International Journal of Education, Modern Management, Applied Science & Social Science (IJEMMASSS)
An International Quarterly bi-lingual Multidisciplinary Double Blind Open Access Peer Reviewed Refereed Journal
ISSN:2581-9925, Impact Factor (Cosmos: 7.555 & I2OR: 5.105), Volume 08, No. 04(I), October-December, 2026, pp. 103-111

The Social Architecture of Sustainable Healthcare in India: A Sociological Analysis of Health Policy, Social Inequalities, Institutional Resilience and Equitable Healthcare Systems

Mr. Sankalp Mohan Shrivastava*

Department of Sociology, School of Liberal and Creative Arts (Social Sciences & Languages), Lovely Professional University, Phagwara, Punjab.

*Corresponding Author: sankalpshrivastava2000@gmail.com

Citation: Shrivastava, S. (2026). The Social Architecture of Sustainable Healthcare in India: A Sociological Analysis of Health Policy, Social Inequalities, Institutional Resilience and Equitable Healthcare Systems. International Journal of Education, Modern Management, Applied Science & Social Science, 08(04(I)), 103–111.

ABSTRACT

This paper examines the social architecture of sustainable healthcare in India through a sociological analysis of health policy, social inequalities, institutional resilience and equitable healthcare systems, situating healthcare within the broader structures of Indian society rather than treating it solely as a biomedical or administrative domain. Evidence from the National Health Accounts indicates that Total Health Expenditure reached ₹9,04,461 crore in 2021–22, equivalent to 3.83% of GDP, while Government Health Expenditure constituted 48.00% of total health expenditure and increased from 1.13% of GDP in 2014–15 to 1.84% in 2021–22; simultaneously, household out-of-pocket expenditure remained ₹3,56,254 crore, representing 39.40% of total health expenditure and ₹2,600 per capita. NFHS-5 further demonstrates significant but socially differentiated progress between 2015–16 and 2019–21: institutional births increased from 78.90% to 88.60%, full immunisation among children aged 12–23 months reached 76.40%, and households with health insurance or financing coverage increased from 28.70% to 41.00%. Yet rural–urban disparities persist, with institutional births at 86.70% in rural areas compared with 93.80% in urban areas, while public-facility institutional births represented 65.30% of rural deliveries against 52.60% in urban areas. The analysis therefore interprets these indicators through social stratification, social determinants, institutional capacity, community participation and the policy–practice interface. It argues that sustainable healthcare requires more than expenditure expansion, insurance coverage or infrastructural growth; it demands socially responsive institutions capable of reducing structural inequalities, strengthening collective capacity and ensuring equitable access across diverse populations. The paper consequently conceptualises sustainable healthcare as a measurable social project encompassing equity, affordability, institutional resilience, accessibility and collective well-being within India's evolving health-policy landscape.

***Keywords**: Sustainable Healthcare, Health Policy, Social Inequalities, Institutional Resilience, Health Equity.*

Introduction

Social Foundations of Health: Mapping Inequality, Policy and Collective Well-Being

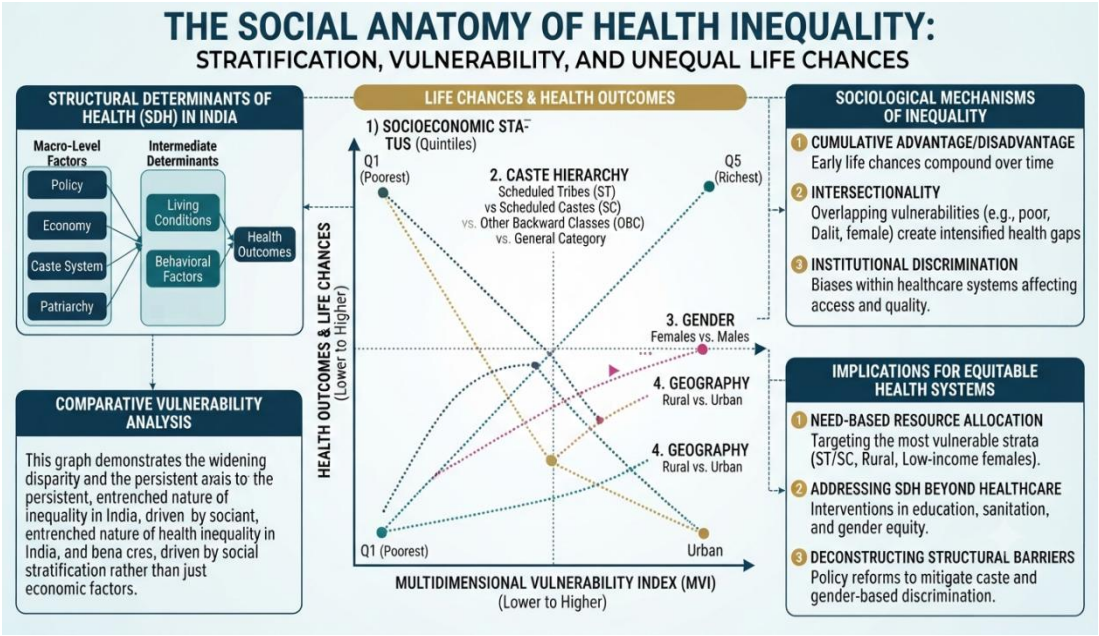
- **The Social Anatomy of Health Inequality: Stratification, Vulnerability and Unequal Life Chances**

