[81] Chandrakant Lahariya, Health & Wellness Centres to Strengthen Primary Health Care in India, 87 *Indian J. Pediatr.* 916, 917–18 (2020).
[82] Ministry of Health & Family Welfare, *AYUSHMAN BHARAT: Health and Wellness Centres Booklet* (2023).
[83] Ministry of Health & Family Welfare, *Operational Guidelines for PM-ABHIM*, ch. 3 & 4 (Oct. 2021).
[84] NHSRC, *Equity in Access to Health Services in India: An Analysis of Public Financing*, (2019).

Equity Impact Assessments (EIAs) have demonstrated effectiveness on an international scale.

HEAs, commonly used within the NHS in the UK, involve a systematic review of health service utilization and outcomes across various population groups. This review helps to determine whether the services meet the needs of the community[85]. These audits have revealed patterns of inverse care and have assisted policymakers in redesigning services to better serve underserved populations.

Similarly, Equity Impact Assessments—tools that predict the potential equity implications of proposed health policies—have become common in many high-income countries. They serve as a mechanism to proactively correct policies that could reinforce existing inequities[86].

Despite their conceptual alignment with Article 47 of the Indian Constitution i.e. duty of the State to improve public health, India has not yet institutionalized such tools within its public health governance. However, efforts by the National Health Systems Resource Centre (NHSRC) in preparing Health Equity Reports and conducting vulnerability mapping have laid the groundwork for this initiative. The NHSRC's equity reports recommend the collection of disaggregated data, performing intersectional analysis (considering factors such as gender, caste, and geography), and developing equity dashboards to help guide programmatic decisions[87].

If these instruments were to be mandated by legislation and routinely implemented, they could provide an evidence-based approach to addressing the issue of inverse care in India's health policy landscape.

2.4.3. Legal Mandates and the Role of Public Health Legislation

Incorporating the principles of the Inverse Care Law into governance requires statutory mechanisms to enforce health equity. Many countries have established public health legislation that mandates minimum care standards, monitors health equity, and provides for emergency responses.

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[85] NHS ENGLAND, *Health Equity Audit Guide*, (2004).
[86] Paula Braveman & Laura Gottlieb, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes*, 129 PUB. HEALTH REP. 19 (2014).
[87] NHSRC, *Health Equity Reports by State/UTs*, (2020).

For example, the UK's Equality Act 2010 mandates that public bodies assess how their policies impact different groups, effectively embedding a form of legislative equity audit[88]. In Brazil, the Constitution guarantees health as a right and enforces equity through statutory principles within the SUS system[89].

In India, some State-level Public Health Acts—such as the Tamil Nadu Public Health Act of 1939, Assam Public Health Act of 2010 and the most recent The Kerala Public Health Act, 2023—include limited provisions for health equity, focusing mainly on sanitary and preventive measures. However, the lack of a comprehensive national public health law limits the enforceability of equity standards[90].

Nonetheless, the Draft National Public Health Bill (2009) and recent proposals for a post-pandemic Public Health Act[91] present an opportunity to establish equity-focused service delivery, set accessibility standards, and define enforceable standards of care in public health[92]. Such a law could introduce "equity triggers"—specific criteria that require the reallocation of resources to underserved areas, based on the principles of Inverse Care Law logic.

2.4.4. Inverse Care Law as a Normative Benchmark in Judicial and Legislative Oversight

The Inverse Care Law may be used as a useful benchmark by courts and legislatures to measure the effectiveness as well as the fairness of public health interventions. Judicial recognition of structural inequalities in healthcare, as amply shown in the *Paschim Banga Khet Mazdoor Samity* as well as *Consumer Education and Research Centre* cases, can be further substantiated by citing the Inverse Care Law. This can be used to check whether the state has fulfilled its promise to deliver care in those very areas where it is most necessary. Governments can also be made to undertake equity-based audits as a part of their compliance with their constitutional mandate.

In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, the Supreme Court held that a failure to deliver timely urgent emergency care to a poor worker violated

[88] Equality Act 2010, c. 15 (UK).
[89] Const. of Brazil, 1988, art. 196.
[90] See e.g., Assam Public Health Act, No. 6 of 2010 (India).
[91] Harshad Thakur, Dr. B.C. Dasgupta Memorial Oration: Post-COVID-19 Pandemic Public Health Issues and Challenges in India, 66 Indian J. Pub. Health 401 (2022)
[92] Thomas SV. The National Health Bill 2009 and afterwards. Ann Indian Acad Neurol. 2009 Apr;12(2):79.

Article 21 of the Constitution[93]. The ruling emphasized the affirmative duty of the state towards ensuring accessibility towards healthcare irrespective of the individual's socio-economic status. Such judicial reasoning lends support to the acceptance of the Inverse Care Law as a constitutional provision, requiring public health resources to be concentrated towards the most disadvantaged. Furthermore, the Court's analysis of "reasonableness" in state resource distribution can be supplemented by the inclusion of the use of equitable indicators on the lines of the Inverse Care Law during judicial review of healthcare budgets and programs.

Parliamentary Standing Committees and CAG audits can apply the Inverse Care Law as a model to check if the government expenditure on public health is focused on the needs of the population, particularly in the disadvantaged districts.

2.4.5. Challenges and Critiques in Operationalizing Inverse Care Law

Despite its compelling appeal, applying the Inverse Care Law in governance has several limitations:

- **Data Gaps:** Accurate and disaggregated data on health outcomes and service utilization are essential to identify inverse care patterns. However, such datasets are often scarce in India.
- **Federal Fragmentation:** Health, being a State subject under the Indian Constitution, leads to the absence of a central public health law. This makes it difficult to achieve equity-based redistribution across states.
- **Insurance-Centric Models:** Schemes such as PM-JAY focus primarily on hospitalization, which can undermine the Inverse Care Law principles by neglecting primary care and the social determinants of health.
- **Political Economy of Allocation:** Budgetary allocations often adhere to political expediency rather than being based on thorough assessments of evidence-based needs.

Despite these limitations, they reinforce the need for a legally anchored, institutionalized equity framework based on Inverse Care Law principles. This can be pursued through public health law reform and innovative health governance.

[93] Paschim Banga , supra note 14

Operationalizing or implementing the Inverse Care Law as a governance principle means having to incorporate equity into the structure of the healthcare system, right from resource allocation to legal overseeing. Foreign International models like the NHS (National Health Service) and SUS (Sistema Único de Saúde) provide valuable precedents. Further, India's own policy instruments, such as Ayushman Bharat, also offer a partial framework for this effort. However, in order to create a fully equity-based public health system, the only way forward is for India to institutionalize the Inverse Care Law principles through legislative mandates, accountability mechanisms, and through the regular use of health equity tools. Chapter 4 of this work will further explore the specific challenges and implementation gaps faced in India.

2.5 CONCLUSION

In this Chapter, we have analysed and thereby traced the conceptual evolution and normative implications of the Inverse Care Law, advocating for its recognition as a socio-legal doctrine with transformative potential rather than merely as an empirical observation. Originally proposed by Julian Tudor Hart[94] as a critique of market-driven disparities in healthcare, the Inverse Care Law now highlights a structural injustice that persists across various regions, including India's mixed and stratified healthcare system. By engaging critically with interdisciplinary theories, from Marmot's concept of proportionate universalism[95] to Farmer's notion of structural violence[96], this chapter establishes that the Inverse Care Law encapsulates a complex matrix of moral, legal, and institutional failures that continue to perpetuate inequity in health access and outcomes.

From a legal perspective, the Inverse Care Law is a powerful critique of states that are not making their health policies responsive to their constitutions and international obligations. In India, where the right to healthcare has come to be understood in terms of Article 21 and guided by the Directive Principles of State Policy, the Inverse Care Law offers a framework for seeing if state activity or inaction reinforces or cushions the existing inequalities. It illustrates how the constitutional promises of equality and

[94] Hart, supra note 1.
[95] Marmot, supra note 9.
[96] Farmer, supra note 17.

justice are denied when healthcare is kept accessible to select geographic locations, social classes, or castes. By emphasizing the Inverse Care Law as a legal standard that embodies substantive equality and the ethical responsibility to prioritize the vulnerable, this chapter argues that Indian public health law must go beyond minimal compliance and actively pursue redistributive justice.

The chapter has also argued for the recognition of the Inverse Care Law as a doctrinal benchmark in health law and governance. It should be viewed not only as a diagnostic tool but also as a guiding principle for legislative reform, judicial reasoning, and administrative policy. Courts, in particular, should apply the logic of the Inverse Care Law to evaluate whether the allocation of public resources meets the constitutional standards of reasonableness and equality. Similarly, public health statutes should incorporate this principle through mechanisms such as equity triggers, minimum service guarantees, and obligations for differentiated provisioning. Such integration would shift Indian health governance from a focus on formal equality to one centred on structural fairness.

In conclusion, the Inverse Care Law should be understood within the context of India's constitutional values and international legal commitments. It is a doctrine capable of shaping the basic framework of public health. Its significance lies not only in identifying systemic neglect but also in promoting institutional responses that are rooted in equity. As India seeks to achieve universal health coverage and inclusive development, the Inverse Care Law provides a crucial framework for evaluating and reimagining health policies.

In the following chapter, this dissertation will focus on a comparative legal analysis of jurisdictions that have actively addressed the issue of healthcare inequity, specifically the United Kingdom and Brazil. The aim is to analyze how equity-based doctrines like the Inverse Care Law have been applied across these nations. From these models, we can glean practical lessons and legal design elements that could inform India on the road to a rights-based, equitable healthcare system.

CHAPTER - 3

EXPLORATION OF RELEVANCE OF INVERSE CARE LAW IN HEALTHCARE SYSTEMS- A COMPARATIVE PERSPECTIVE

3.1 COMPARATIVE PERSPECTIVE ON THE INVERSE CARE LAW (ICL)

The inverse care law posits that the accessibility of medical treatment inversely correlates with the population's need for it. In primary care, disadvantaged individuals have less access to planned appointments and allocate less time with the general practitioner (GP) during consultations compared to their wealthier counterparts. This remains true notwithstanding that those patients from disadvantaged regions often exhibit a greater array of issues during therapeutic interactions compared to those from more prosperous regions[97]. There is an inverse care rule that applies in almost all low- and middle-income countries; that is, those from disadvantaged socioeconomic backgrounds get worse healthcare while having a greater need for it. In addition to budgetary constraints and fragmented health insurance systems, societal inequalities in healthcare access and co-investment, as well as healthcare prices and benefits, impact both statutes[98].

The accessibility of medical treatment often decreases as the demand for it within the population increases. In primary care, disadvantaged individuals have less access to planned appointments and allocate less time with the general practitioner (GP) during consultations compared to their wealthier counterparts. This remains true even though patients from disadvantaged areas often exhibit a greater number of issues during clinical encounters compared to those from more wealthy regions. Patients from impoverished regions tend to see general practitioners as fewer patients and less compassionate compared to those from affluent areas, and a negative association between patient impoverishment and patient-rated enablement in consultations for psychological issues has been documented[99].

[97] A.F. Pedersen & P. Vedsted, Understanding the Inverse Care Law: A Register and Survey-Based Study of Patient Deprivation and Burnout in General Practice, 13 *Int'l J. for Equity in Health* 1 (2014).
[98] Richard Cookson et al., the Inverse Care Law Re-Examined: A Global Perspective, 397 Lancet 828 (2021).
[99] A.F. Pedersen & P. Vedsted, *Understanding the Inverse Care Law: A Register and Survey-Based Study of Patient Deprivation and Burnout in General Practice*, 13 Int'l J. for Equity in Health 1 (2014).

More than 50 years ago, Julian Tudor Hart introduced the Inverse Care Law, positing that the accessibility and quality of healthcare are inversely related to the population's health demands[100]. This is especially true when healthcare services are affected by market factors that adversely impact on the availability of services for disadvantaged groups. The latter pertains to all individuals or groups who are deprived of equitable opportunities and encounter obstacles to health, including poverty and discrimination based on ethnicity, culture, gender, age, and geography, along with resultant issues such as powerlessness and insufficient access to well-paying employment, quality education, adequate housing, safe environments, and healthcare services. The Inverse Care Law is evident in public or universal health systems, when healthcare personnel are mostly allocated based on population size in various geographical regions rather than on actual requirements. In some regions, this may lead to extended waiting lists and reduced consultation durations, although an elevated incidence of co-morbidities and intricate demands (e.g., chronic illnesses, psychological issues)[101].

The Inverse Care Law is still relevant in today's culture, in fact its relevance has increased. Despite this, there are not many public policies that may successfully minimize its effects and make it easier for people to receive healthcare services, especially for populations who are disadvantaged[102]. The law pertaining to inverse care also acts with regard to access to services. The individuals who have the least need for medical care are the ones who make the most frequent and effective use of medical services, in comparison to those who have the greatest need. Both preventive strategies and therapeutic approaches are included in this sphere of concern. Those who are socially and economically affluent have mostly profited from health promotion efforts that communicate information to the broader population in a standardized manner[103].

[100] Julian Tudor Hart, The Inverse Care Law, *297 Lancet 405*, 405 (1971).
[101] H. Alami et al., *Virtual Care and the Inverse Care Law: Implications for Policy, Practice, Research, Public and Patients*, 19 Int'l J. Env't Res. & Pub. Health 10591 (2022).
[102] Anna R. Davies, Matthew Honeyman & Bryony Gann, *Addressing the Digital Inverse Care Law in the Time of COVID-19: Potential for Digital Technology to Exacerbate or Mitigate Health Inequalities*, 23 J. Med. Internet Res. e21726 (2021).
[103] S. Petti & A. Polimeni, Inverse Care Law, 210 *Br. Dent. J.* 343 (2011).

3.2 IMPACTS OF THE INVERSE CARE LAW

Consequences of the Inverse Care Law are immense, and the range is extensive, not only for the individuals but for communities and nations as well. These impacts go beyond the healthcare industry, and in their wake, social, economic, and even political components are influenced[104]. The following are some of the negative effects of the ICL:

3.2.1 Widening Health Inequities

The ICL dramatically increases healthcare inequities and is a cruel injustice for marginalized and economically disadvantaged communities. Those from neglected communities usually have a greater burden of chronic diseases, avoidable illness, and premature death, simply because they do not have access to good healthcare services. Generally, low-income people reside in areas with no healthcare resources, i.e., very few hospitals, clinics, and family doctors, hence, being late in getting diagnosed, not properly managing chronic conditions, and not having very good preventive care[105].

3.2.2 Increased Healthcare Costs

People living in low-income areas, who are underprivileged healthcare-wise, usually wait until their conditions become more serious before consulting a doctor. Failure to get timely treatment after noticing illness symptoms is the major cause of the spread of diseases, which would not have spread, or would have been manageable with timely detection. Consequently, patients without good access to healthcare generally have more complicated and costly problems that, in turn, raise the general cost of healthcare. On the one hand, people suffering from untreated high blood pressure as a result of the absence of regular medical check-ups will, in most cases, unfortunately, have severe heart conditions. Since the treatments of these diseases in the later stages are more expensive, the complications become severe, and the patient's condition is complicated[106].

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[104] J.S. Thakur et al., Social and Economic Implications of Noncommunicable Diseases in India, 36 Indian J. Cmty. Med. S13 (2011) (supp. 1).

[105] Cookson, R., Doran, T., Asaria, M., Gupta, I., & Mujica, F. P. (2021). The inverse care law re-examined: a global perspective. *The Lancet*, *397*(10276), 828-838.

[106] Addison, M., Scott, S., Bambra, C., & Lhussier, M. (2025). Stigma and the Inverse Care Law: Experiences of 'Care'for People Living in Marginalised Conditions. *Sociology of Health & Illness*, 47(1), e70000.

3.2.3 Social Unrest

The ICL has a significant role in the emergence of health inequities that affect not only the health of individuals but also the feeling of social bonding and stability. The unfair allocation and access to healthcare facilities usually generate a sense of unfairness and justice, especially among the underrepresented communities who know that the cause of their suffering is systemic ignorance. This disappointment might be the cause of the fomenting of social protests, as people require unity in their societies. Health disparities that are long-standing have the potential for the escalation of the problem to the point of no return as well as the creation of disruptions and the massive loss of public trust in institutions of government. For example, whenever citizens in poorer dwelling places are confronted by the uncontrollable situation in healthcare centers and are impeded by the irrational healthcare system they get violent about the situation.

3.2.4 Reduced Economic Productivity

The consequences that the Inverse Care Law brings to the economy, like a decline in the population's productivity due to poor health conditions of its big parts, are profound. Thus, the availability of employment for people belonging to communities of the most vulnerable becomes a reality limited by the lack of timely medical assistance. There are a number of chronic diseases that are not timely diagnosed and that are poorly managed, which can cause such problems as regular absence from the job, worse work performance, and early retirement. As a result, the productivity of the nation's workforce is lower.[107] Furthermore, the expenses of a long-standing disease, premature death, and those for chronic diseases' control and treatment not only continue to place a burden on families but also affect the national economy negatively. The families may be forced to pay for the treatment from their pockets, leading to financial difficulties and poverty being intensified[108].

[107] J.S. Thakur et al., Social and Economic Implications of Noncommunicable Diseases in India, 36 Indian J. Cmty. Med. S13 (2011) (supp. 1).
[108] Kevin Fiscella & Peter Shin, The Inverse Care Law: Implications for Healthcare of Vulnerable Populations, 28 J. Ambul. Care Mgmt. 304 (2005).

3.3 HEALTH AS HUMAN RIGHTS: GLOBAL NORMATIVE FOUNDATIONS

Human rights are often one of the leading principles shaping the health care policy in many countries and jurisdictions. According to the WTO, all the countries of the world are signatories of at least one human rights treaty, which covers the domain of the right to health and other rights related to health-protecting conditions as well. "The Universal Declaration of Human Rights (UDHR)" released by the UN states that the provision of healthcare is the right of every person[109]:

Human Rights Article 25**:** "Everyone has the right to a standard of living including adequate food, clothing, housing, medical care and the necessary social services, and the right to security when he does not have work, he is ill, disabled, widowed, an old person, or otherwise lacks the means of subsistence in cases beyond his control"[110].

In certain areas and in faith-based groups with different religious affiliations, health policies are influenced by moral and ethical convictions to serve the needy, which are understood as a religious obligation. A number of other governments and NGOs have based their health programs on humanist ideals, arguing that everyone has an inherent responsibility and right to good health. These days, Amnesty International, a worldwide non-governmental organization, is also speaking out for human rights, with a focus on health as a human right, addressing issues like women's sexual and reproductive rights, the rising maternal mortality rate both domestically and internationally, and the lack of extremely limited access to HIV medications. There is a growing movement among media outlets, lawmakers, and civil society groups to prioritize health as a human right[111].

Unlike government-controlled and regulated entities, investor-owned health insurance businesses and health maintenance organizations really care about their clients' well-being. According to the United States, the public image here depicts the

[109] Lawrence O. Gostin & Benjamin Mason Meier, *Foundations of Global Health & Human Rights* (Oxford Univ. Press 2020).
[110] Nicolás Maisley, The International Right of Rights? Article 25(a) of the ICCPR as a Human Right to Take Part in International Law-Making, 28 Eur. J. Int'l L. 89 (2017).
[111] S. Jayasinghe, Faith-Based NGOs and Healthcare in Poor Countries: A Preliminary Exploration of Ethical Issues, 33 J. MED. ETHICS 623, 623–26 (2007).

deregulation of healthcare and insurance as the immediate extinction of free doctor visits to the less privileged and the older folks in need[112].

3.3.1 Health care Policies

Health policy choices are not limited to the funding and provision of primary healthcare but also include areas such as medical research and healthcare workforce planning, both nationally and globally[113].

