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A CRITICAL STUDY OF COMPENSATION POLICIES AND MEDICAL TREATMENT RIGHTS FOR ROAD ACCIDENT VICTIMS IN INDIA

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KEYWORDS

Motor Vehicles Act, 1988; road accident victims; just compensation; emergency medical treatment; Causes of road accident in India.

ABSTRACT

In India, the intersection of compensation law and emergent care governance is synergistically critical to the victim of an accident in a road traffic incident. This research attempts to analyze the extent and meticulousness of the participant-rights-based solution of the Indian legal system with respect to the absence of medical treatment and monetary compensation post road traffic incidents. The study adopts a policy-oriented and a doctrinal research approach grounded on Article 21 of the Constitution of India, the Motor Vehicles Act of 1988, recent landmark judgements of the Supreme Court, and contemporary official statistics on road traffic incidents, treatment, and the pending status of claims. This study concludes that the legal system in India has positively and proactively been transformed beyond the age-old framework of a fault-liability system. The Judicial system, as a doctrine, supports the provision of medical treatment and a system of compensation that is both rational and just and that which considers the catastrophic nature of injury, the future of the victim, the provision for prosthetic devices, and the personal health care insurance benefits which will not be deducted. The study, however, maintains that the system, as a model, is still constructively fragmented, and lacks cashless medical treatment, remedies by a tribunal that are significantly compromised by a huge backlog of claims, and compensation that still does not include the costs of rehabilitation in a sufficient or substantial manner. Overall, Indian law has established a significant majority of the normative constructs justifying post-accident compensation. However, the full realization of these benefits, especially emergency medical compensation, rehabilitation, and a seamless system of compensation, depend on better coordination and a more rational compensation system.

1. Introduction

Road traffic injuries in India are not only an issue of transportation management. This is a problem of public health. This can result in anything from sudden death or permanent impairments to long-term poverty for households caused by severe, unexpected expenses. The World Health Organization estimates the annual number of global

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road traffic deaths to be about 1.19 million. India continues to account for a disproportionate number of these deaths (World Health Organization [WHO], 2023; World Bank, 2022). The 2023 statistics published by the Ministry of Road Transport and Highways indicate that 462,825 people were injured in road traffic accidents in India, and 172,890 died; these numbers demand an urgent need for protective legal mechanisms for accident victims (Ministry of Road Transport and Highways [MoRTH], 2025).

It has been a slow and uneven evolution for compensation to be provided for road accident victims. The 1988 Motor Vehicles Act provided for victims to access the courts (Adjudication before the Motor Accident Claims Tribunal). Since then, the courts and the legislature have moved progressively toward a mixed welfare model. This model combines the provision of fault liability, no-fault and statutory funds, and emergency services. This is provided by the Motor Vehicles Act, 1988, sections 161, 162, 164, and 164B. While this is the case, the existence of these laws does not ensure timely treatment or even adequate compensation. This is mainly due to the delay in claims, the inadequate coordination of hospitals, and the underassessment of permanent disabilities (Rajya Sabha, 2026).

This article contends that while Indian law recognizes compensation for road accident victims and the provision of emergency medical treatment as interlinked rights, the system in practice is only marginally rights based. Doctrinally, the Supreme Court has strengthened both the just compensation and treatment-first obligations. Administratively, the system continues to suffer from pendency, arbitrary and inconsistent determinations of the value of serious injuries, and poor integration of hospitals, police authorities, and insurance companies. The discussion is doctrinal and policy-oriented in nature. It examines the constitutional and statutory framework, the recent Supreme Court rulings, and the current official data to evaluate whether India has moved from fragmented victim relief to a more unified model of accident justice.

2. Constitutional and Statutory Foundations

The road accident regime in India is based on a complex legal, regulatory, and policy framework that incorporates constitutional provisions, welfare laws, insurance laws, and judicial pronouncements. The main concern is whether these layers cumulatively form an integrated framework for the protection of victims from the accident location to the final legal adjudication.