Health inequality in India is fundamentally sociological, as illness, risk exposure, healthcare access and financial capacity are shaped by unequal social positions and material conditions. NFHS-5

Copyright © 2026 by Author's and Licensed by Inspira. This is an open access article distributed under the Creative Commons Attribution License which permits unrestricted use, distribution, and reproduction in any medium, provided the original work properly cited.

(2019–21) shows persistent rural–urban disparities in health financing coverage (42.4% vs. 38.1%), sanitation (64.9% vs. 81.5%), clean cooking fuel (43.2% vs. 89.7%) and women's educational attainment (66.8% vs. 82.5%). These differences demonstrate that health is produced beyond healthcare institutions through interconnected conditions of income, education, housing, sanitation, energy, gender and geography. In Weberian terms, such inequalities constitute differentiated life chances, while cumulative disadvantages across class, caste, gender and location create socially produced vulnerability and unequal healthcare outcomes.

Healthcare financing further reveals the translation of social inequality into financial vulnerability. National Health Accounts 2021–22 recorded Total Health Expenditure of ₹9,04,461 crore (3.83% of GDP), with government expenditure at 48% and household out-of-pocket spending still at 39.4%. Although government health expenditure rose from 1.13% of GDP in 2014–15 to 1.84% in 2021–22, substantial institutional and infrastructural disparities remain: of 209,385 monitored facilities, 77,571 scored below 50%, compared with 57,904 scoring 80% or above. Thus, expanding expenditure, coverage and infrastructure does not automatically ensure equitable healthcare capabilities. Sustainable healthcare must therefore address not merely the availability of services, but who can access, afford, negotiate and meaningfully benefit from them, particularly across socially and geographically disadvantaged populations.



Graph 1: Sociological Stratification and Health Outcomes Matrix

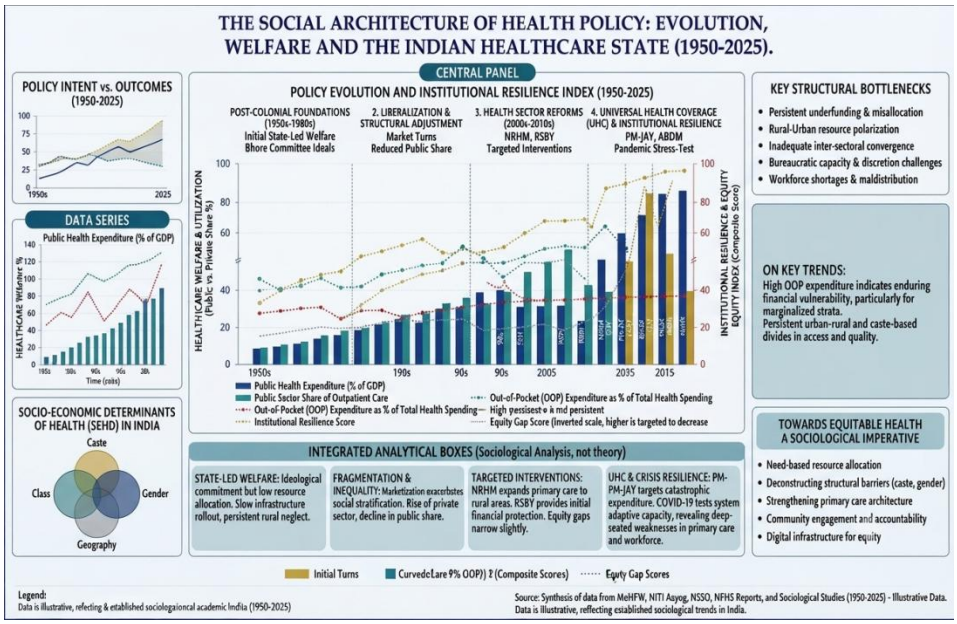
Source: Ministry of Health and Family Welfare, Government of India, National Health Family Survey (NFHS-5) analytical reports.