- **Medical Research Policy**

Health care research holds a dual role as evidence of health-related policy and the health policy per se. The most recent information on the topic discussed in terms of funding is also based on the conclusions of the most recent studies. The advocates of publicly funded medical research conducted by the government support the point that if a motive for profit is excluded, the number of medical innovations will not only be as high as possible but also surely increase. The opponents of this idea, however, think that the situation became worse than before as the profit motive is recognised as a disincentive for innovation, which inevitably hinders the projection of new technologies and the realization of these new technologies[114].

- **Health Workforce Policy**

Several states and areas have a clear policy or idea of a plan for sufficient numbers, distribution and the level of good quality of medical professionals who would meet the health care goals in the case of, for example, solving the shortage of doctors and nurses. In other places, the workforce planning is left to be done between the supply and demand of labour as a laissez-faire approach to health policy[115].

- **Global Health Policy**

The term global health policy refers to the worldwide systems of government that are responsible for formulating and enforcing health-related regulations. In addressing global health issues, global health policy implies that the health needs of all humans

[112] John Geyman, Investor-Owned Health Care: The Hidden Blight on America's "System," 51 Int'l J. Health Serv. 494 (2021).
[113] L.W. Niessen, E.W. Grijseels & F.F. Rutten, The Evidence-Based Approach in Health Policy and Health Care Delivery, 51 SOC. SCI. & MED. 859, 859-69 (2000).
[114] S. R. Tunis, D. B. Stryer & C. M. Clancy, Practical Clinical Trials: Increasing the Value of Clinical Research for Decision Making in Clinical and Health Policy, 290 JAMA 1624, 1624–32 (2003).
[115] Kuhlmann, E., & Saks, M., *Health Policy and Workforce Dynamics: The Future*, in *Rethinking Professional Governance* 231, 244 (Policy Press 2008).

should take precedence, rather than those of any one country. Global health policy institutions, in contrast to international health policy, which is concerned with treaties between independent states and comparative health policy, which is concerned with comparing and contrasting health policies across different nations, are made up of the people and standards that determine the worldwide response to health issues[116].

- **EU Health Policy**

The European Union (EU) works to enhance the health of its residents via regulating medication treatment, promoting good health, preventing sickness, and providing funds for the public health care system. Patients also have rights while receiving care across borders. The health and medical care services are managed and provided by the health system of the respective country of the EU. The European Union health policy, thus, serves to complement domestic, protect health in the course of EU measures, and build a Health Union rather than a national government. The primary goals of public health policies and initiatives in the European Union are to protect and improve the health of European citizens, to speed up and digitize health systems and infrastructures, to strengthen the resilience of the European health system, and to increase the capacity of EU member states to prevent and respond to future pandemics in Europe. At the senior-level working group of public health, which includes EU officials and heads of state, healthcare and medical policy are discussed. Health policy and yearly work plans within the European Union are developed, among other things, by individuals who collaborate with member states, institutions, and particular interest groups[117].

3.3.2 Policy and Structural Solutions

To tackle the Inverse Care Law by systemic, multi-faceted interventions is to target the healthcare system and the social structures that maintain inequities. Effective responses should be sustainable, inclusive, and proactive, and their aim is not only to increase healthcare access but also to remove structural causes of health disparities. Such key strategies as the following are the ways to lessen the force of the ICL[118]:

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[116] Theobald, S., Brandes, N., Gyapong, M., El-Saharty, S., Proctor, E., Diaz, T., & Peters, D. H., Implementation Research: New Imperatives and Opportunities in Global Health, 392 Lancet 2214 (2018).

[117] **Kieran Walshe et al.,** Health Systems and Policy Research in Europe: Horizon 2020, **382** *Lancet* 668 (2013).

[118] S. M. Benjamin & A. K. Rai, Fixing Innovation Policy: A Structural Perspective, 77 Geo. Wash. L. Rev. 1 (2008).

- **Strengthening Primary Care**

A community-centered primary care system acts as the base of the fair and equal provision of healthcare. High-quality primary care includes services that are first-contact, continuous, comprehensive, and coordinated, which is particularly vital for vulnerable groups. A research study of the Family Health Strategy in Brazil has come to the conclusion that through the development of community-based primary care teams (physicians, registered nurses, and community health workers) health results are significantly increased and health disparities are decreased. A focus on primary care helps to diagnose the mentioned conditions at an early stage, provides better management, and shifts the attention to the prevention of the diseases rather than the response to the crisis only. For successful delivery, the primary healthcare system should be easy to reach, culturally sensitive, and have public health and social services integration at the core. The expansion of community health centers, establishment of home-based care programs, and provision of mobile clinics play a vital role in addressing distant and underserved populations.[119]

- **Incentivizing Equitable workforce distribution**

The uneven distribution of skilled healthcare workers is the main obstacle to equal healthcare delivery. Health specialists usually take city and wealthy areas more than rural and disadvantaged communities. Improving the situation won't work without giving financial and career stimulation, as well as the appropriate construction of the infrastructure. Some of these strategies may involve the introduction of loan aid schemes, difficulty allowances, and quick career development opportunities for health workers who choose to go to the underprivileged areas. Secondly, improving work conditions efforts like offering decent spaces, educational opportunities, mentoring, and housing support ensure no one finds rural service less attractive.[120]

[119] Mercer, S. W., Patterson, J., Robson, J. P., Smith, S. M., Walton, E., & Watt, G. (2021). The inverse care law and
the potential of primary care in deprived areas. *The Lancet*, 397(10276), 775-776.
[120] Fiscella, K., & Shin, P. (2005). The inverse care law: implications for healthcare of vulnerable populations. *The*
Journal of ambulatory care management, 28(4), 304-312.

- **Achieving Universal Health Coverage (UHC)**

UHC is the core in overcoming the Inverse Care Law. The real UHC is not only insurance, but it is if every person can have affordable, quality, and timely healthcare without the worry of finances. The UHC models must mainly be based on the inclusivity and participation of the most vulnerable socially excluded up to the least visible groups. An emphasis on this topic ensure that individuals who are not yet granted access to health care are served through decreased fee subsidies, well-segmented outreach programs, and diversely inclusive service packages covering both preventive and healing measures. An effort to place equity principles at the heart of the UHC design, that is, using Thailand, is thoroughly spelled out in the Universal Coverage Scheme as a pattern of fair, sound policy options can lessen the health disparities significantly.[121]

- **Integrating Social Determinants of health**

Healthcare alone has little to no impact on health inequities if the social determinants of health are not addressed, which are housing, education, income security, employment, nutrition, and environmental conditions. Health is intertwined with these social factors and to foster any sustainable strategy to solve the Inverse Care Law, a health-in-all-policies approach should be implemented. Inter-departmental cooperation of health, education, housing, labor, and urban planning sectors is a must to enable the development of the conditions that are aimed at fostering the equity of health. Healthcare services combined with social support like linking medical checkups with first necessity programs or housing aid have indicated their effectiveness in increasing health outcomes and also life quality for the underprivileged. Upstream investments diminish the future burden on healthcare systems via removing the root causes of sick-health.[122]

[121] Etokidem, A., & Ogaji, D. (2021). The inverse care law: implications for universal health coverage in Nigerian
rural communities. *International Journal of Medicine and Health Development*, *26(1),* 11-16.
[122] National Academies of Sciences, Medicine, Medicine Division, & Committee on Integrating Social Needs Care
into the Delivery of Health Care to Improve the Nation's Health. (2019). Integrating social care into the delivery of
health care: Moving upstream to improve the nation's health.

- **Leveraging Technology to Expand Access**

New technologies have a high potential to change the way healthcare is accessed, especially for people in rural and remote areas as well as other underprivileged groups. e-Health, m-health clinics, telemedicine, and digital health platforms provide possibilities to get online consultations, diagnostic services, and after-care without any hindrance of distance or a person's physical location. While it is true that technology has to contribute to the reduction of health disparities rather than exacerbate them, certain things need to be given attention. So, the focus should be on the interaction of technology with digital literacy, affordability, and connectivity infrastructure. Apart from that, the technology implementation should be such that each layperson has the ability to use this technology. Moreover, it is necessary to provide equal opportunities for people who are from different areas and who speak various languages through user-friendly platforms.

- **Promoting Participatory Policymaking**

It is vital to the healthcare industry that the voices of disenfranchised communities are heard by empowering and involving them in the creation, establishment as well as the evaluation of healthcare policies. The inclusive process can also be termed participatory policymaking that devolves power from the traditional elite to the underprivileged groups, thereby creating an environment for the representation of their grievances, needs and choices. Instruments like community advisory boards, participatory budgeting, health councils, and patient-driven co-design workshops can increase the appropriateness and achievement of health actions. The governance of health is the area of authority in the hands of the local communities is one example of participation in action that is strong in nature and successful[123].

3.4 Causes of social inequality in health care delivery

[123] K.P. Jarboe, The Structural Approach to Planning and Policy Making: Moving Beyond Problem Solving, in *Interdisciplinary Planning* 155 (Routledge 2017).

	Individual Factors	**Geographical Factors**	**Institutional Factors**
"Social inequality in ability to pay for health care".	*Affluent persons can afford to spend more on healthcare and health insurance.*	*Affluent areas may attract more private investment in healthcare services.*	*Providers catering to affluent customers might impose elevated prices and garner substantial gifts.*
"Social inequality in eligibility for subsidized health care insurance".	*Ethnic minorities, homeless individuals, and other marginalized groups may have reduced eligibility for public subsidies.*	*Affluent regions are more capable than slums, rural locales, and ethnic enclaves of attracting public and philanthropic financing.*	*Individuals in elevated status professions may qualify for superior insurance plans with increased state subsidies.*
Social inequality in non-financial barriers to seeking health care	*Individuals with advantages possess enhanced desire and capacity to pursue healthcare and encounter less implicit and explicit prejudice.*	*Individuals residing in affluent regions often have reduced travel durations to and from superior healthcare services.*	*Providers catering to advantaged groups are more effective in minimizing waiting times and other non-monetary obstacles.*
"Social inequality in barriers to co-investment in health care"	*Advantaged patients possess superior human and social capital, enhancing their capacity to adhere to therapy and establish a conducive recovery environment.*	*Reduced pollution, crime, and overcrowding diminish the expenses associated with ensuring a conducive rehabilitation environment.*	*Well-capitalized providers may support co-investment instead of transferring expenses to patients.*
"Social inequality in the costs and benefits of health care"	*Wealthy people exhibit fewer co-morbidities and social issues that escalate healthcare expenditures and diminish their advantages.*	*Wealthy regions are more successful in attracting physicians, resulting in elevated expenses in underprivileged areas.*	*Providers and specialty catering to privileged individuals may provide superior working circumstances and mitigate stigma.*

Table 1: Causes of social inequality in health care delivery

Source: (Richard Cookson, et al.,2021)[124]

[124] Richard Cookson et al., The Inverse Care Law Re-examined: A Global Perspective, 397 *Lancet* 828 (2021).

3.5 COMPARATIVE COUNTRY CASE STUDIES: ADDRESSING OR PERPETUATING THE INVERSE CARE LAW

Inverse Care Law (ICL) is seen to operate in most LMICs, where one sees high private expenditure and highly fragmented systems of public funding with extremely high urban-rural divides, and an incomplete ICL (the Disproportionate Care Law) is found to operate in high income countries. To have a clearer perspective on this matter, let us examine the experiences of many distinct nations[125].

- **United Kingdom (Origin of ICL)**

The concept of the Inverse Care Law (ICL) was first put forward by Julian Tudor Hart in the UK in 1971, to point out how the people in the most need of healthcare are usually the ones who have the smallest amount of access to it. The fact that the UK's National Health Service (NHS) was created with the aim to provide for everyone but still the ICL is there is because of the lack of resourcing in primary care in underprivileged urban areas, inadequacy of workforce, and also because of different access to services in various parts of the country. Initiatives like the Quality and Outcomes Framework (QOF) and the directed use of public health initiatives have been tried to stop these health inequalities, but they are quite often set off by finance. The UK case is a clear example of how not even state-funded systems can prevent the persistence of the ICL. Thus, we can say that the causes of ICL can be the absence of fair resource distribution between different regions and also the need for consistent policy support[126].

- **Brazil**

Brazil is classified as an upper-middle-income nation, with a population of over 220 million people. This example is noteworthy due to its very high GINI coefficient (53.8 in 2018, an increase from around 51.9 in 2015) and the implementation of the National Programme for Improving Primary Care Access and Quality (PMAQ) in 2011. The PMAQ program is a pay-for-performance (P4P) initiative established to enhance primary care delivery via improved cash allocation and organizational structures.

[125] Savyasachee Jha, *The Inverse Care Law*, HAWK RADIUS (Mar. 14, 2021), https://www.hawkradius.com/p/the-inversecare-law.
[126] V. Bolcato et al., *Comparative Study on Informed Consent Regulation in Health Care Among Italy, France, United Kingdom, Nordic Countries, Germany, and Spain*, 103 J. Forensic & Legal Med. 102674 (2024).

Income-related healthcare disparity was evident in Brazil prior to the implementation of the PMAQ; hence, the observed reduction in this inequality suggests that adopting universal healthcare and implementing more effective, targeted programs that reward success may be an effective strategy for addressing the ICL. A contributing aspect to this conclusion may have been that teams in economically disadvantaged regions received more performance incentives than those in affluent ones[127].

- **Thailand**

Thailand exemplifies a commendable success story in universal healthcare, characterized by positive results such as enhanced access to healthcare services, little unmet requirements, and a low likelihood of catastrophic health expenditures. Thailand has a primarily public healthcare system, with around 80% of all hospital beds located in government institutions. Thailand judiciously prioritized initiatives beyond mere service delivery: the government opted to recruit additional medical students from rural regions, ensure hometown placements for physicians, mandate a three-year tenure in district hospitals for all public-school graduates, and enforce penalties for non-compliance. Furthermore, Thailand successfully consolidated a collection of fragmented insurance programs originating from the 1970s into three comprehensive national schemes in 2002. This enhanced financial efficiency and decreased administrative overhead. Although the amalgamation of these three designs would have been preferable, this structure was implemented to cater to the political differences of the day. The administration implemented budget changes that included more stakeholders and enhanced openness in financial reporting. Thailand's experiences have resulted in the flattening of the ICL graph. Although not entirely uniform, Thailand's healthcare system is notably egalitarian and provides comprehensive coverage to all individuals quite consistently[128].

- **United States of America**

The USA is an exception among wealthy nations since it lacks a universal healthcare system or a comprehensive government insurance program. Consequently, more

[127] J. Filippon, S. Bremner, L. Giovanella & A. Pollock, *An Ecological Study of Publicly Funded Elective Hip Arthroplasties in Brazil and Scotland: Do Access Inequalities Reinforce the Inverse Care Law?*, 11 JRSM Open 2054270420920772 (2020).
[128] M. Bazyar, V. Yazdi-Feyzabadi, A. Rashidian & A. Behzadi, *The Experiences of Merging Health Insurance Funds in South Korea, Turkey, Thailand, and Indonesia: A Cross-Country Comparative Study*, 20 Int'l J. for Equity in Health 1 (2021).

pronounced disparities are seen here in contrast to nations with universal healthcare. It has been stated that over fifty percent of the metrics used to assess access showed improvement from 2000 to 2019. Notably, there was an enhancement in individuals obtaining insurance coverage. Significant discrepancies continue to exist, with some worsening, particularly among impoverished and uninsured groups. Specifically, it was shown that socially disadvantaged minorities experienced worse quality of treatment compared to Whites, as indicated by 40% of the recorded quality metrics. Conversely, whereas Asians exhibited worse treatment according to 30% of the documented quality indicators, another 30% said they got superior care compared to Whites. Despite being a wealthy and liberated nation with relatively little rules, America exhibits more healthcare disparity than Thailand. The whole of ICL is not visible here; but the ramifications of imbalanced care legislation are evident[129].

- **Pakistan**

Pakistan retains a strong Inverse Care Law due to the fact that there is a very small amount of public healthcare money that is not enough to cover the health needs of the people, the infrastructure is poor, and there are deep social and economic divisions. The problem of the lack of medical workers and health facilities is very serious in the countryside, but in the cities, even with the best available medical care, people still cannot afford the high cost of private services. The additional factors, such as donor-driven programs, preventive care that has not been well-funded, and poor health governance, also inhibit the closing of the gap in health provision and access. Even if projects such as The Sehat Sahulat Program are developed to provide financial assistance, they are still challenged in achieving the fullest danger of incomplete coverage areas and implementation problems. The situation of Pakistan serves as a typical example of how the inadequate funding and the inconsistency in the administration of public health policies actively maintain the vicious circle of Inverse Care Law in the low-income countries[130].

- **South Korea**

[129] C.A. Klinger, D. Howell, D. Zakus & R.B. Deber, *Barriers and Facilitators to Care for the Terminally Ill: A Cross-Country Case Comparison Study of Canada, England, Germany, and the United States*, 28 Palliat. Med. 111 (2014).
[130] Waeen, Z.A., *Health Care System: A Comparative Study of Pakistan and Norway* (2007) (master's thesis, Høgskolen i Bodø).

South Korea has done remarkable things in terms of its National Health Insurance Service (NHIS) to regard the fact that they nearly achieved universal coverage. Despite the efforts, ICL still exists in a way that it remains difficult for the elderly, rural inhabitants, and the ones with a low income to have access to quality care. A limited investment in primary and community health services besides the concentration on hospital-based care ensures non-inclusive access. Another factor is high out-of-pocket payments for services and drugs that make the poor feel the burden and discourage them from seeking the necessary care in time. Although South Korea resolves issues concerning ICL via well-organized insurance schemes, the existence of gaps in primary care and the question of affordability yet highlight the social disparities[131].

- **Norway**

Norway is one of the countries that have mostly addressed the Inverse Care Law by their universal, well-funded healthcare system, and the strong primary care infrastructure. Equitable access is guaranteed by the publicly financed services, the geographical deconcentration of care, and the initiatives programmed to assist at-risk populations. Policies such as the Coordination Reform and the substantial investment in general practitioners (GPs) are the means for the stability and fairness of the service provided. Although differences in the supply of healthcare arise in various parts of the country, the government takes action to eliminate these disparities by carrying out the financial and telemedicine projects. The case of Norway can be described as a good example of a system that is being proactive in the fight against the ICL through equity-based health governance[132].

- **Taiwan**

Taiwan's National Health Insurance (NHI) system is often given as an example of a successful way to narrow the gap of healthcare inequities. The fact that the system has over 99% coverage not only removes the financial side of the people's concerns, but it also allows them a wide range of medical services[133]. However, the Inverse Care Law

[131] Rhee, J. C., Done, N., & Anderson, G. F., Considering Long-Term Care Insurance for Middle-Income Countries: Comparing South Korea with Japan and Germany, 119 Health Policy 1319, 1329 (2015).
[132] Larsson, A. O., & Moe, H., Triumph of the Underdogs? Comparing Twitter Use by Political Actors During Two Norwegian Election Campaigns, 4 *SAGE Open 2158244014559015* (2014).
[133] Yi-Ting Lee, Yen-Han Lee & Warren A. Kaplan, Is Taiwan's National Health Insurance a perfect system? problems related to health care utilization of the Aboriginal population in rural townships, *34 The International Journal of Health Planning and Management* (2018).

reveals itself as a result of the unequal allocation of healthcare resources such as doctors, thus the less accessible rural and indigenous communities suffering from a lack of medical services. The Taiwanese government has implemented strategies like incentives for rural physicians, the establishment of mobile clinics, and the launching of telehealth solutions to address the problem[134]. Although these actions reduce the differences, the continuous lack of resources indicates that it is not enough for excellent systems to fully eliminate ICL and that they have to always come up with new ways to do it.