2.1 Article 21 and the Right to Emergency Medical Treatment

Article 21 is the cornerstone for the right to treatment, especially for the right to access certain forms of medical treatment, particularly those that are time-sensitive and can prevent loss of life. The Supreme Court of India, in *Pt. Parmanand Katara v. Union of India* (1989), opined that saving a life is of utmost importance, and that all physicians, regardless of whether they are employed by a government or a private health care provider, have an obligation to provide treatment to victims of injury. This case was the first instance when the Supreme Court of India decided that the right to access emergency treatment is a right that is constitutionally guaranteed, and therefore is not up

to the discretion of a health care provider.

The case *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) provided further support for this line of reasoning. The Court in this case ruled that if a government hospital fails to provide treatment in time, it is said to have violated the right guaranteed under Article 21. This case not only recognized the right to treatment, but also was the first to acknowledge the obligation of the State to maintain an adequate level of health care services and make available the requisite referral systems. Pinto (2017) notes that in the case of India, the right to emergency treatment goes beyond the traditional non-interference. It means that the right to emergency treatment is only realizable if higher levels of institutional and administrative responsiveness are achieved.

2.2 The Motor Vehicles Act, 1988 After the Welfare Turn

The Motor Vehicles Act, 1988 is no longer a compensation code based on fault. After the 2019 amendments, it operates as a hybrid model, consolidating fault determination by the Motor Accident Claims Tribunal, fixed no-fault compensation, hit-and-run provisions, the Motor Vehicle Accident Fund, and a mandatory provision for golden hour treatment (Motor Vehicles Act, 1988, sections 161, 162, 164, and 164B). This architecture is significant, as it acknowledges that victims of accidents require treatment and need interim financial relief before any determination of fault is conclusively arrived at.

Sections 161 and 164 of the Act exemplify this shift. Section 161, for instance, provides a specific regime for hit-and-run fatalities, while Section 164 offers no-fault death and grievous injury compensation. This design reflects a welfare rationale closer to social insurance and a departure from private law. At the early stage, the design is aimed at alleviating the burden of proof. According to Cane and Goudkamp (2018), the greater the flexibility of an accident compensation system to respond to need as well as blame, the greater the legitimacy of the system. In this respect, the Indian statute is increasingly moving in that direction, albeit mainly through tribunal-based fault claims for full compensation.

2.3 Cashless Treatment, the Motor Vehicle Accident Fund, and Administrative Design

The treatment aspect of this system has recently gained clarity. In *S. Rajaseekaran v. Union of India* (2025), the Supreme Court provided a direct ruling for section 162, instructing the State to implement a scheme for operationalising the cashless treatment during the golden hour. Following this, the Central Government created the Cashless Treatment for Road Accident Victims Scheme, 2025, along with the implementation of the detailed guidelines (Press Information Bureau, 2026a). This scheme allows cashless treatment for up to Rs. 150,000 per victim per accident for a duration of 7 days, and this is funded by the Motor Vehicle Accident Fund (Cashless Treatment for Road Accident Victims Scheme, 2025).

This also shows the improvement in institutional coordination. Parliamentary documents show that hospitals that are involved in the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana are considered designated hospitals, and processing is done through the electronic Detailed Accident Report and

Transaction Management System 2.0. Reimbursements will happen after the ten-day approval period (Lok Sabha, 2026). According to Misra et al. (2023), in India, emergency care is subpar due to fragmentation rather than the absence of a legal rule. Although this scheme is a good start, its implementation is what will determine whether it is successful in bridging the administrative gap between the hospitals, police, insurance and the State.

3. Compensation as a Welfare Jurisdiction

In India, compensation for victims of road accidents entails much more than the informal litigation of the claimant and the insurer. Currently, road accident compensation has become a welfare jurisdiction in which adjudication and statutory presumptions, as well as the judicial standardization of social risks while maintaining the tenets of proof and causation, are adopted.

3.1 From Fault Liability to a Mixed Compensation Model

The statutory system, through structured relief and the simplification of access to claims, has eased the rigidity of this system. While the tort law of negligence and vicarious liability remains the basis of most claims, Ratanlal and Dhirajlal (2023) argue that modern compensation law departs from the common law framework in societies where the social cost of accidents is high and the insurance infrastructure is developed. In India, this shift is obvious in the presence of tribunal adjudication, compulsory third-party insurance, the Motor Vehicle Accident Fund, and fixed statutory compensation, along with public financing of treatment.