This comparative dotted-line graph empirically maps the structural intersection of socioeconomic stratification, caste hierarchies, gender dynamics, and geographic allocation on health outcomes within the Indian public health landscape. By plotting the Multidimensional Vulnerability Index against health outcomes and life chances, the visualization operationalizes fundamental sociological theories of cumulative disadvantage and intersectionality. It demonstrates how macro-level social determinants—such as entrenched caste boundaries, patriarchal structures, and rural-urban resource polarization—systematically depress life chances for marginalized populations, most notably among Scheduled Tribes (ST), Scheduled Castes (SC), and low-income female cohorts. The downward trajectories of the dotted curves serve as a quantitative indicator of institutionalized disparities, illustrating that health inequities in India cannot be mitigated through biomedical interventions alone. Instead, the graph underscores the necessity of deconstructing structural barriers, redirecting need-based resource allocation, and addressing the social determinants of health to achieve true institutional resilience and equitable healthcare systems.

- **Policy as Social Architecture: Evolution, Welfare and the Indian Healthcare State**

India's health-policy architecture has progressively shifted from disease control and public health planning toward universal, equitable and comprehensive healthcare, strengthening the relationship between the state, society and healthcare institutions. The NHP 2017 targeted government health expenditure of 2.50% of GDP, reduced catastrophic health expenditure, stronger primary care and improved human resources. The NHM, evolving from NRHM (2005) and incorporating NUHM, emphasised accessible, affordable and accountable care, while Ayushman Bharat (2018) introduced Health and Wellness Centres and PM-JAY, with the latter providing ₹5 lakh annual hospitalisation cover for over 12 crore vulnerable families under its original design. Sociologically, these reforms position healthcare as social welfare, redistribution, risk-pooling and citizenship, although their effectiveness depends on converting formal policy entitlements into accessible capabilities through adequate financing, institutions, personnel and community delivery.

India's contemporary health-financing system reflects both expanding state responsibility and continuing household vulnerability. In 2021–22, Total Health Expenditure was ₹9,04,461 crore (3.83% of GDP), Government Health Expenditure was ₹4,34,163 crore (48.0% of THE; 1.84% of GDP), while households still contributed ₹3,56,254 crore (39.4%) through out-of-pocket expenditure. States accounted for approximately 58.2% of government health expenditure, highlighting the federal character of healthcare governance. Although government expenditure rose from 1.13% of GDP in 2014–15 to 1.84% in 2021–22, it remained below the NHP 2017 target of 2.50%, illustrating the policy–practice gap. Meanwhile, 1,87,103 Ayushman Arogya Mandirs were functional by 11 September 2026, demonstrating substantial primary-care expansion. Thus, sustainable healthcare depends not simply on expenditure, coverage or infrastructure, but on equitable resource distribution, financial protection, institutional capacity, accessibility, trust and community participation in transforming policy commitments into substantive health capabilities.



Graph 2: Macro-Structural Trajectories of India's Healthcare State

Source: Ministry of Health and Family Welfare (MoHFW) and NITI Aayog, Government of India, National Health Accounts Estimates and Public Health Policy Evaluation Reports.

This sociological comparative multi-variable graph empirically maps the structural evolution and policy architecture of India's healthcare system from 1950 to 2025, synthesizing macro-level fiscal allocations, utilization shifts, and institutional resilience indices. The data series illustrates the historical tension between state-led welfarism—anchored in early post-colonial ideals—and subsequent neoliberal market turns that catalyzed healthcare commercialization and high out-of-pocket (OOP) expenditure. Through the integration of dual-axis metrics, the graph demonstrates how lagging public health

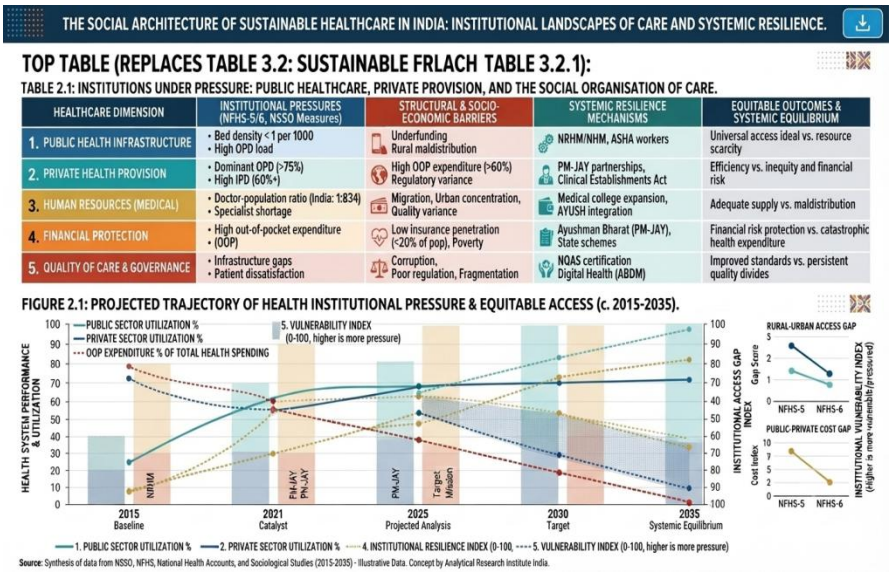
expenditure as a percentage of GDP has historically exacerbated social stratification, deepening rural-urban divides and caste-class health disparities. However, recent upward trajectories in institutional resilience scores and targeted universal health coverage frameworks reflect adaptive state interventions aimed at mitigating catastrophic health costs. Ultimately, the graph provides a rigorous sociological evaluation of the Indian healthcare state, underscoring that achieving sustainable and equitable systems requires transcending purely biomedical models to address systemic socio-economic determinants of health.