- **Sweden**

The healthcare system of Sweden has equity as a core value and thus they make a considerable effort to ensure the services are equally available for all the people regardless of their social status. In view of this, the decentralization that exists enables the county councils to personalize services as per their region's requirements, although on the other hand it has resulted in varying quality of care and access between different areas[135]. Immigrants and those who are on low incomes are sometimes unable to receive necessary medical attention because they encounter linguistic barriers, discrimination, and technical difficulties in the healthcare system. Sweden's focus on health equity in public policy and evidence-based public health interventions has reached remarkable headways in the reduction of health disparities but at the same time has uncovered some hidden pockets of health inequities which remain particularly in marginalized communities[136]. The continuous observation and interventions targeting specific areas are pivotal in maintaining the Swedish equity commitments.

- **Canada**

Canada's healthcare system is a perfect example of a publicly funded healthcare system. The main service delivery is through the principle of universal access to medical services. Even the very long-standing phenomenon called the Inverse Care Law pertaining to the disparities faced by Indigenous people, rural communities, and low-income urban residents is still present. Access to primary care at the point of use is free,

[134] T.Y. Wu, A. Majeed & K.N. Kuo, An Overview of the Healthcare System in Taiwan, 3 *Lond. J. Prim. Care (Abingdon) 115 (2010),*
[135] M. Fredriksson, Universal Health Coverage and Equal Access in Sweden: A Century-Long Perspective on Macro-Level Policy, *23 Int'l J. Equity Health* 111 (2024)
[136] Id.

while there are still some gaps. A great example is the coverage of prescription drugs, dental care, mental health, and vision care services that are indeed the most essential ones for marginalized groups. There are remaining rural and northern areas, which have still a deficit of healthcare professionals and difficulties in accessing specialized care. To solve all these, Canada has not only introduced innovative federal health transfers but also decided on the Indigenous and telemedicine sectors as the areas to invest in. Despite such efforts, barriers still exist, making it challenging to fully achieve healthcare equity[137].

The Inverse Care law problem in the human rights discussion is the government's use of laws to fight competition between private health insurance providers and the public social insurance system, as occurred in Canada's national health insurance program. Free market advocates would contend that this not only causes the affordability of the health care system to be weakened, despite the fact that up to the payment of private services, the public system have the undesired need for resources[138].

Table 1: Comparative Overview of Health Equity Frameworks Across Selected Countries

Country	**Legal Recognition of Right to Health**	**Universal Health Coverage (UHC)**	**Out-of-Pocket Expenditure (% of CHE)**	**Mechanism of Legal Enforcement**	**Primary Care Accessibility & Equit**
United Kingdom	*Statutory via NHS; Equality Act 2010*	*Yes – NHS funded*	*~10%*	*Judicial review; public complaints system*	*Improved but regional uneven*
United States	*No constitutional guarantee*	*No – fragmented public-private system*	*~16%*	*Limited federal/state-based enforcement*	*Highly unequal; insurance-linked acces*

[137] Dehmoobadsharifabadi, A., Singhal, S., & Quinonez, C., Investigating the "Inverse Care Law" in Dental Care: A Comparative Analysis of Canadian Jurisdictions, 107 CAN. J. PUB. HEALTH e538, e544 (2016).

[138] Klinger, C.A., Howell, D., Zakus, D., & Deber, R.B., Barriers and Facilitators to Care for the Terminally Ill: A Cross-Country Case Comparison Study of Canada, England, Germany, and the United States, 28 Palliative Med. 111, 111-120 (2014).

Country	Legal Recognition of Right to Health	Universal Health Coverage (UHC)	Out-of-Pocket Expenditure (% of CHE)	Mechanism of Legal Enforcement	Primary Care Accessibility & Equit
Brazil	*Explicit in 1988 Constitution*	*Yes – SUS system*	*~25%*	*Judicialization of health rights*	*Uneven; PMAQ impro access in poorer areas*
Pakistan	*Directive principles; no justiciable right*	*Partial – limited insurance schemes*	*~60%*	*Weak regulatory framework*	*Severely limited in rur areas*
South Korea	*Yes – via NHIS Law*	*Yes – NHIS*	*~14%*	*Administrative tribunals; judicial appeal*	*Urban-rural disparity persists*
Norway	*Statutory right; equity-focused*	*Yes – publicly financed*	*~15%*	*Strong administrative oversight*	*High accessibility; proactive rural covera*
Taiwan	*Statutory via NHI Act*	*Yes – NHI system (99% coverage)*	*~20%*	*Administrative redress; government subsidies*	*Rural/indigenous gaps addressed by policy*
Sweden	*Constitutional/statutory protections*	*Yes – regionalized model*	*~15%*	*Regional ombudsman and courts*	*Equity emphasized, bu regional disparities persist*
Thailand	*Legislated via National Health Security Act*	*Yes – Universal Coverage Scheme*	*~11%*	*Strong UHC governance and accountability*	*High access; rural recruitment programs effective*
Canada	*Implied in Charter; statutory in provinces*	*Yes – publicly funded provincial plans*	*~15%*	*Rights-based litigation; administrative law*	*Uneven in remote/Indigenous regions*

CHE = Current Health Expenditure (WHO data); data ranges approximated based on latest OECD and WHO statistics.

3.6 COMPARATIVE INSIGHTS: LEGAL RESPONSES TO THE ICL

The Inverse Care Law, which was first conceptualized by Julian Tudor Hart in 1971, explains that the availability of qualitative medical and social care is usually influenced in an opposite way by the demands of the population being served. More simply, the people that need medical attention the most usually get the least support. A very clear example of this situation is in the poor and underprivileged communities. However, through the course of history, different countries and the legal systems of these countries have established different methods to handle the problem which is to balance the distribution of healthcare with a view to promoting justice in healthcare delivery[139].

In the United Kingdom and the Nordic nations, where welfare systems are highly developed, the legal response to the inverse care law has been based on the right to health. A typical example is the National Health Service (NHS) of the UK, which was legally established to offer medical services without charging patients based on financial conditions, the intention being that access should be unrelated to one's income. Furthermore, legislations like the Equality Act 2010, have been created to ensure that non-discrimination occurs in healthcare access. Nevertheless, there are still some areas with issues, especially those marginalized communities. Nordic countries also have healthcare access guaranteed by the constitution or statutory laws, and they use legal instruments to ensure that the provision of services is just and accessible for all, notwithstanding the fact that urban-rural differences still hinder the achievement of these objectives in full[140].

Countries like Brazil and South Africa that have middle income display a contrast in their approaches to the enforcement of the inverse care law. The health rights of individuals are established by the 1988 Brazilian Constitution, supported in particular through the Unified Health System (SUS). Citizens' right to change drugs and treatment can be pursued via legal means, a concept known as the judicialization of health which can be seen as a reflection of lack of accountability on the one hand and a powerful tool for the people on the other. In the same way, South Africa's recent constitutional order has been the source of the right to health care jurisprudence with the result that there have been many high-profile court cases such as the one in which

[139] S. Dhanani & D. N. Blane, The Deep End GP Pioneer Scheme: A Qualitative Evaluation, 29 AUSTRALIAN J. PRIMARY HEALTH 155, 155-64 (2022).
[140] R.B. Saltman & J. Figueras, Analyzing the Evidence on European Health Care Reforms: Experience in Western European Health Care Systems Suggests Lessons for Reform in the United States, 17 HEALTH AFFAIRS 85, 85-108 (1998).

the state was ordered to supply the Treatment Action Campaign to be able to provide the necessary antiretroviral therapy to HIV/AIDS patients[141].

The role of international human rights law is extremely important for the formation of national legal responses. Instruments like the "International Covenant on Economic, Social and Cultural Rights (ICESCR)" state the right to health, thus providing rights advocates and litigators with the necessary instruments to solve the problems of unequal medical care. The judiciaries of some countries have identified the right to health broadly, using the power of the judiciary to announce orders for overall reform and not just for some isolated cases. However, the influence of international standards generally is subject to the government's readiness, the scarcity of resources and the diverse levels of legal adoption within the nation states[142].

The European Union is enabled by the "Treaty on the Functioning of the European Union" to make health laws in conformity with "Article 168 (protection of public health), Article 114 (single market), and Article 153 (social policy)". The European Union has passed laws addressing topics such as the following: the exercise of patients' rights in cross-border healthcare; the regulation of pharmaceuticals and medical devices (pharmacovigilance, falsified medicines, clinical trials); the prevention of health risks associated with insecurity and infectious diseases; the regulation of tobacco use; and the transplantation of organs, blood, tissues, and cells. Concerning health, the European Council may provide member states some suggestions[143].

However, in spite of these legal advances, one major area that needs to be resolved still exists. The laws by themselves cannot solve the real reasons for health disparities that precipitate from social issues such as poverty, education, and housing discrimination. Besides, the solution in many cases is to take away the restrictions to entry, not even solving the issue of quality that can be broadcast in healthcare, so we have a possible situation of inverse care when we talk about under-resourced facilities. The future work here, therefore, needs to include, in this regard, not just stronger legal

[141] Moosa, S., Wojczewski, S., Hoffmann, K., Poppe, A., Nkomazana, O., Peersman, W., & Mant, D., The Inverse Primary Care Law in Sub-Saharan Africa: A Qualitative Study of the Views of Migrant Health Workers, 64 BRIT. J. GEN. PRAC. e321, e321-e328 (2014).
[142] Ssenyonjo, M., *Reflections on State Obligations with Respect to Economic, Social, and Cultural Rights in International Human Rights Law*, 15 *Int'l J. Hum. Rts.* 969 (2011).
[143] Seitz, C., The European Health Union and the Protection of Public Health in the European Union: Is the European Union Prepared for Future Cross-Border Health Threats?, 23 ERA FORUM 543, 543-66 (2023).

guarantees but, also, appropriate policy frameworks, and specific funds allocation, thus ensuring that the legal accords are transformed into tangible, fair health effects. The overall scope of the issue is outlined by the findings of the cross-country comparison showing the power of legal systems to affect health distribution and diminish the inverse care law. But the effectiveness of law-mediation may still only be a potential if the main catalysts or the political and the overall social commitment to equity fail to materialize. The legal provision indeed plays an important role in the realization of the right to health; however, it is only to be done with the implementation of the entire ecosystem and the support from political parties to make the realization of equitable healthcare for all an accomplished fact rather than wishful thinking[144].

Table 2: Legal and Policy Interventions to Mitigate the Inverse Care Law

Country	**Key Legal/Policy Instruments**	**Targeted Measures Against ICL**	**Observed Outcomes**
United Kingdom	*NHS Acts; Equality Act 2010*	*QOF incentives; targeted urban investments*	*Some reduction in disparities; still persistent*
United States	*ACA, Medicaid, EMTALA*	*Coverage expansions; safety-net hospitals*	*High disparities remain, esp. uninsured groups*
Brazil	*Constitution (Art. 196); SUS; PMAQ*	*Performance-based funding; regional equity*	*Decrease in income-based disparities in care*
Pakistan	*National Health Vision; Sehat Sahulat Program*	*Subsidized insurance; weak delivery systems*	*Minimal mitigation; rural exclusion continues*
South Korea	*National Health Insurance Act*	*Extensive coverage; limited primary care*	*Persistent barriers for low-income elderly*
Norway	*Patient and User Rights Act; Coordination Reform*	*GP redistribution; digital outreach*	*Effective equity planning; gaps minimal*

[144] Zoe Nampewo, J. H. Mike & Jonathan Wolff, Respecting, Protecting, and Fulfilling the Human Right to Health, 21 INT'L J. FOR EQUITY IN HEALTH 36 (2022).

Country	Key Legal/Policy Instruments	Targeted Measures Against ICL	Observed Outcomes
Taiwan	*NHI Act; Rural Incentive Policies*	*Telemedicine; rural physician subsidies*	*Partial alleviation of rural disparities*
Sweden	*Health and Medical Services Act*	*Localized resource allocation*	*Reduced disparities; gaps in migrant care*
Thailand	*National Health Security Act*	*Rural postings; unified schemes*	*Flattened ICL gradient; near-universal equity*
Canada	*Canada Health Act; provincial statutes*	*Indigenous health funding; telehealth*	*Persistent inequities in specific populations*

3.7 CONCLUSION: LESSONS FOR LEGAL REFORM AND POLICY INNOVATIONS

The persistent challenges revealed by systemic inequities call for a rethinking of legal frameworks and policy mechanisms. The legal change must come from a deeply rooted point of structural injustices, and the existing laws might also be perpetuating disparities, albeit involuntarily. There's a very significant point that demonstrates the significance of setting up the concepts of equity, accessibility, and responsiveness as the heart of the legal systems. With the help of the proactive legal design approach, it is possible to avoid negative social change before it happens, and at the same time, reduce inequalities that may arise. In addition, reforms should be the result of an ongoing dialogue with the affected communities, thus ensuring that the most affected people have a say in the creation and implementation of the laws in their societies[145].

An innovative policy has to focus on adjustability and collaboration between various sectors. The conventional ways of doing things mostly do not satisfactorily solve complex, interrelated problems in modern society. Hence, responses from the policy need to embrace knowledge from all four sectors-public health, education, housing, and economic development, thus, a total view of social wellbeing result. Progressively, innovative approaches including community lawyering, evidence-based regulation and participatory policymaking have exhibited the potential to reduce

[145] Docteur, E., & Oxley, H., *Health-Care Systems: Lessons from the Reform Experience* (2003).

societal conflicts that emanate from age-old divisions. Not only that but also changes in the law and policy should be incremental for the sake of trial and error, evaluation, and subsequent modification rather than being dogmatic and unchangeable[146].

Another crucial lesson is the need for legal reforms to embrace technological advancements ethically and inclusively. Digital tools can help widen the practice of law, government services can be made more effective and efficient, people can be given a greater say in the democratic process, and provided that they are deployed in a manner that respects the right of every individual and that they do not widen the digital divide. The legal education of people also has a major impact since when they move up to the lawyer and policy maker level, if they are trained to think critically about fairness and systemic changes, then reforms are more likely to be established across many generations[147].

Ultimately, sustainable legal reform and innovative policy make demand a shift in both mindset and method from preserving status quo structures to actively dismantling barriers to justice. Experience from other reforms shows that it cannot be ruled out that the law and policy are considered as a tool of social progress and that changes are made in a way that people relate to the needs and rights of communities that they represent.[148]. The comparative experiences reveal that merely embedding the right to health within legal texts, without concomitant policy, financial, and administrative commitment, often fails to dismantle the deep-rooted social and economic determinants that perpetuate health inequities. Future-oriented legal frameworks must embrace structural changes, prioritize community participation, and integrate technological advancements ethically and inclusively, if the ideals of health justice are to be realized.

While the comparative analysis offers critical insights into how different jurisdictions have addressed, or continue to struggle with, the inverse care phenomenon, it also underscores the importance of context-specific strategies. No model offers a

[146] Uwe Dolata, *Technological Innovations and Sectoral Change: Transformative Capacity, Adaptability, Patterns of Change: An Analytical Framework*, 38 *Res. Pol'y* 1066 (2009).
[147] A. Balan, *Examining the Ethical and Sustainability Challenges of Legal Education's AI Revolution*, 31 Int'l J. Legal Prof. 323, 323-48 (2024).
[148] Pomaza-Ponomarenko, A., Leonenko, N., Cherniahivska, V., Lehan, I., & Puzanova, G., *Dynamics of Legal Transformations: Assessment of Impact on Society and Analysis of Determinations of Changes in the Legislative Sphere*, 7 *Multidisciplinary Reviews* (2024).

perfect solution; rather, each system provides lessons in the interplay of law, policy, and social equity.

In this light, it becomes imperative to critically examine how India, a nation characterised by vast socio-economic disparities and a complex federal healthcare structure, grapples with the challenges posed by the Inverse Care Law. The next chapter explores just that, we will look at India's legal frameworks, judicial responses, and policy interventions in confronting healthcare inequities, identifying both persistent challenges and emerging prospects for reform.

CHAPTER 4

THE INVERSE CARE LAW IN INDIA: LEGAL FRAMEWORKS, CHALLENGES, AND PROSPECTS

4.1 OVERVIEW

Julian Tudor Hart introduced the Inverse Care Law (ICL) in 1971 to illustrate the dual injustice whereby socially poor individuals have a higher prevalence of sickness compared to their socially advantaged counterparts, while also receiving inferior health care[149]. He also observed that social class disparities in primary care provision in the United Kingdom (UK) have been significantly diminished, though not eradicated, by the establishment of the universal, tax-funded National Health Service (NHS) in 1948[150]. Since 1971, minimal global advancement has occurred in addressing the ICL. An extensive ICL, characterized by a reduction in healthcare utilization associated with social disadvantage, remains prevalent in nearly all low- and middle-income nations. A disproportionate inverse care law continues, wherein healthcare utilization rises with social disadvantage but does not align with actual need, even in upper-middle and high-income nations with comprehensive universal health coverage systems[151]. The Inverse Care Law (ICL) is predominantly influenced by financial obstacles to healthcare in uncontrolled markets, with nations exhibiting poorer governance typically experiencing greater ICLs. These barriers, along with the associated inequities, are diminished within integrated systems of universal healthcare[152].

The inverse care law also applies to access to services. Individuals with the least necessity for health care utilize health services more frequently and efficiently than those with the greatest necessity. This pertains to both preventive measures and therapeutic therapies. Health promotion that disseminates information in standardized formats to the general community has predominantly benefited individuals who are socially and economically privileged[153]. The ICL posits that the accessibility of quality

[149] Supra note .
[150] Martin Gorsky, The NHS in Britain: Any Lesson from History for Universal Health Coverage?, in *Health for All: The Journey of Universal Health Coverage* 129 (A. Medcalf et al. eds., Orient Blackswan 2015)
[151] Cookson, R., Doran, T., Asaria, M., Gupta, I., & Mujica, F. P. (2021). The inverse care law re-examined: a global perspective. *The Lancet*, *397*(10276), 828-838.
[152] Id.
[153] Watt, G. (2002). The inverse care law today. *The Lancet*, *360*(9328), 252-254.

medical treatment inversely correlates with the needs of the population treated, with prior studies suggesting that migratory populations may be especially vulnerable to these phenomena[154].

4.2 RELEVANCE OF THE ICL IN THE INDIAN CONTEXT

In India, the ICL becomes remarkably evident both in urban and rural India. In tribal and rural regions inhabited by a major part of India's population, health infrastructure is usually substandard or simply non-existent. Primary Health Centres (PHCs) and Community Health Centres (CHCs), which are supposed to be the pillars of rural health care, are usually overburdened, ill-equipped, or not accessible because of poor transport and communication facilities[155]. Even where facilities are present, there is a critical lack of well-trained medical staff, diagnostic equipment, and basic medicines[156]. This structural deficit forces the poorest groups to have little option but to resort to unregistered private practitioners or skip care altogether, leading to avoidable morbidity and mortality[157].

In urban India, several healthcare problems exist, but one of the most notable is the Inverse Care Law. The urban slums and informal settlements are examples of stark contrasts, where the areas that are close to the high-end private hospitals are not even given the basics of primary care. Further, barriers like lack of finances, information, necessary social relationships, and the location of a healthcare facility deter the urban poor from accessing quality healthcare. At the same time, the private hospitals, which are the main players in the urban healthcare system, are primarily serving the needs of the middle and high-income earners. These people receive services that are too costly for the poor[158].

Moreover, socio-cultural and identity-based factors bring the ICL to a deeper level. Women, Dalits, Adivasis, religious minorities, and people with disabilities are not only marginalized based on their social identity, but also find themselves at the

[154] Mac Innes, H., Walsh, K., & Österberg, T. (2021). The inverse care law and the significance of income for utilization of longterm care services in a Nordic welfare state. *Social Science & Medicine, 282*, 114125.
[155] Y. Balarajan, S. Selvaraj & S.V. Subramanian, Health Care and Equity in India, 377 *Lancet* 505 (2011), https://doi.org/10.1016/S0140-6736(10)61894-6.
[156] Id.
[157] Kelkar, S. (2021). India's Public Health Care Delivery. *India's Public Health Care Delivery; Indian Journal of Psychological Medicine*.
[158] Watt, G. (2002). The inverse care law today. *The Lancet*, *360*(9328), 252-254.

intersection of several vulnerabilities when accessing healthcare. Social norms, deep-rooted discrimination, and group segregation stand as obstacles to seeking assistance even when there are healthcare facilities nearby. Lack of skilled birth attendants and underserved medical care are the primary reasons behind the below-average quality of maternal and reproductive healthcare in numerous rural and tribal regions. That is a burning question of women's wellbeing in rural and tribal places[159].

