One Hospital Bill is Enough to Push a Middle-Class Family into Poverty

By Ramoji Tejomurtula
Healthcare Management and Financial Consultant, Associated with healthcare industry for about 25 years, t.ramoji@gmail.com

Abstract:
This article critically examines the financial vulnerability of middle-class and low-income households in India arising from healthcare expenditure, arguing that a single hospitalisation event can precipitate downward economic mobility and, in many cases, poverty. Drawing on national datasets and policy reports, the study highlights that despite improvements in public health spending and expansion of insurance schemes, out-of-pocket expenditure continues to constitute a significant share of total health spending, thereby exposing households to financial shocks.

The analysis conceptualises healthcare costs as a continuum, encompassing pre-admission diagnostics, in-patient treatment, and long-term post-discharge care, demonstrating how cumulative expenses transform acute medical episodes into prolonged financial liabilities. It further explores coping mechanisms such as savings depletion, informal borrowing, and asset liquidation, emphasising their long-term implications, including indebtedness and reduced economic resilience.

The article situates these dynamics within a broader structural context, identifying gaps in insurance design, limited public healthcare capacity, and lack of price transparency as key systemic challenges. It concludes by advocating for integrated policy interventions like strengthened public provisioning, comprehensive financial protection mechanisms, transparent pricing frameworks, and patient-centric financial counselling, to ensure that health shocks do not translate into irreversible economic distress.

Key Words:
Catastrophic Health Expenditure; Healthcare Financing; Out-of-Pocket Expenditure; Structural Poverty Trap; Medical Inflation

Introduction:
The phrase “One Hospital Bill is Enough to Push a Middle-Class Family into Poverty” sounds dramatic until you meet a middle-class family in the hospital billing queue. For them, the phrase is not a metaphor. It is life’s new arithmetic. A father calculates which of his dreams to sacrifice. A mother counts the gold bangles left to pledge. A young adult wonders whether that student loan can be stretched to include a life-saving scan. One slip on the staircase of health and the wallet plummets with the patient.

As per the findings from the report released by People Research on India’s Consumer Economy (PRICE) India had 31% of population in Middle-class segment which is expected to double to 61% by 2047 (People Research on India’s Consumer Economy, n.d.; NITI Aayog, 2023).

The Problem:
With about 450 million in Middle-class segment expected to grow to more than 1 billion by 2047 as the country looks to celebrate Viksit Bharath, if the healthcare spend is not addressed, we may see more than 100 million people swinging back to poverty web every year. Math is simple: In an average, one will need a serious

hospitalization once in 7 years, which takes about 150 million people, out of 1 billion middle-class lot, facing the challenge every year. With less than 1/3rd covered through some safety network, a 100 million swinging back to poverty is a potential threat.

The middle class is often described as India's engine contributing towards paying taxes, aspiring upward, investing in education, building modest savings, and dreaming of stability. Yet for millions of families, that stability is far more fragile than it looks. One unexpected hospitalisation can behave like an economic earthquake: it arrives suddenly, demands cash quickly, and leaves long aftershocks like debt, asset sales, disrupted schooling, delayed care, and a permanent dent in the family's ability to recover.

While policy makers have sufficiently defined the so called middle-class both in terms of individual and also as a family (by annual income of individual or the family as the case may be), one healthcare spend can potentially swing them back to poverty line. Hence, there is a thin line between the Middle-class status and the Poverty.

With meagre income levels with hand-to-mouth existence, middle class families hardly have a saving potential of around 15% of their income. Quite often such savings were aimed at meeting financial goals such as higher education and marriages of children, building retirement corpus, acquiring necessary white goods etc. With hospitalization bills ranging from Rs. 75,000 to Rs. 2.5 las and upwards (for chronic diseases like cancer, organ transplantation etc), savings of years can get wiped out apart from distorting the planned financial goals (National Sample Survey Office, 2018; Public Health Foundation of India, n.d.; Institute for Health Metrics and Evaluation, n.d.)

The day the hospitalization bill becomes bigger than the disease

Most families can narrate a version of the same moment. The doctor explains the condition such as appendicitis, a blocked artery, pneumonia, a suspected cancer, a complicated delivery etc. The family focuses on one thing: "Please save them." Then the second conversation begins: "Advance payment," "ICU deposit," "Package details," "Insurance approval," "Cashless not applicable," "We need consent."