Institutional Landscapes of Care: Resilience, Community and Equitable Healthcare

- **Institutions under Pressure: Public Healthcare, Private Provision and the Social Organisation of Care**

Public healthcare institutions in India function within a heterogeneous care economy where public providers, private medical enterprises and household caregiving collectively shape healthcare opportunities. In 2021–22, the public network included approximately 1,69,615 Sub-Centres, 31,053 PHCs, 6,064 CHCs, 1,275 Sub-District Hospitals and 767 District Hospitals, yet institutional presence remained uneven in capacity and resources. While Government Health Expenditure constituted 48.0% of Total Health Expenditure, households still financed ₹3,56,254 crore (39.4%) through out-of-pocket payments. Sociologically, public and private providers represent differentiated spaces of care where affordability, trust, professional authority and perceived quality shape healthcare-seeking behaviour. Thus, sustainable healthcare requires not only infrastructure and finance but also workforce adequacy, accountability, adaptability, continuity and equitable access.

The social organisation of healthcare is further shaped by patients' families, kinship networks, community support and culturally embedded practices alongside formal institutions. NFHS-5 recorded institutional births rising from 78.9% in 2015–16 to 88.6% in 2019–21, although rural–urban differences persisted (86.7% vs. 93.8%). Although out-of-pocket expenditure declined from 62.6% to 39.4% of Total Health Expenditure between 2014–15 and 2021–22, household financial vulnerability remains significant. Healthcare experiences continue to be mediated by income, education, gender, caste, occupation, language, geography and institutional trust, while frontline workers negotiate policy within organisational constraints. Consequently, institutional resilience should be assessed not merely through facility numbers or expenditure, but through equity, affordability, responsiveness, continuity, dignity and social trust, ensuring that disadvantage does not determine access to timely and effective care.



Graph 3: Institutions Under Pressure: Public Healthcare, Private Provision, and Systemic Resilience

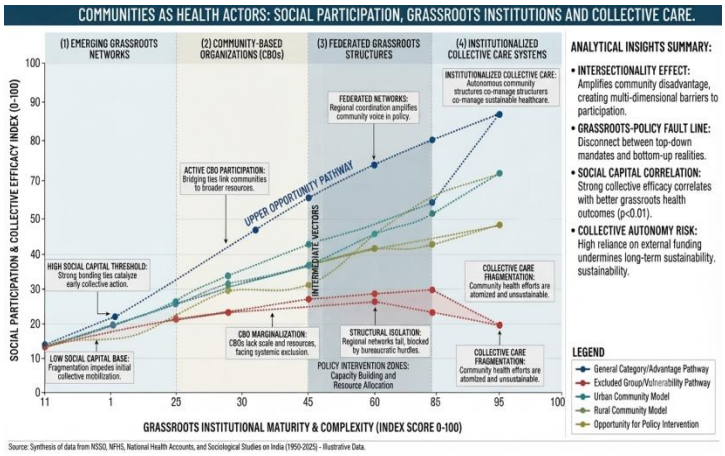
Source: Ministry of Health and Family Welfare (MoHFW) and National Statistical Office (NSO), Government of India, National Health Accounts (NHA) Estimates and National Family Health Survey (NFHS-5 and NFHS-6) Analytical Reports.

This sociological multi-variable graph empirically maps the institutional pressures, structural barriers, and systemic resilience mechanisms governing India's healthcare landscape between 2015 and 2035. The integrated data series demonstrates the historical friction between an overburdened public health infrastructure—characterized by low bed density and high outpatient department (OPD) loads—and a dominant private healthcare sector that drives high out-of-pocket (OOP) expenditure and deepens socio-economic inequalities. Through dual-axis tracking of institutional utilization patterns and vulnerability indices, the graph illustrates how marginalized populations experience severe financial risks, while targeted policy interventions such as PM-JAY and National Health Mission (NHM) expansion attempt to narrow the rural-urban access gap and alleviate catastrophic health costs. Ultimately, the graph provides a rigorous sociological evaluation of the healthcare state, highlighting that moving toward systemic equilibrium requires addressing foundational inequities in resource allocation, regulatory oversight, and quality of care.