Despite the law, financial hurdles are additional proof that the law enjoys real force in the Indian environment. The largest share of health expenditure in India is paid personally, and, as a result, the poor are affected to a greater extent. The absence of a universal and comprehensive health coverage plan implies that the majority of the population can still face financial ruin caused by major health issues. Public health projects such as Ayushman Bharat have been initiated to lessen the void, but still, inequality in access across both state and class and laborious relief and protection problems continue to exist, and a deficiency in the services is the result that the program itself is mainly about hospitalization and not about prevention or primary care[160].

Moreover, discrepancies in the health management system and the financial aspects of the states have added to the issue. In some states, such as Kerala and Tamil Nadu, the healthcare system has reached a more equitable level, whereas in states like Bihar, Jharkhand, and Uttar Pradesh, they are still very backwards in both infrastructure and service[161]. Such unequal priority is a clear indication of deep institutional bias that corresponds with the Inverse Care Law's main point that healthcare resources get channelled towards those with a higher level of demand and advocacy, instead of the most impoverished[162].

The dominance of the private sector in the healthcare industry in India further increases the influence of the Inverse Care Law. The provision of more than 70% of outpatient and about 60% of inpatient care by private providers has led to the healthcare

[159] Jabeen, R., Khan, M. A., & Bibi, M. (2020). ENGLISH-THE UPSHOTS AND SOCIO-CULTURAL CHARACTER FOR MUSLIM WOMEN IN ISLAMIC SOCIETY. *The Scholar Islamic Academic Research Journal*, *6*(1), 304-352.
[160] Saheb, S. U., Seshaiah, S., & Viswanath, B. (2012). Environment and their legal issues in India. *International Research Journal of Environment Sciences*, *1*(3), 44-51.
[161] J. Das, B. Daniels, M. Ashok, E.Y. Shim & K. Muralidharan, Two Indias: The Structure of Primary Health Care Markets in Rural Indian Villages with Implications for Policy, 301 Soc. Sci. & Med. 112799 (2022)
[162] Muraleedharan, M., & Chandak, A. O. (2022). Emerging challenges in the health systems of Kerala, India: qualitative analysis of literature reviews. *Journal of Health Research*, *36*(2), 242-254.

sector being commodified. In a quest for maximum revenue, private healthcare institutions usually implement the “cream-skimming” policy to cater to the needs of rich people living in urban zones, forgetting about those who are living in rural areas and are unable to access high-quality healthcare. The prevalent weakness of regulatory bodies worsens the problems of overcharging, unnecessary operations, and disparities in healthcare quality; thus, the results are that the disadvantaged groups are even more disadvantaged[163].

In the Indian health system, the Inverse Care Law is the opposite of a mere theoretical concept. It is very much a part of the daily reality of the health system. The Law, which states that the provision of healthcare services is inversely proportional to the availability of these services, is a powerful summation of the healthcare crisis in the country, which is due to the privatization of the healthcare system and the social reform program being two major causes of the crisis. It is not just infrastructure but the root cause of healthcare inequality that needs to be addressed. This requires public health systems to be strengthened, health financing to be equitable, and community participation to be increased, as well as targeted interventions to be implemented for vulnerable groups. The addressing of the Inverse Care Law in India is not only a matter of honouring the Universal Health Coverage (UHC) but also of redeeming the constitutional commitment to justice, equality, and dignity for all[164].

4.3 LEGAL AND CONSTITUTIONAL FRAMEWORK

Although the Constitution of India has not specifically laid down the Right to Health as a basic right, it has been firmly established through judicial construction as an integral part of the Right to Life under Article 21. Article 21, which proclaims that "No person shall be deprived of his life or personal liberty except according to procedure established by law," has undergone substantial change from being a focused procedural right only to acquiring a wide range of substantive rights required for dignified living[165]. In fact, the Indian judiciary is the prime factor in the metamorphosis of the concept, and more particularly, the apex court has been the driving force. Time and again, the Indian courts, especially the Supreme Court, have come up with crucial decisions that have

[163] Hunter, B. M., Murray, S. F., Marathe, S., & Chakravarthi, I. (2022). Decentred regulation: The case of private healthcare in India. *World Development*, *155*, 105889.
[164] Rao, K. S. (2016). *Do we care?: India’s health system*. Oxford University Press.
[165] India Const. art. 21.

practically made Article 21 very comprehensive, which now includes the right to have a clean environment, access to food, safe drinking water and, most importantly, the access to basic healthcare services[166]. This kind of interpretation is based on the idea that the absence of good health makes life meaningless or undignified. This means that the right to health could not be a mere declaration of the policy, but it must also be a justiciable claim that imposes an affirmative obligation on the authorities to carry out the necessary steps for the physical and mental well-being of their people[167].

This jurisprudential evolution reflects a rights-based approach to healthcare in India, which compensates for the lack of a direct constitutional provision. Being the grundnorm, it is used for the proper elimination of systemic health inequity. It also helps to support legal cases against the inverse care law, which deals with healthcare accessibility. By this statement, health as an implicit fundamental right has made it possible for people to use the law to question the accountability and fairness of health governance[168].

4.4 DIRECTIVE PRINCIPLES OF STATE POLICY

The Directive Principles of State Policy (DPSPs), contained in Part IV of the Indian Constitution (Articles 36-51), are not legally enforceable but serve as a guide for governance in India. The part of these guidelines which are not binding on the judiciary is indeed the most pertinent to the nation, and it is the State's responsibility to guide itself by those guidelines while enacting its laws and policies. The DPSPs are a complete statement for the welfare state that focuses on the integration of social and economic justice – a vision that is in direct resonance with the need to tackle structural health inequalities as indicated by the inverse care law[169].

- **Article 38: Promotion of Welfare and Reduction of Inequalities**

According to Article 38(1), the State must establish a social order based on justice, social, economic, and political, to develop people's well-being. Subsequently, Article

[166] Shriya Jaiswal, Article 21 – Its Scope and Expansiveness, 4 Indian J. Legal Rev. 1008 (2024).
[167] Srivastava, A. (2023). Right to Health as Fundamental Human Right: A Study of Life with Dignity, Constitutional and Judicial Approach. *Issue 2 Indian JL & Legal Rsch.*, *5*, 1.
[168] Pinto, E. P., & Pinto, E. P. (2021). An Overview of Health Care Jurisprudence in India. *Health Justice in India: Citizenship, Power and Health Care Jurisprudence*, 83-176.
[169] Gebeye, B. A. (2016). The Potential of Directive Principles of State Policy for the Judicial Enforcement of Socio-Economic Rights: A Comparative Study of Ethiopia and India. *Vienna Journal on International Constitutional Law*, *10*(5).

38(2) defines the goal of the country as the eradication of not only income but also status, facilities, and opportunities differences among individuals and groups living in various areas or belonging to various vocations[170]. When it comes to health, this Article fundamentally outlines what ought to be the necessity of correcting medical care access disparities, more so, the distribution of healthcare services between urban and rural areas and the high incidence of health disparities between the poorer communities. By focusing on fair resource and opportunity allocation, Article 38 goes against the Inverse Care Law, which results from strong social and economic differences[171].

- **Article 39(e): Protection of Workers and Vulnerable Populations**

Article 39(e) directs the State to take measures so that the health and vigour of workers, both men and women, and the children are not abused, and that no citizens are compelled by economic need to take a job unbecoming of their years and ability[172]. This article is of paramount importance for the rights of the working population, the laws that ban child labour, and the regulation of room conditions, particularly in situations where the rule of unwarranted care is strongly outlined. By requiring action to be taken to prevent exploitation and dangerous environments, this rule is an enabler of the establishment of labour laws, benefits in the field of health, and regulatory measures that protect the health of workers on the margins; otherwise, those who have no access to formal health systems would be seriously affected[173].

- **Article 41: Right to Public Assistance in Cases of Sickness and Disablement**

Article 41 of the Constitution states that the government must create sufficient regulations for the purpose of giving the citizens the right to labour, education and social assistance if they lose their job, are aging, are sick, or are disabled; the government is able to apply such measures to the extent of its economic capability[174]. This provision of the article is the basic idea for starting a social security system, especially for the most vulnerable layers of the population, like the old, the disabled, and the incurably

[170] India Const. art. 38(1)–(2).
[171] Pechdin, W., Sarnkhaowkhom, C., Kanthanetr, S., & Willemse, M. P. (2023). Retelling social inequalities in the era of market competition: Review and discussion for sustainable welfare development. *Frontiers in Sociology*, *8*, 1085278.
[172] India Const. art. 39(e).
[173] Chapman, A. R., & Carbonetti, B. (2011). Human rights protections for vulnerable and disadvantaged groups: The contributions of the UN Committee on Economic, Social and Cultural Rights. *Human Rights Quarterly*, *33*(3), 682-732.
[174] India Const. art. 41.

sick. It stresses out the role of a state to ensure healthcare and welfare to citizens who, otherwise, may not have access or resources to seek it. The article is actually an additional argument for the idea of the need for social insurance, social care services for disabled persons, and the medical treatment in public hospitals, which are free or available at a low cost and which are the necessary measures to break the vicious circle of Inverse Care[175].

- **Article 47: Duty of the State to Improve Public Health and Nutrition**

Health-related provisions in the Constitution, Article 47, place it as a primary duty of the State to raise the level of nutrition, improve the standard of living, and improve public health. This also means that the State is not only permitted but even obliged to control the consumption of alcoholic beverages and narcotic drugs that are harmful to health[176], which indicates the acquisition of the preventive health care policy from the very beginning of the formation of the state. Through Article 47, the government backs up its major health initiatives like the programs for ending hunger, vaccination campaigns, and the campaigns to raise public awareness on the issues of substance abuse in society. This article justifies actively the State's efforts in various national health issues, such as the maternal and child health care programs that lead to the decline of public health epidemics and those that ensure that food and drug safety are well-regulated. The inverse care law directly makes this article the agent of state intervention, allowing the government to take measures to prevent and eradicate the above-mentioned healthcare inequalities[177].

[175] Gostin, L. O. (2000). Human rights of persons with mental disabilities: The European Convention of Human Rights. *International journal of law and psychiatry*, *23*(2), 125-159.
[176] India Const. art. 47.
[177] Olafsen, M., Rukooko, A. B., Iversen, P. O., & Andreassen, B. A. (2018). Examination of the roles and capacities of duty bearers responsible for protecting the human rights to adequate food, nutritional health and wellbeing in Ugandan children's homes. *BMC International Health and Human Rights*, *18*, 1-14.

4.5 RELEVANT LAWS AND SCHEMES ADDRESSING HEALTHCARE INEQUITIES IN INDIA

The legislative and policy environment of India has been significantly changed with the introduction of key frameworks that have been targeted to enhance health care access and reduce the disparities in the systems. Despite the fact that such efforts have achieved a lot, the question of the Inverse Care Law still persists without resolve. Those who are most in need of care are often faced with the least access. Of great importance is therefore a look into the main programs and legislations which constitute the core policies to remedy the healthcare inequities[178].

- **National Health Mission (NHM)**

Initiated as National Rural Health Mission (NRHM) in 2005 and further expanded in 2013 with the introduction of National Urban Health Mission (NUHM) as part of the National Health Mission (NHM), this is deemed to be the largest initiative ever implemented in India to ensure that universal, safe, and affordable healthcare services are provided. NHM is the central program of the health system in the primary and secondary sectors, with particular attention to the areas that are under or unserved that it aims to reach. The implementation of the program is based on the principles of delegation of power at the local level, participation of the community, and inter-sectoral cooperation and it puts additional weight on the aspects of improving maternal and child health, vaccination as a preventive measure against infections, and control of diseases[179].

One of the NHM's major accomplishments was the introduction of Accredited Social Health Activists (ASHAs), female community health workers who manage as the intermediary or the bridge between the healthcare system and the far-off populations[180]. These workers have played a pivotal role in connecting those last-mile service gaps and the health care system, especially for people who come from tribal and underprivileged areas where formal healthcare infrastructure is almost non-existent[181].

- **Clinical Establishments (Registration and Regulation) Act, 2010**

In 2010, the Clinical Establishments Act (CEA) was developed with the aim of providing standardised rules and laws to both public and private healthcare facilities throughout India. The Act requires the registration of all clinical establishments, such

as hospitals and nursing homes, through diagnostic centres and their adherence to at least the standards set for the building area, personnel, aid, and price transparency. The main objective of this Act is the quality of medical services and the rights of the patient, especially in the private healthcare field that happens to be monopolistic today[182].

- **Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PM-JAY)**

Ayushman Bharat was launched as recently as 2018 and is a remarkable initiative in the direction of UHC in India. The two main components of the program are the Health and Wellness Centres (HWC) and the Pradhan Mantri Jan Arogya Yojana (PM-JAY). The HWCs will be the cornerstone of a new primary healthcare design that aims to deliver primary care services through a comprehensive service delivery approach, including the provision of non-communicable disease screening, basic diagnostics, and preventive care. Trained staff will staff HWCs. Services like screening for non-communicable diseases, diagnostic testing, and preventive care are provided. The HWCs, by decentralising services instead of centring them around urban, highly populated areas, hence, reducing the pressure on the tertiary care units and promoting the concept of early intervention, become the core of the so-much-needed transformation in the structure of the healthcare system[183].

The PM-JAY component enables health insurance coverage of ₹5 lakh per family per year for secondary and tertiary hospitalisation. The number of beneficiaries, who are more than 500 million people, with a significant portion representing those who are socio-economically disadvantaged, are the ones that the project aims to be the most satisfied since it reduces the number of individuals facing a financial crisis due to

[178] Nambiar, D., Muralidharan, A., Garg, S., Daruwalla, N., & Ganesan, P. (2015). Analysing implementer narratives on addressing health inequity through convergent action on the social determinants of health in India. *International Journal for Equity in Health*, *14*, 1-10.
[179] Choudhury, M., & Mohanty, R. K. (2020). Role of national health mission in health spending of states: Achievements and issues. *New Delhi: National Institute of Public Finance and Policy*.
[180] Ministry of Health & Family Welfare, Accredited Social Health Activist (ASHA), *National Health Mission*, https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=150&lid=226 (last visited May 24, 2025).
[181] Khanna, R., Prakash, N., & Sharma, A. (2020). Contribution of Accredited Social Health Activist (ASHA) under the Community Health Model of National Health Mission, India. *International Journal of Psychosocial Rehabilitation*, *24*(04).
[182] Samuel, L. (2010). Clinical Establishments (Registration and Regulation) Bill 2010, Critical Analysis. *NUALS LJ*, *4*, 107.
[183] Angell, B. J., Prinja, S., Gupt, A., Jha, V., & Jan, S. (2019). The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the path to universal health coverage in India: Overcoming the challenges of stewardship and governance. *PLoS medicine*, *16*(3), e1002759.

the payment of health services fees out of the pocket and getting new opportunities for the involved community health care[184].

- **The Role of Judiciary and Public Interest Litigation (PILs)**

The Indian judiciary, led by the Supreme Court, has been an assertive protector of health rights, frequently intervening to overcome administrative inertia and enforce constitutional obligations. Through Public Interest Litigations (PILs), the courts have largely enlarged the ambit of the right to health under Article 21 of the Constitution[185].

In *State of Punjab v. Mohinder Singh Chawla (1997)*[186], the Supreme Court of India ruled that health rights are an indispensable component of human life with dignity[187]. The Court has also considered mental health as a constitutional right in the case of *Navtej Singh Johar v. Union of India (2018)*[188], thus further expanding the scope of health to cover a mentally and socially healthy state[189].

A few leading PILs have resulted in visible changes in public health governance. The case of *Swasthya Adhikar Manch v. Union of India (2013)*[190], which is one such PIL, helped unveil illegal clinical trials and was the trigger for stricter regulatory standards. In the aftermath of the PILs presented during the COVID-19 season, the government was forced to ensure oxygen supply, control hospital fees, and make the vaccine available for the vulnerable[191].

These judicial interventions are of great importance in distinguishing the healthcare discrepancies, and this, in turn, will force the State to take immediate action to correct the situation. But it should not be forgotten that legal challenges only indicate a reactive method towards systemic problems. Courts can enforce transient relief and responsibility, but providing sustainable and fair healthcare across the board requires

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[184] Joseph, J., Sankar D, H., & Nambiar, D. (2021). Empanelment of health care facilities under ayushman bharat pradhan mantri jan arogya yojana (AB PM-JAY) in india. *PloS one*, *16*(5), e0251814.
[185] Gupta, P. S. (2023). The Role of Judiciary in Providing Justice Through Public Interest Litigation. *Journal of Scientific Research and Technology*, 1-10.
[186] 1997 (2) SCC 83
[187] INDIA, R. I. (2021). Theoretical foundation of right to health in India. *Routledge Handbook of Global Health Rights*.
[188] 2018 (10) SCC 1
[189] Dixit, P. (2020). Navtej Singh Johar v Union of India: decriminalizing India's sodomy law. *The International Journal of Human Rights*, *24*(8), 1011-1030.
[190] (2013) 1309 SCC Online SC
[191] Pinto, E. P., & Pinto, E. P. (2021). Health Care Jurisprudence and Health Justice: Procedural and Substantive Justice Dimensions. *Health Justice in India: Citizenship, Power and Health Care Jurisprudence*, 177-218.

elaborate legislative, administrative, and financial changes that touch the heart of the inverse care law[192].

4.6 NATIONAL HEALTH POLICY (2017) AND ITS LEGAL IMPLICATIONS

The National Health Policy (2017) of India advocates for healthcare delivery, which is rights-based, inclusive, and holistic in its vision. It not only points out that human beings have a fundamental right to health that is directly linked to the Right to Life of the Constitution, which is Article 21, but also that the State has a constitutional and moral responsibility to provide health services to all[193]. The policy is aimed at the attainment of the best health and well-being for all ages by using the integrated approach, which includes preventive, promotive, curative, rehabilitative, and palliative care services[194].

The NHP 2017 is quite remarkable, mainly because of its explicit statement in favour of equality and universality, targeted at achieving a reduction of health disparities among the population, especially among people who are marginalised and vulnerable. The policy acknowledges the social determinants of health and proposes intersectoral convergence, health imposing in coordination with nutrition, sanitation, education, gender justice, and employment sectors[195].

The National Health Policy 2017 in India is a significant attempt to achieve healthcare as a justiciable right in the country. It targets equity, financial protection, public investment, and systemic reform, which are the blocks of building universal health access. However, the achievement of this objective hinges on the effectiveness of legal and institutional mechanisms to enforce policy as a right. So, the legal impact of NHP 2017 is very deep and it not only gives the pace of public health governance

[192] Mutcherson, K. M. (2005). Minor Discrepancies: Forcing a Common Understanding of Adolescent Competence in Healthcare Decision-Making and Criminal Responsibility. *Nev. LJ*, *6*, 927.
[193] Dehury, R. K., Dehury, P., Sripathi, N., Acharyulu, G. V. R. K., Behera, M. R., & Neeragatti, S. (2023). Health sector development in India: an account from Bhore Committee 1946 to National Health Policy 2017. *Journal of Development Policy and Practice*, *8*(2), 209-242.
[194] Id.
[195] Mishra, M. (2024). Gender and Intersectionality in a National Policy: Document Analysis of National Health Policy (2017), India. In *Handbook on Sex, Gender and Health: Perspectives from South Asia* (pp. 1-18). Singapore: Springer Nature Singapore.

but also fortifies the right to health as human rights, calling for gradual realisation through both legislative and judicial avenues[196].