In the fog of fear, families sign forms they do not fully understand. Costs are discussed in ranges. A few items are covered; many are not. And the bill doesn't arrive as a single number, it arrives as a series of demands, each urgent, each time-sensitive, each tied to life-and-death decisions.

While we touch upon how hospitalisation can potentially push middle-class households into poverty, the experience of families already living below or near the poverty line is qualitatively different. It essentially deepens the existing poverty. For these households, illness does not represent a downward mobility event alone; rather, it often entrenches poverty, reinforces structural disadvantage, and initiates a cycle from which recovery is extremely difficult.

Health shocks among poor households operate not as temporary disruptions, but as poverty traps, where limited resources, weak institutional access, and fragile livelihoods interact to produce long-term deprivation. Unlike middle-class households that can temporarily absorb shocks by drawing down savings or selling assets, poor households face a binding liquidity constraint at the very first point of care.

For households already living in poverty, recovery after hospitalisation is often limited or impossible without sustained external support. Productive assets, once sold, are rarely regained, and debt burdens persist long after medical recovery.

Health shocks therefore function not as temporary setbacks, but as structural poverty traps, reinforcing inequality and limiting upward mobility. Although publicly funded health insurance schemes aim to protect poor households, multiple barriers limit effective access. These include lack of documentation, low awareness, administrative complexity, and uneven provider participation.

In emergency situations, these barriers become particularly restrictive, resulting in:

- Out-of-pocket payments despite nominal coverage
- Referrals to private facilities with higher costs
- Exclusion from cashless treatment pathways

Consequently, the existence of entitlements does not always translate into financial protection at the point of care. Poor Remains Poor was often heard by us in the context of financial and social status. Health issue is the biggest and most probably the single most factor in 'remaining poor' because it functions as a Structural Poverty Trap (Amartya Sen, 1999; World Health Organization, n.d.; World Bank, n.d.)

When hospitalisation becomes unavoidable, poor households depend heavily on informal sources of credit, including moneylenders, employers, neighbours, and self-help groups. These forms of borrowing are characterised by high interest rates, short repayment horizons, and significant social costs.

Medical debt is non-productive. Unlike loans taken for education or enterprise, healthcare borrowing does not generate future income and often results in:

- Chronic indebtedness
- Wage bondage or exploitative labour arrangements
- Intergenerational transmission of debt

As a result, medical expenses deepen poverty not only through expenditure but also through long-term financial dependency. Further, most poor households depend on informal employment, daily wage labour, or self-employment. Illness disrupts income generation immediately and often entirely.

Thus, hospitalisation introduces a dual income shock:

- The patient is unable to work
- A caregiver, frequently a woman, must forgo employment to provide care

This simultaneous loss of earnings and increase in expenditure creates a compounding economic effect, accelerating household impoverishment during health crises.

Now, let us blend these two sets of people (middle class and poor) in terms of financial catastrophe with healthcare emergency and understand the complexities and think of policy level interventions to address them.

Is the Private Healthcare a luxury?

This is not a story about extravagance or waste. It is the story of how healthcare financing works in practice, and why, despite real improvements in public health spending, out-of-pocket payments still dominate many household decisions. Government data shows that India's out-of-pocket expenditure (OOPE) has declined over time, but it remains around 39.4% of Total Health Expenditure (THE) in 2021-22. That single statistic explains why medical emergencies so often become financial emergencies (Ministry of Health & Family Welfare, 2022; World Health Organization, n.d.)

Does a Care Cost?

Healthcare in India has advanced faster than our wallets can keep pace. We can cure a failing heart with a stent made of platinum yet a middle-class heart skips a beat when the cost estimator prints out the bill. The contrast is fluorescent. India's private hospitals are much more welcoming than the government hospitals but everything comes at a price. A care has a Cost, sometimes prohibitive.

Apart from hospitalization costs, out-patients cost and chronic disease spending, which aren't fully cushioned by many schemes, often bleed families slowly.

Hospitalisation is often just the visible peak. The real expense curve has three phases:

1) Before admission: the diagnostic chase

Many conditions begin with weeks of consultations, tests, repeat imaging, and travel. This phase is mostly out-of-pocket for many households. By the time a patient is admitted, savings may already be thinning.

2) During admission: the bill's hidden architecture

Families see a lump sum of "₹2.5 lakh package", but the bill is actually built from components: room/ICU, procedure charges, professional fees, medicines, diagnostics, consumables, implants, oxygen, and "miscellaneous." Even when a package exists, exclusions and add-ons multiply quickly.