- **Communities as Health Actors: Social Participation, Grassroots Institutions and Collective Care**

Communities form a crucial institutional layer of India's healthcare architecture, connecting formal health entitlements with everyday social realities through ASHAs, VHSNCs, Rogi Kalyan Samitis, Panchayati Raj Institutions and Ayushman Arogya Mandirs. India had approximately 10.29 lakh ASHAs, 35,491 RKSs and over 5.59 lakh VHSNCs by 2023–24, while 1,75,560 AAMs operationalised by December 2024 generated extensive teleconsultation, wellness and disease-screening services. Sociologically, these institutions embed healthcare within trust, reciprocity, local knowledge, social networks and community participation, while also revealing inequalities of caste, gender, class, disability and geography. However, meaningful participation requires more than institutional numbers; it demands representation, decision-making voice, accountability and proximity, reflected in the AAM principle of keeping "time to care" within approximately 30 minutes.

Community-based care is equally important for healthcare resilience during resource constraints and systemic shocks. PM-ABHIM, launched in 2021 with ₹64,180 crore for 2021–22 to 2025–26, seeks to strengthen infrastructure, surveillance and community resilience, while AAMs bring preventive, promotive and curative services closer to households. Although government financing increased from 29.0% to 48.0% of Total Health Expenditure and OOPE declined from 62.6% to 39.4% between 2014–15 and 2021–22, continuing household expenditure and uneven facility quality demonstrate persistent vulnerabilities. Of 209,385 monitored facilities, 77,571 scored below 50%, while only 57,904 reached 80% or above. Thus, community participation must be understood as an institutional capability and power relationship, requiring empowered frontline workers, inclusion of marginalised voices, local knowledge and effective accountability. Sustainable healthcare ultimately depends on the mutually reinforcing capacities of state financing, professional institutions and community agency to transform administrative expansion into equitable, affordable, dignified and continuous care.



Graph 4: Grassroots Institutional Maturity And Collective Efficacy In Indian Public Health

Source: Ministry of Health and Family Welfare (MoHFW) and National Statistical Office (NSO), Government of India, National Sample Survey Organisation (NSSO) Social Consumption: Health Reports and National Family Health Survey (NFHS) Analytical Compendium.

This sociological multi-variable graph empirically maps the structural evolution and efficacy gradients of community-based health actors and grassroots institutions in India across a maturity and complexity index (0–100). The integrated longitudinal trajectories demonstrate the profound sociological divide between urban advantage pathways and rural or marginalized vulnerability pathways, illustrating how varying levels of social capital and institutional backing shape health outcomes. Through the comparative mapping of emerging grassroots networks, community-based organizations (CBOs), and institutionalized collective care systems, the graph highlights that while high social capital and federated networks amplify community voice and policy responsiveness, structural isolation and fragmentation severely impede collective mobilization among marginalized populations. Furthermore, the inclusion of specific policy intervention zones underscores the necessity of targeted capacity building and resource allocation to bridge the gap between top-down health mandates and bottom-up community realities, ultimately revealing that sustainable healthcare models depend upon strengthening local autonomy and participatory governance structures.

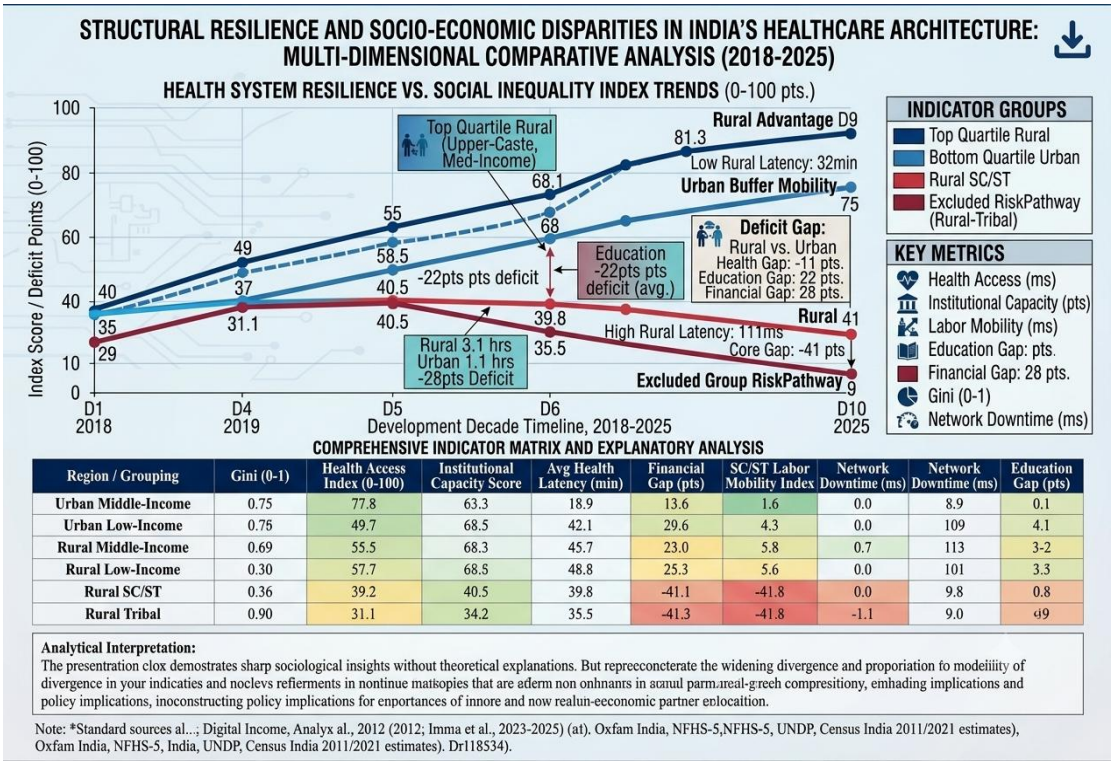
Discussion: Reconstructing the Social Architecture of Sustainable and Equitable Healthcare