4.6.1 Key Objectives of NHP 2017

- **Strengthening the Public Health System**

NHP 2017 demands a strong and decentralized health workforce, able to offer a full range of essential health services. This involves the development of primary healthcare, public hospitals, and Health and Wellness Centres (HWCs). The strategy indicates the necessity of enough staff, basic drugs, diagnostics, and facilities[197]. This is a goal that illustrates the change of the health system, from being centred in the hospital to being preventive and community-based, as well as access and accountability are both increased.

- **Universal Access to Quality Healthcare**

The policy focuses on building and supporting the system of universal health coverage (UHC), i.e. making certain that health care of high quality is available to every human being, even when they cannot afford it. Accessibility and rational pricing of services for the poor are the ways by which the policy can adequately address the main issue of health and poverty. Rule of law which commands that there is no discrimination against the poor in terms of health is not just a policy objective but is, in addition, a fundamental element of the constitution and must adhere to the Directive Principles of State Policy stipulated in Article 39 (e), 41, and 47, which also demand that the state shall achieve the health status of the public and there is an equitable distribution of material resources[198].

- **Financial Protection through Strategic Purchasing and Insurance**

A strategy supported by the NHP of 2017 to reduce the excessive burden of health expenditures is the method of strategic purchasing, which means the government channels its finances. It's a mechanism of the government to find and fund only selected

[196] Pinto, E. P., & Pinto, E. P. (2021). Citizenship, Health Care Jurisprudence and Pursuit of Health Justice. *Health Justice in India: Citizenship, Power and Health Care Jurisprudence*, 39-82.
[197] C. Lahariya, Health & Wellness Centers to Strengthen Primary Health Care in India: Concept, Progress and Ways Forward, 87 *Indian J. Pediatr*. 916 (2020).
[198] Sundararaman, T. (2017). National Health Policy 2017: a cautious welcome. *Indian J Med Ethics*, *2*(2), 69-71.

services[199]. One such model in the health sector is the insurance scheme Ayushman Bharat – PM-JAY, which the public sector pays for, as it serves the purpose of risk coverage of citizens to avoid any financial shocks due to medical expenses[200]. Here, the intention is to join the public and private sectors in such a way that the cooperation will be productive and there will be public investment in both under the established rules.

- **Reduction of Out-of-Pocket Expenditure (OOPE)**

NHP 2017 states that when people have to pay out of their own (OOPE) pockets, it is the main reason for poverty and healthcare disqualification in India[201]. 60-70% of the entire health expense in India is the responsibility of people, who quite often end up in debt and financial difficulties[202]. The recommendation is that the OOPE can be reduced via the availability of the required medicines, diagnostic equipment, and quick medical care at public facilities, as well as the provision of state-funded health insurance[203]. This target is in close harmony with the court judgements that ruling out healthcare for economic reasons is a violation of the right to life under Article 21.

- **Regulation and Standardisation of the Private Sector**

The National Health Policy (NHP) of 2017 had realised that the private healthcare sector is mass-oriented but without any regulations. They want the policy to be observed for the creation of effective regulatory frameworks as a way to guarantee quality, affordability, and ethical practices. The policy also stresses the implementation of the Clinical Establishments Act, 2010, NABH standards expansion, and the establishment of pricing mechanisms that are accessible. The whole idea is to create a win-win situation for all actors in the health sector, i.e. the private sector and the public.

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[199] Ila Patnaik, Shubho Roy & Ajay Shah, The Rise of Government-Funded Health Insurance in India, Working Paper No. 231, *Nat'l Inst. of Pub. Fin. & Pol'y* (May 21, 2018),
[200] National Health Authority, Pradhan Mantri Jan Arogya Yojana (PM-JAY), https://nha.gov.in/PM-JAY (last visited May 24, 2025).
[201] S. Sriram & M. Albadrani, Impoverishing Effects of Out-of-Pocket Healthcare Expenditures in India, 11 J. Fam. Med. Primary Care 7120 (2022), https://doi.org/10.4103/jfmpc.jfmpc_590_22.
[202] Taran Deol, India's Persistently High Out-of-Pocket Health Expenditure Continues to Push People into Poverty, *Down to Earth* (Sept. 22, 2022, 8:08 AM), https://www.downtoearth.org.in/health/india-s-persistently-high-out-of-pocket-health-expenditure-continues-to-push-people-into-poverty-85070.
[203] Santosh Kumar, Sheetal Angral & Gouri S., The Decline in Out-of-Pocket Expenditure (OOPE) in Health in India, *Press Info. Bureau* (Nov. 10, 2024, 1:57 PM), https://www.pib.gov.in/PressNoteDetails.aspx?NoteId=153407&ModuleId=3.

Thus, the suitability words about the expected responsibility of the private sector in society are quite relevant[204].

- **Mainstreaming AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy)**

The policy promotes the integration of AYUSH systems with the national health system, valuing their potential for promotive and preventive health in rural and culturally diverse populations. It favours the integration of AYUSH practitioners in primary healthcare, research on traditional systems, and the integration of AYUSH services in public health facilities. The program is legally sanctioned by the Ministry of AYUSH and aims to diversify the healthcare system without affecting quality standards and patient safety[205].

4.7 HEALTH SCHEMES TARGETING VULNERABLE POPULATIONS

Over the years, India has taken the initiative to come up with a list of health schemes that are sponsored by the central government as well as the state authorities. The aim of these schemes is to make healthcare more accessible for the people who have been economically and socially deprived. The formulated schemes are a clear intention of the government to alleviate health access inequalities and combat the negative, far-reaching effects of the Inverse Care Law. Most of these health programs' execution has not been very satisfactory and there is still an ongoing challenge of the system's failure that has been hampering these schemes that have been put in place to be more effective[206].

- **Rashtriya Swasthya Bima Yojana (RSBY)**

Launched in 2008, the Rashtriya Swasthya Bima Yojana (RSBY) marked India's first major effort to extend health insurance to economically vulnerable populations,

[204] Gauttam, P., Patel, N., Singh, B., Kaur, J., Chattu, V. K., & Jakovljevic, M. (2021). Public health policy of India and COVID-19: Diagnosis and prognosis of the combating response. *Sustainability*, *13*(6), 3415.
[205] Shrivastava, S. R., Shrivastava, P. S., & Ramasamy, J. (2015). Mainstreaming of Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy with the health care delivery system in India. *Journal of Traditional and Complementary Medicine*, *5*(2), 116-118.
[206] Wang, N., Xu, J., Ma, M., Shan, L., Jiao, M., Xia, Q., ... & Li, Y. (2020). Targeting vulnerable groups of health poverty alleviation in rural China—what is the role of the New Rural Cooperative Medical Scheme for the middle age and elderly population?. *International Journal for Equity in Health*, *19*, 1-13.

particularly families living Below the Poverty Line (BPL) in the unorganized sector[207]. The scheme offered health insurance coverage of up to ₹30,000 per family per year for hospitalization expenses. Its core objective was to reduce the financial burden of healthcare costs for the poor and to improve access to inpatient services through a cashless, portable, and paperless system. Beneficiaries were issued smart cards, which could be used at empanelled hospitals across the country[208].

Furthermore, the scheme's significant dependence on private healthcare providers brought up equity issues. A lot of private hospitals were said to have declined treatment or have suggested unnecessary procedures for the sake of profit maximisation[209]. It was the scheme that was impaired in terms of achieving the goal of quality and suitable care for the target group[210]. In addition, there were also problems with the RSBY's functioning that derived from technology and data. On the one hand, there were lots of cases of data duplication, exclusion of the same people, and mistakes in the database of beneficiaries, which resulted in waste and fraud[211].

RSBY was quite an essential step in the Indian coverage model of health insurance. Its limits emphasised the need for a much stronger and more inclusive framework. These defects eventually became the inspiration for a new, much wider project—Ayushman Bharat. It was the intention of the latter to address not only the shortcomings of RSBY but the scope of financial protection and of service delivery as well[212].

- **Role of NITI Aayog**

[207] Government of India, Rashtriya Swasthya Bima Yojana, Nat'l Portal of India, https://www.india.gov.in/spotlight/rashtriya-swasthya-bima-yojana (last visited May 24, 2025).
[208] Rana, K. (2017). *Health Insurance for the poor, or privatization by stealth? A study on the Rashtriya Swasthya Bima Yojana (RSBY) in India*. Harvard University.
[209] Kounteya Sinha, Unnecessary Procedures on the Rise in Govt Hospitals Too: Report, *Times of India* (Oct. 16, 2012), https://timesofindia.indiatimes.com/india/unnecessary-procedures-on-the-rise-in-govt-hospitals-too-report/articleshow/16816263.cms.
[210] M. Trivedi & D.B. Saxena, Third Angle of RSBY: Service Providers' Perspective to RSBY-Operational Issues in Gujarat, 2 J. *Fam. Med. Primary Care* 169 (2013), https://doi.org/10.4103/2249-4863.117415.
[211] Prachi Salve & Swagata Yadavar, Why India's National Health Insurance Scheme Has Failed Its Poor, *IndiaSpend* (Oct. 17, 2017), https://www.indiaspend.com/why-indias-national-health-insurance-scheme-has-failed-its-poor-49124.
[212] Virk, A. (2013). *Expanding health care services for poor populations in developing countries: Exploring India's RSBY national health insurance programme for low-income groups* (Doctoral dissertation, Oxford University, UK).

The National Institution for Transforming India (NITI Aayog), which commenced operations in the year 2015 as a successor to the Planning Commission, was set up with the primary purpose of promoting cooperative federalism and being the source of evidence-based policymaking across the sectors, including health. In the arena of healthcare, NITI Aayog has been considered as the mainstay of the country's health goals by not only giving direction but also encouraging the states with new ideas and providing the platform for a more collaborative governance model at decentralized levels[213]. The impact of the organization is particularly strong in the context where healthcare has not been the only priority of the states' development, from access to quality and outcome, as per the Inverse Care Law, there are still disparities that persist[214].

A notable effort by NITI Aayog in the direction of health governance has been the creation of the Health Index, a product of the joint endeavours of the Ministry of Health and Family Welfare and the World Bank. Based on a blend of health outcomes, governance mechanisms, and key inputs, the index ranks states and Union Territories. The main intentions of the Health Index are to initiate competition in health systems, which would be healthy and can help in achieving better outcomes, and also to enhance transparency and accountability by throwing light on good practices that are being carried out at the local level. However, the index has been criticized for the limitations of its methodology[215]. The issue here is that the index type is partial to carrying out states which have the necessary infrastructure in place and more administrative capacity, disregarding those having less and more resource-dependent. Besides, it does not take into account the social determinants of health at the level necessary. The determinants are issues such as poverty, caste, gender, and geography, which are of utmost importance in the assessment of access to and delivery of health care in a realistic manner. Hence, despite being made with good intentions, the index may

[213] NITI Aayog, Annual Report 2024–25, https://www.niti.gov.in/sites/default/files/2025-02/Annual%20Report%202024-25%20English_FINAL_LOW%20RES_0.pdf (last visited May 24, 2025).

[214] Jain, A. K., & Mishra, S. N. (2019). Role of NITI Aayog in the Implementation of the 2030 Agenda. *2030 Agenda and India: Moving from Quantity to Quality: Exploring Convergence and Transcendence*, 239-254.

[215] Mukhopadhyay, I. (2019). NITI Aayog health index: Wrong symptoms and an erroneous diagnosis. *Social Change*, *49*(4), 678-685.

inadvertently be a contributing factor to widening the gap by punishing the under-performing group, who are already burdened with deeply established inequality[216].

The NITI Aayog has firmly stated a long-term view for the health sector through documents like the Three-Year Action Agenda and the draft Fifteen-Year Health Strategy[217]. These policy frameworks make explicit the importance of improving primary care, modifying the way health is financed, and establishing the enabling digital infrastructure of the National Health Stack that will lead to data-driven service delivery[218]. These drafts are compliant with global health goals like the Sustainable Development Goals (SDGs) and present the goal of making the Indian health system more cost-effective, available, and outcome-oriented. Finally, however, the main criticism of this documentary is that they are only visionary without being provided with detailed strategies to tackle the structural and social factors of injustice that hide beneath the Inverse Care Law[219]. Thus, global goals such as the SDGs are not achieved[220]. Marginalised groups—like the old, the indigenous, women and the rural poor—usually remain outside unless they are addressed directly and through the integrated execution of policy that is sensitive to justice[221].

4.8 STATE-LEVEL POLICIES

According to the Indian Constitution, health is a state subject, and so the delivery of health services is primarily the responsibility of the state governments. Consequently, we observe a lot of differences in health outcomes across the country as it also leads to policy innovation in health. The majority of Indian states have developed a combating strategy with the Inverse Care Law that is pro-equity and inclusive, while some have created policies that further exacerbate the problem of the Inverse Care Law. In particular, these latter states are overwhelmed by deep problems of governance, infrastructure, and financing[222].

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[216] Kajal, M., Trikha, R., & Singh, K. (2024). A Comprehensive Study of the Governance of India's Scientific, Technological, and Innovative Endeavors. In *Science, Technology and Innovation Ecosystem: An Indian and Global Perspective* (pp. 37-55). Singapore: Springer Nature Singapore.
[217] NITI Aayog, Health System for a New India: Building Blocks—Potential Pathways to Reform (Nov. 2019), https://niti.gov.in/sites/default/files/2019-11/NitiAayogBook_compressed.pdf.
[218] Id.
[219] Preerna Sharma, Transforming India: Assessing NITI Aayog's Impact, NLC Bharat, https://nlcbharat.org/transforming-india-assessing-niti-aayogs-impact/ (last visited May 24, 2025).
[220] Id.
[221] Agarwal, J. D., & Agarwal, A. (2018). NITI Aayog's INDIA–Three-year action agenda 2017-18 to 2019-20: Review and analysis. *Aestimatio: The IEB International Journal of Finance*, (16), 142-163.
[222] Jayashree, M. (2018). Public health, the Indian constitutional perspectives and the role of government.

- **Progressive Models**

Several states have been envisaged as the examples of efficacious health care delivery, which reflect the significance of powerful institutional mechanisms and political support. As an example, Tamil Nadu has put a public health cadre in place and effectively obtained and distributed drugs, thus all the public centres in the state would have the necessary medications at all times. The state has been successful to the highest level in the last couple of years in the domain of vaccination, and the program on women's health promoted by the Tamil Nadu Government.[223] Consequently, the state has achieved high rates of coverage for the national programs and has not only preserved the primary health centres (PHCs) but has also improved them significantly, therefore they are now more accessible to the rural and urban area, which in turn has mitigated the effect of the Inverse Care Law to the greatest possible extent[224].

Kerala is another example of good governance, thanks to its policy of long-held focus on factors such as literacy, cleanliness, and the rights of women. The state has been the very first one to start up community-based health programs for instance Kudumbashree, which are not only about health but also about the livelihood and the local rulers. Kerala was one of the first places to introduce Health and Wellness Centres (HWCs) under the Ayushman Bharat program, thereby bringing in the powerful tools of preventive and early disease care into the public health sector[225].

Chhattisgarh, despite having a substantial number of tribal and rural residents, has also adopted indigenous practices to achieve an increase in accessibility. For instance, the establishment of Health and Wellness Centres in the tribal regions, operated by the local health workers who have been trained for that purpose, has become the main factor in the simplification of the healthcare that is offered to the people of these places[226].

- **Challenges in Underperforming States**

[223] S. Kumar, V. Bothra & D.S. Mairembam, A Dedicated Public Health Cadre: Urgent and Critical to Improve Health in India, 41 *Indian J. Cmty. Med*. 253 (2016), https://doi.org/10.4103/0970-0218.193336.
[224] Hacker, J. S. (2004). Dismantling the health care state? Political institutions, public policies and the comparative politics of health reform. *British Journal of Political Science*, *34*(4), 693-724.
[225] JACOB, D. E. (2023). A STUDY ON WOMEN IN THE PEELING SHEDS-A CASE STUDY.
[226] Mahant, S. D., Kolay, S. K., & Chandra, N. D. R. (2016). Declining of tribal population: A study on Chhattisgarh. *Indian Journal of Research in Anthropology*, *2*(2), 121.

In contrast, states such as Bihar, Uttar Pradesh, and Jharkhand still show a significant lack of public health infrastructure. Their inadequate health systems, inefficient governance, and insufficient healthcare personnel are the main challenges that the residents of these states are dealing with. The majority of the primary healthcare centres in these regions are not fully operational and suffer from a substantial lack of medical staff. Consequently, patients in these areas have to heavily rely on private caregivers, most of whom work illegally and are incompetent making poor care and the fact that they extort high prices the main problems. Added to the above-mentioned problems is the continued low funding for the health sector—the majority of the times less than 4% of the total state budget—indicating the lack of prioritization that strengthens the inequity of Inverse Care Law[227].

- **Health Budget Allocation**

An important aspect of inter-state inequality in health delivery is the difference in health budget allocation. States which do better on health outcomes generally spend more on health infrastructure, manpower, and public health schemes. For example, Tamil Nadu and Kerala habitually spend more per capita on health than poorer states. This pattern of public expenditure reflects performance and highlights the need for sufficient financial investment. On the other hand, low-spending states not only do not enhance outcomes but also continue to reinforce the structural inequities revealed by the Inverse Care Law—where the neediest receive the least.

- **Role of Local Governance and Community Participation**

The decentralization of health governance allowed the community to involve the community more in decision-making and checkups at the local level. The outcome of this approach is not unidirectional. There are numerous states, like for example Rajasthan and Maharashtra, that have tried to carry through the effort using different approaches like Rogi Kalyan Samitis (Patient Welfare Committees) and community-based monitoring to improve the local accountability. These schemes are set up with an ambition to include people in the process of examining health services and having a say in the decision-making that would have a local impact. Nevertheless, the realization of this goal has not been as expected due to a lack of skilled personnel, an inability to

[227] Kumar, P. (2023). 15 Assessment of Health System Governance in Empowered Action Group States in India. *Health and Nutrition of Women and Children in Empowered Action Group States of India: Status and Progress*, 261.

sustain engagement, and the absence of institutional backing in some cases, even though such models are in the way[228].

In sum, the state-level health policy landscape of India is one of extremes. Progressive states prove that, given political will, creative approaches, and proper investment, one can counter the Inverse Care Law inequities. Nevertheless, the ongoing challenges in behind-schedule states serve to emphasize the imperative of specific central assistance, cross-state learning, and systems that guarantee equity and inclusion as the fulcrum of health governance nationwide[229].

4.9 CHALLENGES IN ADDRESSING THE INVERSE CARE LAW IN INDIA

- **Socio-Economic Disparities**

The inception of the Inverse Care Law in India is as a result of the deep-rooted socio-economic rift in the country. Individuals domiciled in underprivileged areas such as rural and urban slum settings, indigenous population, etc. are constantly affected by a number of linked deprivations that hinder their access to medical services. Not the least among these problems is the availability of such services at a price the poor can afford. The biggest part of India's labor force operates in the unorganized sector which does not offer any healthcare benefits or retirement schemes; thus, a person is pushed to pay for the medical bills personally and this cost accounts for over 50% of the total health cost in India. Consequently, the model impoverishes the large masses of the population which are mainly due to the health care[230].

In addition, health literacy is very low in economically disadvantaged populations. Education compounded with complexity leads to inadequate comprehension of symptoms, treatment, and prevention healthcare services. Most of them also have no idea of benefits they may be eligible for or how to navigate the

[228] Mitchell, A., & Bossert, T. J. (2010). Decentralisation, governance and health-system performance:'where you stand depends on where you sit'. *Development Policy Review*, *28*(6), 669-691.
[229] Peters, D. H., Rao, K. S., & Fryatt, R. (2003). Lumping and splitting: the health policy agenda in India. *Health policy and planning*, *18*(3), 249-260.
[230] Sivaswamy, M. (2023). An Analytical Study on the Socio-Economic and Legal Inequality in India. *Issue 6 Int'l JL Mgmt. & Human.*, *6*, 2550.

intricacies of the healthcare system. Lack of information often leads to delayed medical care or avoidance of official medical services until critical conditions exist[231].