The normative value of a mixed model is claiming that it distributes accident loss more relatively compared to a purely fault-based model. However, it also induces doctrinal imbalance. Fast and fixed-sum relief may be inadequate, while resorting to complete adjudication may be accurate, but is practically delayed. According to Jai (2010), the motor accident case in India has experienced a long history of delays due to problems of documentary proof, valuation, and execution. Although the promise may be welfare driven, it may fail to deliver even if the doctrinal entitlements are generous on the face of it.

3.2 Just Compensation and Judicial Standardisation

The phrase “just compensation” has become the doctrinal nucleus of motor accident law. In *Sarla Verma v. Delhi Transport Corporation* (2009), the Supreme Court of India rationalised the use of the multiplier method to reduce inconsistency pertaining to assessment of compensation in fatal accident claims. In *National Insurance Company Limited v. Pranay Sethi* (2017), the Court further established consistency in the assessment of future prospects and the traditional heads of damages. These emerging trends are bringing motor vehicle accident compensation from the domain of ad hoc notions to the logic of comparability, which, in turn, positively impacts the fairness and predictability of compensation awarded by the tribunals.

Standardisation is clearly still a work-in-progress and not a finalised project. In *Hanumantharaju B v. M. Akram Pasha* (2025), the Court put functional disability and future prospects back on the valuation map. Likewise, in *V. Pathmavathi v. Bharthi Axa*

General Insurance Company Limited (2026), the Court termed future prospects as essentials for just compensation. Through these rulings, the law is not only concerned with strict mathematic valuation but also with compensation that preserves the future economic and career potential which has been lost due to the accident.

4. Catastrophic Injury, Future Care, and Medical Expense Recovery

Severe injuries present situational injuries and demonstrate the non-ethical limits of a death-focused compensation scheme. Financial compensation falls far short of the cost of the long-term care, nursing, therapy, aids, and assistive technology, and loss of independence that are not fully captured by the cost of short-term medical care. In *Kajal v. Jagdish Chand* (2020), the Court, in a case involving a child with an extremely debilitating injury, took a long-term view by focusing on future care, lifelong dependency, and loss of independence. Herring (2020) argues that medical law is slowly moving toward compensation for dignity and ongoing need, and away from just purely direct monetary loss.

Two recent decisions also crystallize this approach. In *Prahlad Sahai v. Haryana Roadways* (2026), the Court acknowledged that the costs of replacement cycles for prosthetic limbs, in addition to the prosthesis itself, would also need to be compensated. In the second case, *New India Assurance Company Limited v. Dolly Satish Gandhi* (2026), the Court ruled that amounts received in settlement of medical expenses under a personal Mediclaim Policy would not be offset under the accident compensation award for medical expenses. These judgments have a significant impact since claimants suffering from serious injuries will no longer be penalized for living with life-long requirements, or for having to pay for their own healthcare protection.

The economic theory is in support of this shift in approach. Kumar et al. (2012) state that in urban India the cost of injuries from road traffic accidents results in large out-of-pocket expenses, as well as the financial collapse of many households. Thomas et al. (2024) show that accidents and injuries continue to represent a serious economic burden in India, when the need for treatment and the loss of income is prolonged. Therefore, the doctrine of compensation cannot be fully articulated by the formulas of tribunals; it must be also balanced with the costs of ongoing care and treatment of injured persons, as well as the burden on the household.

5. Medical Treatment Rights in Practice

Medical treatment rights only become operative when treatment is provided prior to monetary compensation. The primary concern is more practical than it is doctrinal. The law must accommodate rapid stabilisation and admission without any monetary negotiation. Moreover, institutional responsibility fragmentation must be addressed to avoid pathway failures in emergency situations.

6. The Judicial Construction of a Treatment-First Principle

Indian case law advocates for the treatment-first approach. The combined effect of *Pt. Parmanand Katara v. Union of India* (1989) and *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996) establishes that emergency treatment

is a constitutional requirement and, therefore, is not a voluntary act of humanitarianism. This assertion holds particular significance in cases of road accidents. The time lapse between sustaining injury and the first contact with a hospital is often the deciding factor in whether the injured individual survives, and whether he or she sustains a long-term disability. Chandrasekharan et al. (2016) cite pre-hospital delays in the context of urban India, and this underscores the case law necessity to increase the legal system's response to rapid admission and referral.