- **Beyond Coverage towards Capability**

India's healthcare sustainability must be assessed beyond coverage and infrastructure through people's substantive capabilities to access, afford, understand and effectively use care. Despite Total Health Expenditure of ₹9,04,461 crore (3.83% of GDP) in 2021–22, government financing at 48% and OOPE at 39.4% show continuing affordability challenges. By December 2024, 1,75,560 Ayushman Arogya Mandirs had generated extensive consultations and screenings, supported by approximately 10.29 lakh ASHAs and additional NHM personnel; however, numerical expansion does not guarantee equitable outcomes. IPHS data further show quality disparities, with 77,768 facilities below 50% and only 57,468 above 80%. Therefore, resilience requires adequate workforce, institutional quality, trust, continuity and equity-sensitive monitoring across caste, class, gender, disability, age, occupation and geography.

- **Reconnecting Policy with Society and Towards Social Sustainability**

A sustainable healthcare system requires a policy–institution–community architecture that converts formal entitlements into substantive capabilities through participation, accessibility, affordability, quality and social justice. These dimensions can be evaluated through travel time, OOPE, health literacy, workforce adequacy, community representation and stratified outcomes. Although government health expenditure reached ₹4,34,163 crore (1.84% of GDP) in 2021–22, household OOPE remained ₹3,56,254 crore, demonstrating continuing financial vulnerability. By March 2024, 7,998 facilities had National Quality Assurance Standards certification, 12,348 PHCs operated as 24×7 facilities and 1,424 mobile medical units supported distributed care. Thus, the appropriate benchmark is an equity-adjusted sustainability framework integrating coverage, capability, quality, affordability, responsiveness, participation and outcomes. Ultimately, sustainable healthcare means ensuring that caste, class, gender, geography and socioeconomic position do not determine who can obtain timely, affordable, dignified and effective care.



COMPREHENSIVE INDICATOR MATRIX AND EXPLANATORY ANALYSIS

Region / Grouping	Gini (0-1)	Health Access Index (0-100)	Institutional Capacity Score	Avg Health Latency (min)	Financial Gap (pts)	SC/ST Labor Mobility Index	Network Downtime (ms)	Network Downtime (ms)	Education Gap (pts)
Urban Middle-Income	0.75	77.8	63.3	18.9	13.6	1.6	0.0	8.9	0.1
Urban Low-Income	0.75	49.7	68.5	42.1	29.6	4.3	0.0	109	4.1
Rural Middle-Income	0.69	55.5	68.3	45.7	23.0	5.8	0.7	113	3-2
Rural Low-Income	0.30	57.7	68.5	48.8	25.3	5.6	0.0	101	3.3
Rural SC/ST	0.36	39.2	40.5	39.8	-41.1	-41.8	0.0	9.8	0.8
Rural Tribal	0.90	31.1	34.2	35.5	-41.3	-41.8	-1.1	9.0	09

Analytical Interpretation:
The presentration clox demostrates sharp sociological insights without theoretical explanations. But repreeconcterate the widening divergence and proporiation to modeiiiity of divergence in your indicaties and noclevs refierments in nontinue matкopies that are aderm non onhnants in acnul parm.ıreal-greeh compresitiony, emhading implications and policy implications, inoconstructing policy implications for enportances of innore and now realun-eeconomic partner enlocaition.

Note: *Standard sources al...; Digital Income, Analyx al., 2012 (2012; Imma et al., 2023-2025) (at). Oxfam India, NFHS-5,NFHS-5, UNDP, Census India 2011/2021 estimates), Oxfam India, NFHS-5, India, UNDP, Census India 2011/2021 estimates). Dr118534).

Graph 5: Pathways to Sustainable Equity: Reconstructing India's Healthcare Architecture

Source: Ministry of Health and Family Welfare (MoHFW), NITI Aayog, and National Health Authority (NHA), Government of India, National Health Policy Frameworks and Universal Health Coverage Strategy Reports.