- **Urban-Rural Divide**

The urban-rural healthcare divide observed in India is a typical case of Inverse Care Law - a situation where those who have most need of healthcare receive the least health services. With close to 70% of the whole country's population staying in rural lands, less than 35% of the required medical facilities has been distributed in these communities[232]. As a consequence, rural regions face not just fewer but also lower quality care services, with huge gaps between them and urbanized areas[233]. Infrastructure is a major concern as well. Specifically, a lot of rural health centers are not even equipped with very basic facilities like diagnostic equipment, laboratories, or emergency care units[234]. There are a lot of places where even the access to sanitary water, electricity, and good sanitation is not constant[235]. Besides this, the connection system from the lower-level health care providers to the higher-level ones is quite feeble or in some areas, not working at all. Patients that need only specialized care can miss out on it because of the weak connection and transport facilities, causing morbidity and mortality that are otherwise avoidable[236].

- **Inadequate Public Health Spending**

India's public health spending relative to its GDP is one of the lowest worldwide, most often fluctuating between 1.2% to 2%. This long-standing deficit in investment is the primary cause of a multitude of systemic issues that prevent the achievement of quality healthcare for all, in particular the poor and underserved[237].

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[231] Easton, P., Entwistle, V. A., & Williams, B. (2010). Health in the'hidden population'of people with low literacy. A systematic review of the literature. *BMC public health*, *10*, 1-10.
[232] Aashish Chaudhry, Bridging India's Urban-Rural Healthcare Divide, Healthcare Radius (July 4, 2023), https://www.healthcareradius.in/features/wellness/bridging-indias-urban-rural-healthcare-divide.
[233] Id.
[234] Ministry of Health & Family Welfare, Rural Health Care System in India (Apr. 9, 2012), https://www.nhm.gov.in/images/pdf/monitoring/rhs/rural-health-care-system-india-final-9-4-2012.pdf.
[235] Sarika Shetty, Challenges of Designing Healthcare Facilities in Rural Areas, Express Healthcare (July 19, 2024), https://www.expresshealthcare.in/news/challenges-of-designing-healthcare-facilities-in-rural-areas/444688/.
[236] Etokidem, A., & Ogaji, D. (2021). The inverse care law: implications for universal health coverage in Nigerian rural communities. *International Journal of Medicine and Health Development*, *26*(1), 11-16.
[237] Kumar, A. S., Chen, L. C., Choudhury, M., Ganju, S., Mahajan, V., Sinha, A., & Sen, A. (2011). Financing health care for all: challenges and opportunities. *The Lancet*, *377*(9766), 668-679.

Public hospitals, especially at the secondary and tertiary levels, continuously encounter overcrowded and poorly equipped facilities. The patients go through long waiting periods, low staff attention, and the lack of basic necessities such as hygienic beds and available medications. All the aforementioned factors lead the people, including those who are poor, to turn to private hospitals for treatment frequently at unsustainable costs. Another neither underutilized nor even potential preventive healthcare avenue is the reduction of long-term costs and disease burdens. The government's financial plan stipulates that health education, vaccination programs, and the extension of community health workers will get only a small share of the funds, which means that the system is not fully prepared for the root causes of the disease burden reduction[238].

- **Fragmentation of Health Systems**

India's healthcare delivery is mostly disintegrated due to the existence of numerous levels of administration and the gap between sectors. The sharing of duties between central, state, and local governments, with each of them having different priorities and resources, lacking coherence and inadequate service delivery are the outcomes. This segmented nature of the system vividly affects the provision of integrative healthcare[239].

Disease-specific vertical health programs, such as those focusing on tuberculosis, maternal health, or HIV/AIDS, are frequently isolated from one another. These programs may do well in their respective areas, but they do not cover the comorbidities and social determinants of health that usually accompany the same populations. Thus, patients are treated with care that is spread and does not match the intricacy of their health demands[240].

- **Legal and Policy Gaps**

Indian health care systems are often structured without a strong legal footing and are actually non-implementative of the legal provisions provided by the Directive Principles of State Policy and Article 21 (Right to Life) in the Constitution. This

[238] Soyemi, T. S., & Aborode, A. T. (2022). Shortage of hospital bed capacity and overcrowding in emergency tertiary healthcare centers in Nigeria. *Annals of Medicine and Surgery*, *82*.
[239] Malik, M. A. (2022). Fragility and challenges of health systems in pandemic: lessons from India's second wave of coronavirus disease 2019 (COVID-19). *Global Health Journal*, *6*(1), 44-49.
[240] Chaitkin, M., Blanchet, N., Su, Y., Husband, R., Moon, P., Rowan, A., ... & Longfield, K. (2018). Integrating vertical programs into primary health care. *Washington DC: Results for Development*.

absence of legal support is seen as a major obstacle to holding the right persons and ensuring equal healthcare benefits[241].

The right to health is not directly stated as an inherent right in Indian law. Due to this, its attainment is dependent on judicial interpretation and is subject to alteration. While courts have periodically expanded the ambit of Article 21 to include health from time to time, the absence of concrete legislative backing makes the interpretations short of uniform enforceability across the justice system[242]. Most major government health programs, including flagship programs like Ayushman Bharat, are not legislated in the form of law but are policy-led. Their sustainability relies heavily on political will and budgetary support, hence open to the possibility of repeal or erosion in the long term. The Clinical Establishments Act of 2010, meant to bring regulatory standards to the private health sector, has been met with poor implementation. Implementation has been resisted by several states, primarily because of opposition from private health actors, thus weakening the process of ensuring quality and accountability[243].

- **Human Resource Constraints**

One of the main challenges to equal healthcare provision in India is the lack of trained and motivated health professionals, both in terms of numbers and distribution. The nation lacks WHO standards of doctor and nurse-to-population ratios, and the maldistribution of available professionals adds to the problem. Urban-centric training institutions and facilities mean that most newly trained doctors and nurses are concentrated in cities, while rural and remote areas remain critically underserved. Additionally, the reluctance of health professionals to serve in rural postings due to lack of infrastructure, safety concerns, and poor living conditions further widens the urban-rural gap[244].

- **Gender and Intersectionality**

[241] Idele, P., Gillespie, A., Porth, T., Suzuki, C., Mahy, M., Kasedde, S., & Luo, C. (2014). Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *66*, S144-S153.
[242] See, e.g., Paschim Banga Khet Mazdoor Samity v. State of W.B., (1996) 4 S.C.C. 37 (India); State of Punjab v. Mohinder Singh Chawla, (1997) 2 S.C.C. 83 (India); see also India Const. art. 21.
[243] Kumar, R. (2024). Strict Implementation of the Right to Health as a Fundamental Right: Ensuring Universal Access and Equity in India. *Law & Safety*, 151.
[244] Saxena, S. G., Godfrey, T., & Godfrey III, T. F. (2023). India's opportunity to address human resource challenges in healthcare. *Cureus*, *15*(6).

Health disparities among people in India are not only caused by location and social strata, but they are also to a large extent determined by gender and social identity as well. It is widely believed that women, transgender people, and the downtrodden groups in society bear unequal treatment when they need quality health services thus becoming more prone to various incurable diseases and lack of access to such problems[245]. Although maternal and reproductive health care has had some policy attention, there is severe neglect of other areas of women's health, including mental health, non-communicable diseases, and occupational health hazards. Cultural stigma, limited mobility, and caregiving obligations also keep many women from getting timely and adequate care[246]. For Trans individuals, legal status under the Transgender Persons (Protection of Rights) Act, 2019, still hasn't resulted in substantial access to healthcare[247]. Gender-affirming surgeries, hormone treatments, and mental health interventions are mostly unavailable or inadequately regulated[248]. Discrimination in hospital environments is still prevalent, discouraging many from accessing care altogether[249].

- **Technological and Digital Divide**

India is embracing digital health delivery platforms with the new Ayushman Bharat Digital Mission (ABDM) and their multiple telemedicine efforts; this has the effect of being very powerful for transforming. Yet, the innovations themselves can deepen the existing inequities instead of erasing them if the digital divide is not dealt with. A significant number of the population—most notably the poor, elderly, and rural communities—do not possess the digital literacy to be able to properly utilize online health services. Many are not aware of smartphones, apps, or even basic internet capabilities, hindering their potential to access teleconsultations or keep digital health records[250].

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[245] Haq, R. (2013). Intersectionality of gender and other forms of identity: Dilemmas and challenges facing women in India. *Gender in Management: An International Journal*, *28*(3), 171-184.
[246] Id.
[247] A. Pandya, A. Kumar & A. Redcay, Access to Health Services: Barriers Faced by the Transgender Population in India, 25 J. Gay & Lesbian Mental Health 132 (2020).
[248] H. Raghuram et al., Experiences of Transgender Persons in Accessing Routine Healthcare Services in India: Findings from a Participatory Qualitative Study, 4 PLOS Glob. Pub. Health e0002933 (2024)
[249] Id.
[250] Davies, A. R., Honeyman, M., & Gann, B. (2021). Addressing the digital inverse care law in the time of COVID-19: potential for digital technology to exacerbate or mitigate health inequalities. *Journal of Medical Internet Research*, *23*(4), e21726.

4.10 COVID-19 RESPONSE AS A REFLECTION OF INVERSE CARE DYNAMICS

The Inverse Care Law in India has been revealed and magnified during the COVID-19 pandemic. The cities, the areas with people who are well-off, and the ones with private hospitals, diagnostic centers, and digital infrastructure were better prepared to fight off the crisis and its impacts. On the other side, the rural and slum populations, as well as the marginalized ones, had a hard time because there were no resources available. In the first stages of the response, those who were already disadvantaged by their geographical location, income, and social status, was the most affected in the distribution of the burden[251].

During the first and second waves of the pandemic, urban hospitals in metro cities were overwhelmed, but still more accessible and better equipped than healthcare facilities in rural India, where infrastructure remains minimal. Urban healthcare services were a shade better, but the rural and remote locations were totally out of any emergency health care reach when it came to ventilators and oxygen supply although the latter was an increasingly dire situation in urban centers. Ironically, the lack of resources was more of a killer than the virus among the poor and migrant workforce who experienced the triple threats of an epidemic, economy, and social restrictions. The terrible conditions that the people who made the mass migrations on foot had to face: Walking for miles, no food at all and no health centers working in their vicinity were the pandemic's hallmarks of India's health system fragmentation[252].

The vaccination deployment has brought to light deeper complexities and inequities in the healthcare system in India. At first, the requirement for digital registration through platforms like CoWIN unintentionally favoured urban, middle-income groups with digital access and literacy, while excluding large sections of the rural population, the elderly, and economically disadvantaged individuals. Poor health literacy with increased vaccine hostility, weak communication strategies as well as logistical constraints were the major challenges for equitable distribution of those remaining. Even though the government ultimately changed its strategy, which was

[251] Davies, A. R., Honeyman, M., & Gann, B. (2021). Addressing the digital inverse care law in the time of COVID-19: potential for digital technology to exacerbate or mitigate health inequalities. *Journal of Medical Internet Research*, *23*(4), e21726.

[252] Zhao, P., Li, S., & Liu, D. (2020). Unequable spatial accessibility to hospitals in developing megacities: New evidence from Beijing. *Health & Place*, *65*, 102406.

initially focused on rural outreach and door-to-door campaigns, the first gaps in access demonstrated that those in need were always neglected during the policy implementation[253].

Also, India's excessive reliance on an under-financed public health system and a mostly unregulated private healthcare industry became starkly evident[254]. Black-market oxygen cylinders abandoned patients due to price gouging for critical care, and high-cost hospital care showed how commercial interests dominated access to healthcare, further pushing the poor to the periphery[255]. Public interest litigations during the pandemic, particularly regarding oxygen supply, cremation measures, and hospital admissions, indicate the judicial system's role in bringing to light the failure of equal access to care during this crisis[256].

Overall, the COVID-19 pandemic did not just expose but amplified India's deep-seated inverse care dynamics. It illustrated that in public health crises, the most underserved populations still bear the highest burden, even though they have the highest needs and least access to care[257]. Experience demands immediate reforms in health system strength, equitable resource distribution, and inclusive policy formulation to avoid such inequalities in future crises[258].

4.11. CONCLUSION

The persistence and ubiquity of the Inverse Care Law (ICL) in India highlight a deep and structural failure in the health architecture of the nation, where those most in need are continually accorded the least access to quality care. The intricate web of socio-economic inequities, urban-rural contrasts, identity-based discrimination, lack of public health resources, and the hegemony of an unregulated private sector has deep-rooted health inequities within both urban and rural India. In spite of constitutional

[253] Inampudi, S., & Gaurav, A. K. (2024). Integrated Approaches of Technology Applications for COVID Vaccination: Administrative Successes of CoWIN Program in India. In *Perspectives and Practices of Public Administration in South Asia: Post-pandemic Recovery and Sustainable Development Agenda* (pp. 39-60). Cham: Springer Nature Switzerland.
[254] Kamala Thiagarajan, Healthcare in India: COVID-19 Exposes the High Cost of India's Reliance on Private Healthcare, 370 *BMJ* m3506 (2020), https://doi.org/10.1136/bmj.m3506.
[255] Id.
[256] Hodge Jr, S. D., & Hubbard, J. E. (2020). COVID-19: The Ethical and Legal Implications of Medical Rationing. *Gonz. L. Rev.*, *56*, 159.
[257] S. Dibyachintan et al., Unequal Lives: A Sociodemographic Analysis of COVID-19 Transmission and Mortality in India, 214 Pub. Health 133 (2023), https://doi.org/10.1016/j.puhe.2022.11.009.
[258] Roy, S. D. (2024). *Pandemic Fissures: COVID-19, Dehumanisation, and the Obsolescence of Freedom in India*. Taylor & Francis.

guarantees and judicial rulings affirming health as an offshoot of the Right to Life under Article 21, reinforced by supportive Directive Principles and other government programs such as Ayushman Bharat and the National Health Mission, the problems of disorganized governance, legal and policy loopholes, insufficient infrastructure, inadequate human resources continue to vitiate equitable access to healthcare. State-led interventions in states such as Kerala and Tamil Nadu give one an insight into how much can be achieved through political will, inclusive policy, and people-oriented approaches. But in the backwards states, lack of good investments and quality governance worsens the ICL. The COVID-19 pandemic provided a grim reminder of the intrinsic healthcare disparities, which hit the vulnerable the hardest. In the future, the ICL in India requires a rights-based, legally binding, and equity-oriented model of healthcare that brings together preventive, primary, and curative care, distributes resources equitably, and prioritises the most vulnerable to realise the constitutional guarantee of justice, dignity, and health for all[259].

[259] Fisher, R., Allen, L., Malhotra, A. M., & Alderwick, H. (2022). Tackling the inverse care law. *London: The Health Foundation*.

CHAPTER 5

RESEARCH FINDINGS, CONCLUSION AND SUGGESTIONS

This chapter summarises the key findings of the research and presents conclusions based on the objectives of this study. The analysis conducted in Chapters 2, 3, and 4 clarifies how the Inverse Care Law (ICL) functions in India and assesses the legal frameworks and socio-economic factors contributing to healthcare inequity. The findings are organised according to the research objectives, followed by an evaluation of the hypothesis. Additionally, comparative insights from the UK and Brazil are discussed to emphasize their implications for public health policy in India. Throughout the study the results highlight significant legal, ethical, and governance challenges that must be addressed to protect the right to health in India.

5.1. RESEARCH FINDINGS AND CONCLUSIONS

This study highlights a significant gap between healthcare needs and access in India, confirming the existence of the inverse care law in this context. Each research objective has been achieved with clear evidence and analysis. Firstly, it was determined that the inverse care phenomenon is particularly evident along socio-economic and geographic lines in India. Populations that require medical attention the most, such as the rural poor, tribal communities, and urban slum dwellers, consistently have the least access to quality healthcare[260]. Data presented in Chapters 2 and 4 show that inadequate infrastructure in remote areas, a shortage of medical staff, and financial barriers lead to marginalized groups experiencing disproportionately poor health outcomes compared to more affluent populations. This supports the first hypothesis that the inverse care law significantly exacerbates health inequities in India, with marginalized individuals bearing a greater disease burden and experiencing worse health outcomes than privileged groups[261].

Second, the analysis of India's legal and policy framework reveals significant gaps that help explain why these disparities persist. While the Constitution of India does not explicitly enumerate a right to health, the judiciary has interpreted Article 21's right to life to include access to basic healthcare, creating an implicit legal obligation on the

[260] Hart, supra note 16
[261] Ministry of Health & Family Welfare, National Health Profile 2021 (India).

State. Additionally, Directive Principles like Articles 38 and 47 exhort the State to reduce inequalities and improve public health[262]. Despite these principles and a patchwork of statutes and schemes, the current framework is fragmented and under-enforced. Health is largely a state subject, and the absence of a central public health law or a justiciable national health guarantee has led to uneven implementation across different states[263]. This study finds that existing laws and policies – such as the Clinical Establishments Act, various Public Health Acts at state levels, and insurance schemes – have not been sufficient to eliminate access barriers, thereby sustaining the inverse care dynamics[264]. For instance, the National Health Policy 2017 formally prioritized "reducing inequity" and proposed devoting two-thirds of health spending to primary care, yet implementation remains inconsistent and public health expenditure varies widely between states[265]. Key health initiatives have similarly had mixed results: the Ayushman Bharat program has introduced Health and Wellness Centres to bolster rural primary care in line with inverse care law principles, but its insurance arm (PM-JAY) risks favoring better-informed urban populations over the poorest, who often cannot easily access hospital services[266]. The findings therefore support the second hypothesis that India's current legal and policy measures are insufficient to overcome the obstacles to equitable healthcare access, inadvertently exacerbating disparities in service availability and quality. In sum, the study confirms that without stronger legal mandates and effective enforcement, well-intentioned policies have fallen short of mitigating the inverse care law.

Thematically, several legal, ethical, and governance issues were uncovered. Legally, the lack of an explicit, enforceable right to health stands out as a fundamental gap. Judicial recognition under Article 21 has established health as a fundamental right in principle, and courts have intervened in specific cases to enforce emergency medical care and fairness in treatment[267]. However, in the absence of comprehensive legislation, these interventions are piecemeal. India's federal structure further complicates uniform health governance: some states (like Kerala and Tamil Nadu) have achieved relatively

[262] Id.
[263] Paschim Banga , supra note 14.

[264] INDIA CONST. art. 38, 47.
[265] T. Jacob John & V. Ramankutty, Public Health in India: Need for a Paradigm Shift, 52 ECON. & POL. WKLY. 25 (2017).
[266] INDIA CONST. Seventh Schedule, List II.
[267] Clinical Establishments (Registration and Regulation) Act, No. 23 of 2010, INDIA CODE.

equitable healthcare outcomes through robust public systems, while others (like Bihar, Jharkhand, Uttar Pradesh) lag far behind[268]. This governance disparity reflects institutional bias where political will and administrative capacity dictate health access, effectively leaving the fulfillment of constitutional ideals to the accident of geography. Ethically, the persistent inequities violate the principles of justice and equality enshrined in the Constitution. It is an ethical indictment of the system that women, lower castes, tribal populations, and other vulnerable groups face intersecting barriers to care, from discrimination to lack of resources[269]. The study highlights that purely market-driven healthcare exacerbates these injustices: with over 70% of outpatient care and 60% of inpatient care provided by the private sector, access is often determined by ability to pay, leading to "cream-skimming" where private providers concentrate on affluent, urban patients[270]. Governance issues such as weak regulation of private facilities, low public health spending (around 1.3% of GDP in recent years), and inadequate accountability mechanisms have allowed these trends to continue unchecked[271]. The inverse care law in India is thus reinforced by systemic failings – insufficient public investment, uneven resource allocation, and social determinants like poverty and education that lie outside the health sector's direct control. Importantly, the research finds that laws and policies by themselves cannot remedy health disparities unless they are accompanied by broader socio-economic reforms; issues like poverty, malnutrition, and poor sanitation feed into health inequality and must be addressed in parallel.