The NSS data even shows that medicines and diagnostics are meaningful components of spending during hospitalisation. The family experiences this as a constant drip of extra costs: "one more test," "one more day," "one more antibiotic," "this implant is better," "this is not included."

3) After discharge: the long tail

Post-discharge medicines for chronic conditions such as cardiac drugs, cancer follow-up, diabetes, renal care, can continue for years. Families who "managed" the hospital bill often discover the real cost is ongoing.

This is how a "single hospital bill" becomes a multi-year financial liability.

The important point is not to debate one number versus another. The consistent message across datasets is this: medical spending can and does impoverish households at scale.

(National Sample Survey Office, 2018; Central Bureau of Health Intelligence, n.d.; World Health Organization, n.d.)

How families cope, and why coping creates long-term damage

When the hospital bill is due, families use a predictable ladder of coping mechanisms:

1. Cash + savings (fast, but limited)
2. Borrowing from relatives/friends (social capital, but finite)
3. High-interest loans (dangerous, often informal)
4. Selling gold (common in India; erodes security)
5. Selling land or long-term assets (irreversible loss)
6. Reducing "non-essential" spending (often education, nutrition, preventive care)
7. Delaying or discontinuing treatment (health worsens, costs rise later)

Coping Mechanism and Long-term Damage:

Coping Method	Short-Term Relief	Long-term Impact
Savings Depletion	Yes	Loss of resilience
Gold sale	Yes	Asset erosion
Informal loans	Partial	Debt-trap
Treatment delay	No	Higher mortality

The middle class is uniquely vulnerable because it often has assets worth selling (gold, a plot of land, an LIC policy), but not enough wealth to absorb the shock without consequences. Poverty in this sense is not only low income, it is the loss of resilience (NSSO Health Expenditure Financing Sources, National Family Health Survey (NFHS) and World Bank household coping strategies studies). And there is an emotional toll: guilt, anxiety, family conflict, and the quiet fear that "one more illness will finish us."

Poor households typically function without savings, insurance coverage, or liquid assets. Daily income is largely consumed by subsistence needs such as food, rent, fuel, and transport. Consequently, even minor medical expenses create immediate financial stress.

In the context of hospitalisation, the absence of financial buffers manifests as (World Health Organization, n.d.; The Lancet Global Health, n.d.; World Bank, n.d.):

- Delayed admission due to inability to pay advance deposits
- Reliance on informal negotiations with providers
- Premature discharge against medical advice

Who should be held accountable?

- Some blame it on governments for apathy. They argue that healthcare should be a fundamental public good like roads and schools. Yet government hospitals remain overwhelmed, understaffed, and underinvested.
- Some blame it on business houses for profit motive. When healthcare becomes an industry, the healing touch can start to wear a price tag.
- Some blame it on doctors for greed for money. A few bad actors stain the white coat with mistrust, while thousands of ethical doctors struggle within the same broken system.
- Some blame it on pharma companies for sales targets. Life-saving medicines are often wrapped in layers of pricing that a common man cannot unwrap.

In this whirlpool of blame, a common man suffers.

Delayed Spend:

Perceived financial catastrophe in the case of middle-class families and the factual financial distress in the case of a family already in the poverty can lead to delayed care-seeking and disease progression. Financial challenges often compel households to postpone medical consultation until symptoms become severe. This delay is frequently misinterpreted as negligence; in reality, it is a rational survival strategy under economic stress.

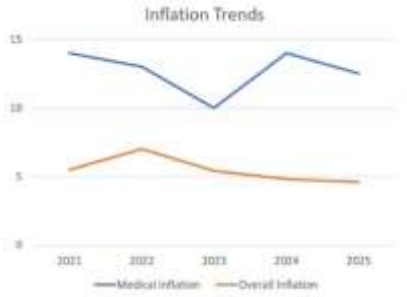
The consequences of delayed care include:

- Escalation of treatable conditions into medical emergencies
- Longer hospital stays and higher treatment intensity
- Increased morbidity and mortality
- Thus, financial stress does not merely correlate with poor health outcomes, it actively amplifies the clinical severity of illness by delaying access to timely care.

While poor silently suffer, middle class loudly suffers. They rush to private care at a cost. Middle class families are not rushing to private hospitals for the want of luxury and comfort. They want best care. They want modern ICUs, compassionate nurses, quicker diagnosis, advanced therapies. They want to save their loved ones without feeling the weight of guilt. They want dignity while they heal.