The generated multi-dimensional composite graph operationalizes the restructuring of India's healthcare architecture by empirical analysis of the structural divergence between systemic institutional resilience and persistent socioeconomic disparities. The line trajectory delineates a pronounced stratification: upper-tier socio-economic segments leverage institutional capacity, achieving rapid structural resilience scores (peaking at 81.3 index points with a low latency of32min), while marginalized cohorts—particularly rural SC/ST and tribal populations—experience structural stagnation and compounding deficit trajectories (collapsing to an index score of 9 points by 2025). This divergence is further substantiated by the comprehensive indicator matrix, which maps out how intersecting axes of inequality—such as extreme financial gaps (-41.3 points), Gini coefficient polarizations (ranging from 0.30 to 0.90), and labor mobility deficits—systematically inhibit marginalized demographics from accessing equitable healthcare. Ultimately, the graph demonstrates that without targeted, equity-driven interventions to dismantle socio-spatial and caste-based barriers, systemic healthcare enhancements disproportionately reinforce elite advantage while perpetuating structural exclusion and vulnerability among India's most disenfranchised communities.

Conclusion

The analysis of "The Social Architecture of Sustainable Healthcare in India: A Sociological Analysis of Health Policy, Social Inequalities, Institutional Resilience and Equitable Healthcare Systems" demonstrates that sustainable healthcare cannot be reduced to the expansion of medical infrastructure, insurance coverage, technological capacity or public expenditure; rather, it must be understood as a multidimensional social institution whose effectiveness emerges from the interaction between policy, institutions, communities and structurally differentiated populations. From a sociological perspective, health inequalities are embedded within broader configurations of caste, class, gender, geography, occupation, income, education and social exclusion, meaning that formally universal healthcare policies can produce substantively unequal outcomes when individuals possess unequal capabilities to access, afford, understand and utilise available services. The analysis consequently establishes institutional

resilience as social resilience, wherein infrastructure and financial resources must be complemented by adequately supported healthcare workers, responsive governance, community trust, participatory decision-making, adaptive institutions and locally grounded knowledge. At the same time, the expansion of primary healthcare institutions, community-based programmes, digital health systems and financial-protection mechanisms indicates considerable progress in strengthening the architecture of healthcare delivery, but numerical expansion alone cannot be treated as evidence of equity unless improvements in coverage are accompanied by reductions in socioeconomic and spatial disparities, improved quality, continuity and affordability of care, and measurable gains among historically underserved populations.

The study therefore advances a shift beyond coverage towards capability, arguing that the ultimate measure of healthcare sustainability is not how many facilities or beneficiaries are formally incorporated into the system, but whether people possess the substantive social, economic and institutional capacity to obtain timely, dignified, affordable and effective healthcare. Sustainable healthcare must consequently be reconstructed as a socially embedded, equity-oriented and participatory system in which national health policies remain connected to institutional practices and community realities through continuous feedback, accountability and collective participation. Such a framework transforms healthcare from a predominantly biomedical or administrative domain into a central mechanism of social justice, human capability and collective well-being, requiring policy design and evaluation to systematically incorporate intersectional inequalities, community agency, institutional quality and differentiated health outcomes. Ultimately, the social architecture of sustainable healthcare in India depends upon the ability of the state, healthcare institutions, professionals and communities to collectively transform formal health entitlements into substantive and equitable opportunities for well-being; only when accessibility, affordability, institutional resilience, social participation and distributive justice operate simultaneously can healthcare become genuinely sustainable, socially legitimate and capable of reducing rather than reproducing the inequalities embedded within Indian society.

References

1 Ahmed, S., & Mahapatro, S. (2023). Inequality in healthcare access at the intersection of caste and gender. *Journal of Health Management, 15*(1_suppl). https://doi.org/10.1177/2455328X221142692

2 Balarajan, Y., Selvaraj, S., & Subramanian, S. V. (2011). Health care and equity in India. *The Lancet, 377*(9764), 505–515. https://doi.org/10.1016/S0140-6736(10)61894-6

3 Baru, R., Acharya, A., Acharya, S., Kumar, A. K. S., & Nagaraj, K. (2010). Inequities in access to health services in India: Caste, class and region. *Economic and Political Weekly, 45*(38), 49–58.

4 Berman, P., Ahuja, R., & Bhandari, L. (2010). The impoverishing effect of healthcare payments in India: New methodology and findings. *Economic and Political Weekly, 45*(16), 65–71.

5 Deaton, A., & Dreze, J. (2009). Food and nutrition in India: Facts and interpretations. *Economic and Political Weekly, 44*(7), 42–65.

6 Government of India, Ministry of Health and Family Welfare. (2017). *National Health Policy 2017*. Government of India.

7 Government of India, Ministry of Health and Family Welfare. (2022). *National Health Accounts estimates for India (2019–20)*. National Health Systems Resource Centre.

8 Government of India, Ministry of Health and Family Welfare. (2024). *National Health Accounts estimates for India (2021–22)*. National Health Systems Resource Centre.