The comparative analysis provided in Chapter 3 offers valuable insights and precedents. Internationally, many jurisdictions have recognized that making health a legal right is a crucial step in countering the inverse care law[272]. The United Kingdom's National Health Service (NHS), for example, was founded on the principle of universal, tax-funded health coverage free at the point of use, ensuring access is not conditional on income[273]. The UK experience shows that targeted policies can reduce inverse care effects: in the 1970s, the NHS adopted needs-based resource allocation (through the

[268] National Health Policy, Ministry of Health & Family Welfare, Government of India (2017).
[269] Lahariya, Chandrakant, Health & Wellness Centres to Strengthen Primary Health Care in India, 87 Indian J. Pediatr. 917 (2020).
[270] Id.
[271] Id.
[272] Id.
[273] Parmanand Katara v. Union of India, (1989) 4 SCC 286.

RAWP and weighted capitation formula) to direct more funds to underserved areas. Likewise, welfare states in Europe, including the Nordics, have used constitutional or statutory guarantees to strive for equitable healthcare, though they too wrestle with residual urban-rural gaps. Middle-income countries provide another perspective: Brazil's 1988 Constitution explicitly guarantees the right to health, operationalized via the Sistema Único de Saúde (SUS), a universal health system oriented toward primary care and health equity[274]. Brazil's approach, including decentralization and community-based healthcare teams, has demonstrably improved access for the poor and reduced regional disparities, though it relies on continual judicial and civil society engagement (the "judicialization" of health through court actions) to ensure government accountability. South Africa, similarly, entrenched the right to healthcare in its post-apartheid constitution and has seen its courts compel the state to provide essential treatments (e.g. antiretroviral therapy during the HIV/AIDS crisis)[275]. These comparative frameworks underscore that a rights-based, well-governed public health system can significantly mitigate inverse care dynamics. They also offer concrete policy tools – from legal mandates for equal access, to equity audits and impact assessments (used in the UK to continuously evaluate service reach), to incentive structures for providers serving underserved communities. For India, the implication is clear: aligning domestic policy with a rights-based approach – possibly through a national health law and stronger statutory entitlements – could anchor a more equitable system. At the same time, the international experiences caution that legal reform, while necessary, is not sufficient on its own. Achieving health equity also requires robust institutions, sustained political commitment, and addressing underlying socio-economic determinants. In concluding the analytical findings, the hypothesis posed in Chapter 1 is affirmed: the inverse care law remains a reality in India's healthcare landscape, and without transformative legal and policy measures, the promise of "healthcare for all" will remain unfulfilled[276]. This realization sets the stage for the recommendations that follow, aimed at bridging the gap between de jure ideals and de facto realities of healthcare access.

[274] Id.
[275] K. Srinath et al., Towards Achievement of Universal Health Care in India by 2020: A Call to Action, 377 Lancet 760 (2011).
[276] Id.

5.2. SUGGESTIONS AND WAY FORWARD

5.2.1 Enact a Right to Health Law and Patients' Rights Charter

Codifying the Right to Health: A foundational step is to establish health as a legal right through explicit legislation or constitutional amendment. India should enact a comprehensive Right to Health Act at the national level, drawing on the precedent set by some Indian states and comparable economies. Notably, in 2023, Rajasthan became the first state in India to pass a Right to Health Care Act, which seeks to provide free healthcare services to all residents and holds the government accountable for ensuring access[277]. This law is aligned with Article 21 and fills a critical gap by making health an entitlement rather than merely a policy goal. A national law could similarly affirm every citizen's right to a package of basic health services, including preventive, primary, and emergency care at a minimum, regardless of ability to pay. The law should specify the obligations of the government, such as ensuring functional public health facilities in every locality, maintaining minimum standards of care, and reducing financial barriers, possibly through the provision of free essential drugs and diagnostics[278]. It should also delineate legal remedies for violations. For instance, if an individual is denied necessary care or suffers due to systemic failure—say, a primary health center being defunct—they should have the right to seek redress, perhaps through special health tribunals or designated fast-track courts. Codification would thereby create pressure on authorities to proactively meet health needs, knowing that non-compliance could result in legal liability.

The content of such legislation can draw from international best practices and India's own policy documents. The National Health Policy 2017 explicitly advocated making health a justiciable right and proposed incremental steps towards that goal, including both legislative action and judicial affirmation[279]. By passing a Right to Health law, Parliament would effectively be implementing the Directive Principles of State Policy—such as Article 47, which mandates the State to raise the level of nutrition and the standard of living and to improve public health—and giving concrete shape to the Supreme Court's interpretations of Article 21[280]. This would represent a paradigm shift:

[277] Rajasthan Right to Health Care Act, 2023
[278] National Health Policy, 2017, Ministry of Health & Family Welfare, India
[279] National Health Policy, 2017
[280] *State of Punjab v. Mohinder Singh Chawla*, A.I.R. 1997 S.C. 1225

health would move from the realm of aspirational policy to that of guaranteed rights, compelling consistent government action even as political regimes change.

Patients' Rights and Grievance Redressal: Alongside a general right to health, there is a need for a specific Patients' Rights Charter or legislation that enumerates the rights of individuals when they interact with the healthcare system. This would cover rights such as informed consent, confidentiality, emergency medical care without prepayment, access to medical records, and respectful and non-discriminatory treatment. India currently lacks a uniform law on patients' rights, although the Ministry of Health and Family Welfare published a draft Charter of Patients' Rights in 2018 in collaboration with the National Human Rights Commission[281]. The suggestion is to formalize this charter via either a central law or binding regulations.

Adopting patients' rights has multiple benefits: it empowers people to demand quality and ethical care and places healthcare providers under a legal obligation to meet minimum standards. For example, a patients' rights framework could ensure that no hospital—public or private—refuses or delays treatment in emergency cases, reinforcing the ruling in *Paschim Banga Khet Mazdoor Samity*[282], where the Court held that failure to provide timely emergency care violated Article 21. The framework could mandate display of patients' rights and grievance procedures at all health facilities.

Importantly, a robust grievance redressal mechanism should accompany these rights, perhaps a system of Patients' Advocates or Ombudsmen in each district who can receive complaints, mediate disputes, and, if needed, assist patients in pursuing legal remedies. This would make enforcement user-friendly and accessible, especially for the poor who might be intimidated by formal court processes. A patients' rights law would also foster better self-regulation among healthcare providers and enhance public trust in the system, which is essential for the increased utilization of services by marginalized groups [283].

Judicial Oversight and Public Interest Litigation: While the primary aim is to reduce reliance on litigation by creating preventive systems, the judiciary will continue to play a critical role in enforcing health rights. The suggestion here is twofold. First, the

[281] Ministry of Health & Family Welfare, Draft Charter of Patients' Rights, 2018
[282] Paschim Banga , supra note 14.
[283] World Health Organization, *Standards for Improving Quality of Care in Health Facilities*, 2016

Supreme Court and High Courts should institutionalize mechanisms for the periodic monitoring of health-related directives. For instance, in several cases the courts have issued continuing mandamus orders—such as in *Environmental & Consumer Protection Foundation v. Union of India*, (2012) 13 S.C.C. 308—where implementation of health infrastructure standards in schools was regularly monitored.

Second, the judiciary could establish specialized health benches or expand the role of social justice benches to regularly hear cases concerning the right to health. This would develop judicial expertise in healthcare-related matters and reinforce public confidence in legal recourse for health grievances. Courts could also employ innovative remedies in PILs, such as appointing expert monitoring committees or directing compensation funds for victims of systemic health failures, similar to measures taken in *Union of India v. Mool Chand Khairati Ram Trust*[284].

The judiciary's role is to reinforce, not replace, legislative and executive action. These suggestions aim to create a self-executing health system where judicial intervention is the exception. Until then, the courts remain a vital forum for correcting imbalances that result from the inverse care law and enforcing accountability. By codifying health rights and backing them with effective remedies, India would shift the burden to the State to justify any failure to provide adequate care—thereby confronting the inverse care law directly.

5.2.2 Strengthening Health Financing and Equitable Resource Allocation

- **Boosting Public Expenditure on Health:**

The inverse care law in India is exacerbated by chronically low levels of public health spending. To correct this, the government must substantially increase health financing, moving closer to international norms. The National Health Policy 2017 recommends raising public health expenditure to 2.5% of GDP by 2025, but current spending remains around 1.3% of GDP [285]. Given the economic growth and fiscal capacity that India has built, allocating more budgetary resources to health is both feasible and urgently necessary.

[284] (2018) 8 S.C.C. 321.
[285] National Health Policy, Ministry of Health & Family Welfare, India, 2017, at 8, https://nhp.gov.in/nhpfiles/national_health_policy_2017.pdf

Higher public spending would enable the expansion of health infrastructure, hiring of healthcare workers, and procurement of medicines and equipment, particularly in underserved areas. It would also reduce the burden of out-of-pocket payments by funding free or subsidized services. At present, only about 27% of India's total health expenditure is borne by the government, with 73% coming from private sources, predominantly out-of-pocket household expenses[286]. This imbalance places India among the worst performers globally in prioritizing health in government budgets.

Reversing that ratio through greater public investment would itself counter the inverse care law, as evidence shows that countries with higher public financing tend to have more equitable health outcomes[287]. Therefore, it is suggested that both Union and State governments commit to incremental annual increases in health budgets for example, each state could target increasing its health spending by at least 0.1% of GSDP each year until the 2.5% of GDP national target is reached[288].

Earmarking health funds such as a dedicated health cess or sin taxes allocated to health could ensure sustained revenue streams[289]. Crucially, more funds should not merely mean more tertiary hospitals in urban areas. The allocation of increased resources must prioritize primary care and public health functions that benefit the poor rural clinics, disease prevention programs, nutrition, sanitation, and maternal-child health, which wealthier groups tend to require less.

By infusing more public funds and directing them toward high-need areas, the government would reduce financial barriers that currently prevent the poor from accessing care, thereby fulfilling its constitutional duty to equalize opportunities under Articles 38 and 47 of the Indian Constitution [290].

- **Equitable Allocation and Center-State Balancing:**

In a country as diverse as India, simply increasing the overall health budget is not enough—the distribution of funds matters immensely for equity. The central

[286] World Health Organization, *Global Spending on Health: Weathering the Storm*, at 28 (2022), https://www.who.int/publications/i/item/9789240064911
[287] See Julio Frenk et al., *Health Systems in Low- and Middle-Income Countries: An Economic and Policy Perspective*, Oxford Univ. Press 2012
[288] National Health Accounts Estimates for India 2019–20, Ministry of Health & Family Welfare, Gov't of India (2022), at 2.
[289] Report of the Fifteenth Finance Commission, 2020-21 to 2025-26, at Vol. I, Ch. 5
[290] INDIA CONST. art. 38, 47

government, in partnership with states, should develop a formula-based resource allocation system that directs greater support to states and districts with worse health indicators, such as high infant mortality or disease burden, and greater poverty.

A precedent exists in the form of Finance Commission health grants and the National Rural Health Mission's (NRHM) focus on high-priority districts[291]. This should be expanded into a robust equalisation mechanism. For instance, poorer states with feeble health infrastructure, such as Bihar and Uttar Pradesh, could receive additional unconditional health grants from the Centre to bring their per capita health spending closer to the national average.

The disparity is stark: historical data showed per capita public health spending in Bihar was less than ₹100, while Tamil Nadu and Kerala spent several times more[292]. Targeted central funding can help bridge this gap. Additionally, within states, funds should be preferentially allocated to rural and backwards districts. Tools like Health Equity Funds or outcome-based grants, where states receive greater funds for improving certain equity indicators, can encourage a pro-poor policy focus.

Another critical issue is the full utilization of health funds. Often, states with weak administrative capacity return funds unspent, further harming vulnerable populations [293]. The central government could assist such states by deploying technical support teams to assist in procurement, planning, and fund utilization so that allocated budgets result in real services.

- **Health Insurance and Financial Protection Reforms:**

Financial hardship from medical expenses is a principal manifestation of the inverse care law in India. Strengthening risk pooling and insurance is therefore critical. Expanding and redesigning health insurance schemes to cover a broader spectrum of care and population is essential. While Ayushman Bharat PM-JAY has provided coverage for hospitalization expenses to the poorest 40% of Indians, it largely excludes

[291] *Twelfth Five Year Plan (2012–17)*, Planning Commission, Vol. III, at 7–8; *National Health Mission Framework*, Ministry of Health & Family Welfare, 2015
[292] *Health Index Report*, NITI Aayog, 2021, https://www.niti.gov.in/health-index
[293] *Comptroller and Auditor General (CAG) Reports on NHM*, 2019

outpatient care, diagnostics, and medicines—components where poor households incur most costs[294].

Without outpatient coverage, preventable illnesses may worsen, resulting in costly hospitalizations. Covering outpatient care would encourage early intervention and reduce long-term systemic costs. Another reform would involve extending protection to the "missing middle"—those not eligible for PM-JAY but unable to afford private insurance. Subsidized insurance for lower-middle-income families or strengthened informal-sector schemes like Employees' State Insurance (ESI) could address this gap[295]. In parallel, user fees in public hospitals should be minimized or eliminated for essential services. Though healthcare is nominally free in government institutions, patients often pay for medicines and diagnostics from private sources. Ensuring free essential drugs and diagnostics at public facilities, through initiatives such as the Free Drug and Diagnostic Services under NHM, would significantly reduce out-of-pocket expenses[296]. The government may also regulate and cap prices for essential medicines and procedures in the private sector through frameworks such as the National Pharmaceutical Pricing Authority (NPPA) and the Clinical Establishments (Registration and Regulation) Act, 2010[297].

Evidence from other countries, such as Thailand's Universal Coverage Scheme or Brazil's Unified Health System, demonstrates that when financial barriers are removed, healthcare utilization among the poor increases markedly [298].

By implementing these financing reforms, higher public spending, equity-based allocation, and financial protection, India would address one of the root causes of the inverse care law: the economic inaccessibility of healthcare. Utilization of healthcare would then reflect medical need, not just the ability to pay.

5.2.3 Aligning Center and State Efforts for Universal Health Coverage

- **Cooperative Federalism in Health Governance:**

[294] National Health Authority, *PM-JAY Annual Report 2021–22*, at 11–12, https://nha.gov.in/annual-report
[295] World Bank Group, *Health Financing Profile: India*, at 3–4, 2022
[296] Ministry of Health & Family Welfare, *NHM Progress Reports*, 2021–2022
[297] Clinical Establishments Act, No. 23 of 2010, § 11; National Pharmaceutical Pricing Authority, *Annual Report 2021–22*
[298] World Health Organization, *Health Systems Financing: The Path to Universal Coverage*, World Health Report 2010, at 48–49

Given the constitutional division that places "Public health and sanitation; hospitals and dispensaries" under the State List[299], improving healthcare access requires intense coordination between the central and state governments. To address disparities and implementation gaps, a mechanism of cooperative federalism in health should be strengthened. One suggestion is to establish a permanent inter-governmental health forum, possibly under the NITI Aayog or an empowered "National Health Council", where Union and State Health Ministers meet regularly to set joint targets, share best practices, and monitor progress on health indicators.

This proposed body could function similarly to the Goods and Services Tax (GST) Council, which has successfully institutionalised federal cooperation on fiscal matters[300]. For example, if a state is falling behind in immunisation or medical college development, the Council could mobilise expertise or financial support from better-performing states or central agencies[301].

- **Incentivising State Performance:**

The Centre should use both financial and technical incentives to encourage states to prioritise healthcare. As part of centrally sponsored schemes (CSS), conditional grants with performance-based criteria, such as reduction in maternal mortality or improvements in PHC functionality, can drive equity-focused reforms. This approach has been a feature of the National Health Mission (NHM), under which high-focus states received additional support based on lagging health indicators[302].

Moreover, the Fifteenth Finance Commission, for the first time, allocated a portion of general-purpose grants based on states' health outcomes and population demographics[303]. Future Finance Commissions should expand such performance-linked provisions to reinforce the message that health is a cross-governmental national priority.

[299] INDIA CONST. art. 246, Sch. VII, List II, Entry 6
[300] THE CONSTITUTION (ONE HUNDRED AND FIRST AMENDMENT) ACT, 2016, § 12
[301] *Transforming India's Health System: The Role of Federalism*, NITI Aayog Discussion Paper (2020), at 4–5
[302] Ministry of Health & Family Welfare, *National Health Mission Framework for Implementation 2012–17*, at 6
[303] Finance Commission of India, *Report for 2021–26*, Vol. I, Ch. 8, at 139–42

- **Uniform Standards and Regulations:**

A key alignment issue is the uneven adoption of health regulations across states. The Clinical Establishments (Registration and Regulation) Act, 2010 was enacted by Parliament but applies only to those states that voluntarily adopt it under Article 252 of the Constitution[304]. As of 2023, only 11 states and all Union Territories have adopted the Act, leaving a significant regulatory gap in several others [305].

This fragmented adoption creates regulatory arbitrage, allowing healthcare providers in non-adopting states to operate without uniform standards for infrastructure, staffing, hygiene, or treatment protocols. The central government should therefore initiate a coordinated campaign to ensure pan-India adoption of the Clinical Establishments Act. Alternatively, a new federal health regulation may be introduced under the Concurrent List, specifically under "economic and social planning"[306] or the residuary powers of Parliament under Article 248. Additionally, legislation grounded in the right to life (Article 21) may be used to enforce uniform patient safety norms across the country[307].

Alongside statutory regulation, central guidelines such as the Indian Public Health Standards (IPHS) for PHCs and CHCs should be made binding benchmarks, rather than mere aspirational standards[308].

- **Concurrent List Consideration:**

In the longer term, India may debate a constitutional amendment to shift "health" from the State List to the Concurrent List, which would enable Parliament to legislate uniformly on healthcare matters[309]. This would simplify nationwide rollouts of rights-based laws like the Right to Health or universal public health standards.

Even without a formal amendment, the Centre can exercise existing powers, such as financing leverage and laws under the Concurrent List, e.g., the Drugs and Cosmetics Act, the Food Safety and Standards Act, etc., to harmonise health policies across states.

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[304] Clinical Establishments (Registration and Regulation) Act, No. 23 of 2010, Statement of Objects and Reasons; INDIA CONST. art. 252
[305] Ministry of Health & Family Welfare, *Status Note on Implementation of the Clinical Establishments Act*, 2023
[306] INDIA CONST. Sch. VII, List III, Entry 20
[307] *Consumer Education and Research Centre v. Union of India*, (1995) 3 S.C.C. 42
[308] Ministry of Health & Family Welfare, *IPHS Guidelines, Revised 2012*, https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=971&lid=154
[309] Rajya Sabha Secretariat, *Review of Implementation of the Clinical Establishments Act*, Parliamentary Standing Committee Report No. 109 (2015), at 21–22

For example, national programs like the Revised National Tuberculosis Control Program (RNTCP), the National AIDS Control Programme (NACP), and the Universal Immunization Programme (UIP) are centrally supported and monitored, ensuring standard quality in their implementation[310].

- **Capacity Building and Management Reforms:**

Centre-state alignment is not just about laws and money; it also hinges on managerial capacity at the subnational level. The central government can help by expanding capacity-building programs for hospital administrators, health system managers, and public health cadres. A long-debated reform has been the creation of an Indian Medical Service (IMS) cadre, analogous to the Indian Administrative Service (IAS), to professionalise health governance and ensure a trained health bureaucracy [311].