Everything Rises:

Medical inflation gallops ahead like an untamed horse. In the past decade, the cost of treatments has grown at nearly double the rate of salaries. A cardiac procedure can swallow multiple years' worth of savings in a single gulp. Cancer treatment can reduce a lifetime of financial discipline into debt within months. Even routine visits have turned into miniature financial events.



Country	Medical Inflation %
India	13%
USA	8-9%
Canada	7.40%
UAE	11.5-12%
Singapore	12%
Global Average	10%

While we cheer up lower single digits in inflation, estimates from industry and cost indices indicate that medical inflation in India has been running at ~12-15% annually, substantially above general consumer price inflation. While official CPI health sub-index figures (around 3.6-3.8% in late 2025) capture price changes for a fixed healthcare goods/services basket, broader medical inflation—reflecting hospitalisation, advanced diagnostics, medicines, and treatment charges—remains high, intensifying financial risk for households (Aon, n.d.; Mercer Marsh Benefits, n.d.; Deloitte, n.d.; Insurance Regulatory and Development Authority of India, n.d.)

It is equally concerning that the medical inflation in India is far higher than in many countries

The truth is, India stands at a crossroads. We have the talent, the technology, and the potential to build a healthcare system that heals without hurting financially. What we lack is a unified will. Policy makers must strengthen public healthcare. Private institutions must innovate responsibly. Insurers must design coverage that understands real-world medical realities. Pharma and device industries must remember that ethics is the most powerful molecule for trust.

Every stakeholder must understand that the common man is not a revenue line. He is the heart of the healthcare system.

One hospital bill should not rewrite someone's destiny. Healthcare must not feel like a gamble where illness decides winners and bankrupt losers. The ultimate measure of progress in a nation is not in the number of super-speciality towers it builds but in how many families walk out of a hospital with hope and without debt.

India's healthcare future is a story still being written. It deserves a happier ending. And that starts with making sure that no family falls into poverty simply because they tried to save a life.

What would make a real difference?

If we accept the theme "one bill can push a family into poverty", then solutions must reduce both the size of the bill and the household's exposure to it.

1. Stronger, accessible public capacity: When public hospitals deliver timely, high-quality care, families don't have to choose between health and bankruptcy.

2. Transparent pricing and standardised billing: Hospitals should publish package rates, common procedure estimates, and clear rules for add-ons. Surprise billing is not just inconvenient; it is financially destructive.
3. Insurance that actually covers what families pay: The biggest frustration is "covered on paper, unpaid in reality." Policies need fewer hidden exclusions, clearer disclosure, and stronger grievance redressal.
4. Outpatient and medicine support for chronic disease: Because long-term medicine spending is often what silently impoverishes families, coverage must extend beyond hospitalisation.
5. Patient financial counselling as a standard service: Hospitals routinely provide clinical counselling; financial counselling should be just as routine like explaining options, likely cost ranges, and cheaper pathways without shame.
6. Digital Outreach: When a cinema experience or a household product can reach even remote villages through a click of button, why not the healthcare? Why patients from towns will have to undergo painful travel to cities seeking the best healthcare incurring heavy non-medical costs? Can there be a digital solution for it?

A healthcare system's effectiveness cannot be judged solely by clinical outcomes; its capacity to protect households from financial ruin is equally fundamental. In India, a single hospital bill can still undo years of economic progress for middle-class families. Addressing this challenge requires systemic reforms that integrate health financing with broader social and economic policy goals.

References:

[1] NITI Aayog. (2023). India's middle class growth projections.
[2] National Sample Survey Office. (2018). Health in India (NSS 75th Round, 2017–18).
[3] Public Health Foundation of India. Health expenditure / private hospital cost studies.
[4] Institute for Health Metrics and Evaluation. India health estimates.
[5] Amartya Sen, (1999). Development as freedom. Oxford University Press.
[6] World Health Organization. Health, poverty and economic development.
[7] World Bank. Poverty traps and health shocks.
[8] Ministry of Health & Family Welfare, Government of India. (2022). National health accounts estimates for India 2021–22.
[9] National Sample Survey Office. (2018). Health in India (NSS 75th Round, 2017–18).
[10] Central Bureau of Health Intelligence. National health profile.
[11] World Health Organization. India health financing profile.
[12] World Health Organization. Universal health coverage reports.
[13] The Lancet Global Health. Studies on delayed care.
[14] World Bank. Health-seeking behaviour studies.