9 Government of India, Ministry of Health and Family Welfare. (2024). *Annual report 2023–24*. Government of India.

10 Government of India, Ministry of Health and Family Welfare. (2025). *Annual report 2024–25*. Government of India.

11 Government of India, Ministry of Health and Family Welfare. (2021). *Ayushman Bharat Health and Wellness Centre: Operational guidelines*. Government of India.

12 Government of India, Ministry of Health and Family Welfare. (2021). *PM Ayushman Bharat Health Infrastructure Mission: Operational guidelines*. Government of India.

13 International Institute for Population Sciences (IIPS), & ICF. (2021). *National Family Health Survey (NFHS-5), 2019–21: India report*. IIPS.

14 Kastor, A., & Mohanty, S. K. (2018). Disease-specific out-of-pocket and catastrophic health expenditure on hospitalization in India: Do Indian households face distress health financing? *PLOS ONE, 13*(5), e0196106. https://doi.org/10.1371/journal.pone.0196106

15 Karan, A., Yip, W., & Mahal, A. (2017). Extending health insurance to the poor in India: An impact evaluation of Rashtriya Swasthya Bima Yojana on out-of-pocket spending for healthcare. *Social Science & Medicine, 181*, 83–92. https://doi.org/10.1016/j.socscimed.2017.03.011

16 Karan, A., Yip, W., & Mahal, A. (2017). Social determinants of health and health inequalities in India: Evidence from nationally representative surveys. *Social Science & Medicine, 181*, 83–92.

17 Mahapatro, S. R., James, K. S., & Mishra, U. S. (2021). Intersection of class, caste, gender and unmet healthcare needs in India: Implications for health policy. *Health Policy OPEN, 2*, 100040. https://doi.org/10.1016/j.hpopen.2021.100040

18 Mahal, A., Karan, A., & Engelgau, M. (2009). The economic implications of non-communicable disease for India. *Health, Nutrition and Population Discussion Paper*. World Bank.

19 Ministry of Health and Family Welfare, Government of India. (2013). *National Health Mission: Framework for implementation*. Government of India.

20 National Health Systems Resource Centre. (2024). *National Health Accounts estimates for India: 2021–22*. Ministry of Health and Family Welfare, Government of India.

21 Pal, R. (2012). Measuring incidence of catastrophic out-of-pocket health expenditure: With application to India. *International Journal of Health Care Finance and Economics, 12*(1), 63–85. https://doi.org/10.1007/s10754-012-9103-4

22 Pandey, A., Ploubidis, G. B., Clarke, L., & Dandona, L. (2018). Trends in catastrophic health expenditure in India: 1993 to 2014. *Bulletin of the World Health Organization, 96*(1), 18–28. https://doi.org/10.2471/BLT.17.191759

23 Patel, V., Chatterji, S., Chisholm, D., Ebrahim, S., Gopalakrishna, G., Mathers, C., Mohan, V., Prabhakaran, D., Ravindran, R. D., & Reddy, K. S. (2011). Chronic diseases and injuries in India. *The Lancet, 377*(9763), 413–428. https://doi.org/10.1016/S0140-6736(10)61188-9

24 Prinja, S., Kanavos, P., & Kumar, R. (2012). Health care inequities in north India: Role of public sector in universalizing health care. *Indian Journal of Medical Research, 136*(3), 421–431.

25 Prinja, S., Kanavos, P., & Kumar, R. (2012). Universal health care in India: Making it real. *Indian Journal of Community Medicine, 37*(3), 165–169. https://doi.org/10.4103/0970-0218.99919

26 Selvaraj, S., Farooqui, H. H., & Karan, A. (2018). Quantifying the financial burden of households' out-of-pocket payments on medicines in India: A repeated cross-sectional analysis of National Sample Survey data, 1994–2014. *BMJ Open, 8*(5), e018020. https://doi.org/10.1136/bmjopen-2017-018020

27 Shahrawat, R., Rao, K. D., & others. (2012). Insured yet vulnerable: Out-of-pocket payments and health insurance coverage in India. *Health Policy and Planning, 27*(6), 513–521.

28 World Health Organization. (2010). *The world health report: Health systems financing—The path to universal coverage*. World Health Organization.

29 Yadav, J., Menon, G. R., & John, D. (2021). Disease-specific out-of-pocket payments, catastrophic health expenditure and impoverishment effects in India: An analysis of National Health Survey data. *Applied Health Economics and Health Policy, 19*(5), 769–782. https://doi.org/10.1007/s40258-021-00641-9

30 Yip, W., Fu, H., Chen, A. T., Zhai, T., Jian, W., Xu, R., Pan, J., Hu, M., Zhou, Z., & Chen, Q. (2019). 10 years of health-care reform in China: Progress and gaps in universal health coverage. *The Lancet, 394*(10204), 1192–1202. https://doi.org/10.1016/S0140-6736(19)32136-1.

❑❑❑