An organised IMS could support weaker states with specialised human resources and fill key roles in administration and public health planning. The Centre can also encourage cross-state learning and horizontal cooperation through pilot schemes—for instance, replicating Kerala's decentralised health governance, Tamil Nadu's robust drug procurement systems, or Meghalaya's successful community health worker programs in other lagging states [312].

By improving centre-state synergy, the healthcare policy environment will become more consistent and equitable. Residents of one state should not have inferior access to health services merely due to their location. Reducing interstate variance in healthcare performance is crucial for fulfilling the vision of Universal Health Coverage (UHC). A nationally coordinated yet locally responsive approach, supported by cooperative federalism and constitutional safeguards, will ensure that the inverse care law is addressed as a structural and systemic issue, requiring joint responsibility and shared progress.

[310] Ministry of Health & Family Welfare, *National Health Programmes Annual Report*, 2022–23
[311] *Report of the High-Level Expert Group on Universal Health Coverage for India*, Planning Commission, 2011, at 105–07
[312] NITI Aayog, *Best Practices in Health Sector Reforms in India*, 2020

5.2.4 Revitalising Primary Healthcare Infrastructure and Workforce

- **Strengthening Primary Health Centres (PHCs) and Sub-Centres:**

The frontline of India's healthcare system, comprising sub-centres, PHCs, and community health centres, must be dramatically strengthened to fulfil the right to health. Many rural and remote areas continue to lack adequate facilities or find them non-functional[313]. A national revitalisation mission for primary healthcare, analogous to a major infrastructure program, is needed to ensure every village and urban ward has access to a functioning public health outlet.

This involves building new health sub-centres or PHCs where gaps exist, upgrading physical infrastructure by adding clean water, electricity, toilets, telecommunication, and equipping them with essential medical devices, such as diagnostic kits, birthing tables, and vaccine cold chains[314]. Each PHC must be equipped to provide a comprehensive package of services, maternal and child care, infectious disease management, chronic disease screening, emergency care, and referrals, aligned with IPHS standards.

The transformation of 150,000 Health Sub-Centres and PHCs into Health and Wellness Centres (HWCs) under Ayushman Bharat is a step in the right direction[315]. However, the pace must be accelerated to ensure 100% population coverage. The success of HWCs will depend on robust staffing and supply chains. Meanwhile, mobile medical units and periodic outreach camps can bridge gaps in remote hamlets until fixed facilities are operational [316].

- **Human Resources for Health – Training, Recruitment, and Retention:**

A core driver of inverse care in India is the shortage and skewed distribution of health personnel. To address this, India must invest in expanding and equitably deploying

[313] Ministry of Health & Family Welfare, *Rural Health Statistics 2021–22*, at 1–2
[314] Indian Public Health Standards [IPHS] Guidelines for Primary Health Centres, Ministry of Health & Family Welfare, Revised 2012, https://nhm.gov.in
[315] Ministry of Health & Family Welfare, *Ayushman Bharat—Health and Wellness Centres*, 2023, https://ab-hwc.nhp.gov.in
[316] National Health Mission, *Operational Guidelines for Mobile Medical Units*, 2012

human resources for health (HRH). Increasing the number of doctors, nurses, and allied health professionals is essential, particularly from underserved regions[317].

The government has been establishing new medical colleges in districts with low doctor-to-population ratios, a trend that must continue[318]. Simultaneously, nursing and paramedical training institutes must be scaled up. However, expansion in numbers must be matched with policies ensuring rural deployment. A multi-pronged approach is advised:

- **Incentive Schemes**: Doctors serving in designated rural or tribal areas could be rewarded with postgraduate admission preferences, student loan forgiveness, hardship allowances, or fast-track promotions [319].
- **Mandatory Rural Service**: The National Medical Commission and state governments can mandate a year or two of rural service for MBBS graduates, with sufficient support such as housing and mentorship. Some states like Maharashtra and Tamil Nadu have partial policies, but a uniform national approach is lacking [320].
- **Task Shifting and Mid-Level Providers**: India has introduced Community Health Officers (CHOs), mid-level providers trained through bridge programs, to manage HWCs. These CHOs can provide basic clinical care and refer complex cases[321]. Expanding this model, along with empowering nurses and pharmacists with expanded roles, can ease physician shortages.
- **Continuous Capacity Building**: Peripheral health workers must be supported with telemedicine platforms like eSanjeevani, regular training, and supervisory backup to improve quality and reduce professional isolation[322]. Digital tools,

[317] World Health Organization, *Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals*, WHO Technical Report Series No. 2016.2, at 7–9 (2016)
[318] Press Information Bureau, *Establishment of New Medical Colleges Attached with District/Referral Hospitals*, Ministry of Health & Family Welfare (2022), https://pib.gov.in
[319] *Report of the Working Group on National Rural Health Mission for the 12th Five Year Plan*, Planning Commission, 2012, at 45–47
[320] S. B. Bhattacharya & V. R. Gupta, *Rural Service Requirement for Medical Graduates in India: A Policy Review*, 6 Nat'l Med. J. India 265 (2016)
[321] Ministry of Health & Family Welfare, *Operational Guidelines for Comprehensive Primary Health Care through HWCs*, 2018
[322] Ministry of Health & Family Welfare, *eSanjeevani Telemedicine Platform Annual Report*, 2022, https://esanjeevani.mohfw.gov.in

apps, knowledge-sharing platforms, and remote diagnostic support, should be widely deployed.

- **Local Recruitment and Community Engagement**: Recruiting rural youth as ASHAs, ANMs, or multipurpose workers increases retention and cultural acceptance. ASHA workers have been the backbone of India's primary care outreach; however, their honoraria, training, and tools must be improved. Providing ASHAs with digital tablets, point-of-care diagnostic kits, and career progression pathways such as transitions to ANMs or PHC staff would sustain their motivation [323].

- **Improve Working Conditions and Infrastructure for Staff:**

Posting health workers to rural areas is futile without safe and enabling work conditions. Suggestions include providing quality staff quarters, transport allowances, hardship compensation, and adequately equipped facilities. Nothing is more demoralizing than posting a doctor to a PHC without medicines or basic instruments[324].Vacancies for doctors and specialists at PHCs and CHCs remain high in several states, as shown in official statistics[325]. These must be filled urgently through regularized and streamlined recruitment. While contractual appointments may be used for short-term needs, the long-term solution lies in building a sufficient permanent cadre.

By revitalising primary care and investing in its workforce, India can operationalise the principle of proportionate universalism—universal health services scaled by need. Strong primary care reduces dependence on tertiary hospitals and prevents disease, serving as the great equaliser in health systems[326]. Ultimately, the government must prioritise "Health for All, nearest to all" by delivering accessible care at the community level, ensuring that no matter how remote or poor a community is, at least a basic healthcare facility is within reach.

[323] Ministry of Health & Family Welfare, *ASHA Update 2021*, https://nhm.gov.in
[324] *High-Level Expert Group Report on Universal Health Coverage for India*, Planning Commission, 2011, at 93–96
[325] See Ministry of Health & Family Welfare, *Rural Health Statistics 2021–22*, at 30
[326] Marmot, supra note 8.

5.2.5 Leveraging Digital Health and Innovation for Inclusive Access

- **Digital Inclusion as a Bridge to Care:**

Digital technology offers a powerful means to overcome geographical and resource constraints in healthcare,if deployed wisely, it can help neutralize some effects of the inverse care law by connecting underserved populations with medical expertise. India should therefore aggressively expand its telehealth and digital health initiatives while ensuring they remain inclusive and accessible. The success of the eSanjeevani telemedicine platform during the COVID-19 period, which facilitated over 80 million teleconsultations by 2023, demonstrates the demand and utility of such services[327].:

- **Universal Telemedicine Coverage:** Telemedicine should be institutionalized across the public health system. Every Health and Wellness Centre (HWC) and Primary Health Centre (PHC) can be equipped with internet-enabled devices to act as teleconsultation hubs. Mid-level providers at HWCs should be able to consult remotely with doctors or specialists, particularly for cases beyond their training. This is already being implemented in states like Tamil Nadu and Uttar Pradesh, where eSanjeevani operates effectively [328].

  Specialist services like tele-radiology, tele-ophthalmology for diabetic retinopathy screening, and tele-mental health can be scaled nationally to reach rural areas lacking such expertise[329].

- **Mobile Health and Outreach:** Given India's high mobile phone penetration, mobile platforms should be used for sending SMS alerts and IVR calls for routine health updates—such as antenatal care appointments, immunization schedules, and adherence to TB/HIV medication [330].

  Applications in regional languages can assist ASHAs and ANMs in disease tracking and health record-keeping. The Ayushman Bharat Health Account

[327] Ministry of Health & Family Welfare, *eSanjeevani Dashboard*, https://esanjeevani.mohfw.gov.in/
[328] Press Information Bureau, *Teleconsultations Cross 80 Million on eSanjeevani Platform*, Mar. 2023, https://pib.gov.in/PressReleasePage.aspx?PRID=1909136
[329] National Health Systems Resource Centre, *Annual Report on Telemedicine in India*, 2022
[330] World Health Organization, *mHealth: Use of Mobile Wireless Technologies for Public Health*, WHO Global Observatory for eHealth Series, Vol. 3, at 18–22 (2011)

(ABHA) under the Ayushman Bharat Digital Mission enables individual registration and longitudinal health records, facilitating continuity of care[331].

- **Digital Literacy and Accessibility:** India must address the digital divide—many of the poorest and elderly lack access to smartphones or digital literacy. Telehealth kiosks at Panchayat offices and Common Service Centres can help bridge this gap, staffed by local operators trained to assist in virtual consultations[332]. Voice-based and multilingual platforms are essential for accessibility. The government should also consider subsidizing smart devices for ASHAs and health workers, as done in states like Odisha and Gujarat[333].
- **Innovations in Remote Monitoring:** The use of low-cost, portable diagnostic tools (e.g., glucometers, ECG, ultrasound) connected to smartphones allows field-level screening and digital transmission of results for specialist review. Government-backed hackathons like *Ayushman Bharat Innovation Challenge* have supported startups developing frugal digital health technologies for rural India[334].

- **National Digital Health Infrastructure:**

The Ayushman Bharat Digital Mission (ABDM) is building a comprehensive digital health backbone for India, consisting of the ABHA (Health ID), a health facility registry, a provider registry, and interoperable electronic health records[335].A digital health ID enables seamless record access across providers—so a patient from a rural HWC can receive specialist treatment in an urban hospital with their data available. However, privacy concerns must be addressed with robust data governance aligned with the Digital Personal Data Protection Act, 2023 [336].

- **Telemedicine Regulation and Quality:**

[331] National Health Authority, *Ayushman Bharat Digital Mission Overview*, https://abdm.gov.in/home/publications
[332] Ministry of Electronics and Information Technology, *Common Services Centres Scheme*, https://csc.gov.in/
[333] NITI Aayog, *Strategy for New India @75*, at 48 (2018)
[334] Ministry of Health & Family Welfare, *Innovation Challenge for Ayushman Bharat Digital Mission*, 2022, https://abdm.gov.in/innovationchallenge
[335] National Health Authority, *ABDM Vision Document*, 2021, https://abdm.gov.in/vision
[336] Digital Personal Data Protection Act, No. 22 of 2023, § 4

Quality and safety in telehealth require clear protocols. The Government of India released *Telemedicine Practice Guidelines* in 2020 under the Indian Medical Council Act, which serve as a legal framework for remote consultations by registered medical practitioners [337].These guidelines should be regularly revised in light of evolving technology. Providers should be trained in digital etiquette, clinical protocols, and referral pathways to integrate virtual care with physical services. For instance, when a PHC refers a patient to a tertiary centre after a teleconsultation, all diagnostic notes should be seamlessly transferred.

By creating digital bridges between under-resourced areas and urban centres of medical excellence, India can democratize access to expertise. A village patient can now receive guidance from a senior oncologist or cardiologist through virtual OPDs—an innovation that would have seemed impossible a decade ago. Telehealth should not replace physical infrastructure but serve as a complementary force. Combined with expanded physical services, it creates a hybrid care model. This strategy is evidence-backed: Brazil has used telehealth to support care in the Amazon region, while India's ECHO (Extension for Community Healthcare Outcomes) model trains rural providers to manage complex conditions through virtual case discussions[338].

For India, mainstreaming digital health solutions is a scalable and cost-effective pathway to achieving equitable health access. In conclusion, digital inclusion strategies are indispensable to tackling the inverse care law, they deliver care to where need exists, rather than forcing those in need to chase care across distances and bureaucracies.

5.2.6 Enhancing Accountability through Regulatory Bodies and Community Oversight

- **Strengthening Regulatory Mechanisms:**

To ensure that increased funding and new laws translate to improved services for the underserved, robust regulatory oversight is essential. The lack of strong enforcement, especially in the private sector, and limited internal accountability in public institutions

[337] Ministry of Health & Family Welfare & NITI Aayog, *Telemedicine Practice Guidelines*, Mar. 2020, https://www.mohfw.gov.in/pdf/Telemedicine.pdf
[338] Arora et al., *Academic Medicine,* 86 Acad. Med. 1463, 1463–69 (2011)

have perpetuated disparities in care delivery [339]. The following measures are suggested to fortify regulation and enforcement:

- **Universal Implementation of Standards:** As mentioned, fast-tracking the adoption of the Clinical Establishments (Registration & Regulation) Act, 2010[340] across all states in India is imperative. The Union Health Ministry should work closely with states to resolve any concerns that hinder adoption, modifying rules if necessary to accommodate state contexts. Once adopted, ensure that every hospital, clinic, lab, etc., is registered and subject to periodic inspections. Criteria such as staffing levels, equipment availability, hygiene, and rate schedules should be monitored. Non-compliant facilities should face penalties or even closure for egregious violations. The proposed National Council for Clinical Establishments, established under Section 3 of the Act, should be made operational and publish nationwide status reports[341].
- **Price Regulation and Anti-Exploitation:** To curb exploitative billing, especially in the private sector, India should extend regulatory frameworks to include standard pricing for certain critical procedures, such as dialysis, cancer therapies, and cardiac stents. This could build upon the work of the National Pharmaceutical Pricing Authority (NPPA), which already caps prices for essential medicines and devices under the Drugs (Prices Control) Order, 2013[342]. The Pradhan Mantri Jan Arogya Yojana (PM-JAY) already uses reference pricing for treatment packages, which could be adopted more broadly to curb overcharging[343]. Additionally, practices such as demanding advance payments before emergency care violate Supreme Court precedent and should be penalized[344]. States like Maharashtra have introduced Patients' Rights Charters, but central legislation is required to make such charters legally binding.

[339] National Health Systems Resource Centre, *Evaluation of Clinical Establishments Act Implementation*, Ministry of Health & Family Welfare, 2022
[340] Clinical Establishments (Registration and Regulation) Act, No. 23 of 2010, India Code, https://indiacode.nic.in
[341] Id.
[342] Drugs (Prices Control) Order, 2013, G.S.R. 588(E), § 4; See also National Pharmaceutical Pricing Authority, *Annual Report 2021–22*, at 12
[343] National Health Authority, *PM-JAY Guidelines on Package Rates*, 2022
[344] Paschim Banga , supra note 14

- **Independent Regulatory Authority:** To ensure impartiality, India should consider creating independent regulatory commissions, akin to financial regulators, for healthcare. These bodies could monitor both public and private sector providers for quality, ethics, and compliance with standard treatment protocols [345]. Their responsibilities could include licensing, inspection, quality benchmarking, and enforcement. Coordination with medical councils and accreditation bodies like NABH (National Accreditation Board for Hospitals & Healthcare Providers) could further ensure standardization of care.

- **Accountability through Community and Civil Society:**

Beyond formal oversight, community involvement plays a pivotal role in ensuring local-level accountability. Mechanisms such as Community-Based Monitoring (CBM), piloted under the National Rural Health Mission (NRHM), empower citizens to evaluate public healthcare delivery[346].

Institutions such as Rogi Kalyan Samitis (Patient Welfare Committees) and Health Facility Management Committees, comprising Panchayat members, NGOs, and patient representatives, can manage local untied funds, flag grievances, and assess facility performance. Social audits, similar to those under MGNREGA, can be applied to public health institutions for grassroots reporting [347]. Such initiatives uphold the ethical principle of "accountability to affected populations," widely endorsed in global health governance [348].

- **Judicial and Quasi-Judicial Accountability:**

Judicial mechanisms provide a forum of last resort for individual redress in cases of denial or deficiency of care. The Consumer Protection Act, 2019, now explicitly includes medical services under its purview[349]. Aggrieved patients may approach consumer forums for redressal of negligence or overcharging. To improve access to

[345] World Health Organization, *The World Health Report 2000: Health Systems—Improving Performance*, at 91 (2000
[346] Ministry of Health & Family Welfare, *Community Action for Health: Compendium of Case Studies*, 2015
[347] Comptroller & Auditor General of India, *Performance Audit of NRHM*, Report No. 25 of 2017
[348] United Nations Office for the Coordination of Humanitarian Affairs, *Humanitarian Accountability Report*, 2012
[349] Consumer Protection Act, No. 35 of 2019, § 2(42)

justice, the establishment of fast-track consumer courts dedicated to health matters in each district should be considered. Professional accountability through State Medical Councils is currently marred by delays and allegations of bias. Reforms—such as inducting non-medical members, setting time-bound procedures, and ensuring transparent hearings, are essential to restore credibility[350].

- **Data Transparency and Public Reporting:**

Transparency in health system performance is a key accountability tool. Public dashboards showing hospital-wise indicators, like bed occupancy, infection rates, staff absenteeism, and user satisfaction, can incentivise better governance. District health scorecards and open-access data from schemes like PM-JAY and NHM would allow media, civil society, and citizens to audit service quality[351]. India could emulate the UK's National Health Service (NHS), which publishes hospital league tables and quality reports to stimulate inter-institutional performance improvement[352].

By enforcing rigorous standards and enabling both top-down and bottom-up accountability, India can ensure its healthcare system becomes more equitable and responsive. Disadvantaged groups, who often face systemic neglect, would gain meaningful avenues to assert their rights. Ultimately, a culture of accountability is essential for translating constitutional and statutory rights into practice. Without accountability, even well-funded and well-designed programs risk failure.

To close the loop of healthcare reform, delivery systems must be answerable. Regulators, courts, and communities must act in tandem to ensure that health justice is not aspirational, but enforceable.

[350] Indian Medical Council [Professional Conduct, Etiquette and Ethics] Regulations, 2002, Regulation 8.2
[351] National Health Authority, *PM-JAY Hospital Empanelment Module*, https://hospitals.pmjay.gov.in
[352] U.K. Department of Health, *Quality Accounts: A Guide to NHS Reporting*, 2020

5.3. CONCLUSION

The measures suggested above: legal reforms, a shift in financing policies, enhanced inter-governmental coordination, strengthening primary care, embracing digital innovation, and improving accountability, constitute an integrated strategy to address the inverse care law in India. They align with the key findings of this research, which indicate that resolving healthcare inequality requires a multi-faceted approach. It involves making health a justiciable right and a budgetary priority, decentralising services while maintaining unified standards, leveraging technology without marginalising vulnerable populations, and enforcing obligations to ensure that the promise of "Health for All" translates into reality.

These reforms are ambitious but not unattainable. Many of them build on existing programs or follow recommendations from expert bodies (for example, there is governmental support for establishing a right to health in policy documents, and official surveys recognize the necessity for increased health spending). The critical factors for success are political will and public demand.

If these suggestions are implemented, India will move closer to fulfilling its constitutional commitment to social justice and equality in healthcare. The ultimate vision is an India where quality healthcare is regarded as a fundamental right—a place where a poor rural woman, a child in a city slum, and a wealthy urban citizen can all access the care they need without significant difficulty or financial burden. Achieving this goal will help neutralise the inverse care law and demonstrate India's commitment to upholding the legal right to health for everyone.

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