The treatment-first principle also provides a new outlook for compensation law. If the state has a duty to provide treatment, then compensation cannot be determined by the assumption that access to treatment was a private market decision. According to Laing and McHale (2025), medical law is viewing emergency medical care more and more as a legal obligation that includes triage, transfer, and continued medical care. Some trace elements of that thinking can be found in Indian accident legislation, but their thinking is that the connection between emergency treatment, rehabilitation, and the ultimate award of compensation is almost completely absent in the legislation and the practice of the tribunals.

7. Cashless Treatment and the Problem of Implementation

The greatest impediment in the early stages of emergency treatment is the inability or unwillingness to pay for the treatment. The Cashless Treatment for Road Accident Victims Scheme, 2025, represents an institutional response that provides a victim with the right to free treatment, up to Rs. 150,000, for no more than seven days following an accident (Cashless Treatment for Road Accident Victims Scheme, 2025). The goal of Figure 1 is to depict the nature and magnitude of the injury caused by accidents in order to justify an emergency intervention.

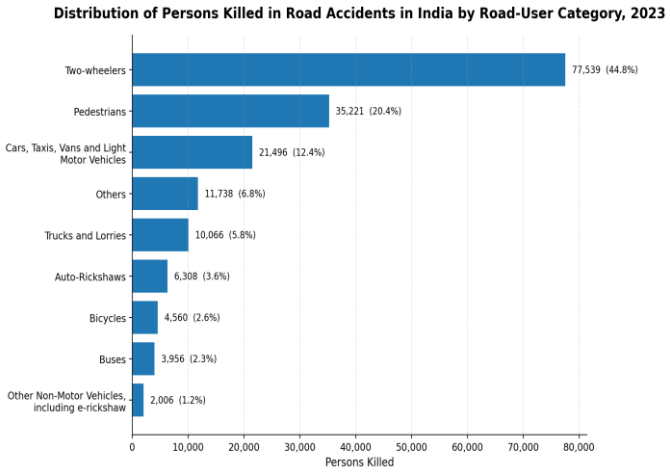

Figure 1. Distribution of persons killed in road accidents in India by road-user category, 2023.

Source: Ministry of Road Transport and Highways (2025).

The issue is not the design of the initiative, but the depth of implementation. Official documentation illustrates a complex design involving designated hospitals, online claim applications, and payments from the Motor Vehicle Accident Fund. Still, the legal connotation of notice rests on the operational integrity of the districts (Lok Sabha, 2026). Misra et al. (2023) describe Indian emergency services as still suffering from shortages, a lack of referrals, and poor inter-institutional compatibility. While a design based on the golden hour is certainly a step in the right direction, the initiative will ultimately gain its legitimacy from the practice at the hospital bedside, rather than the design at the administrative desk.

8. Good Samaritan Protection and Institutional Coordination

The treatment-rights design also depends on the belief of bystanders and the public. If bystanders fear harassment from the police, delays in medico-legal procedures, or refusals from hospitals, crash victims may lose precious time. The recently launched Rah-Veer scheme, which offers a cash prize of Rs 25,000 for saving the life of a victim of a road traffic accident, is aimed at strengthening this first response system (Press Information Bureau, 2026b). While awards of this nature are quite useful, they are no substitutes for clear-cut legal obligations of hospitals, and protected grievance pathways.

Scholarship on comparative health systems states that trauma outcomes can be better when emergency systems, funding, and transport systems are better integrated. Razzak et al. (2022) show that building trauma care capacity in low- and middle-income countries can reduce trauma care deaths. The Indian system is designed in this way, but its segmentation is a problem: the road safety system, hospitals, police, and insurers are linked more through paperwork than through real-time clinical coordination. This is precisely where the convergence of systems design and rights discourse is critically warranted.

9. Empirical and Doctrinal Stress Points

The most challenging component of any accident law regime is ensuring the protection of the most vulnerable. Data from India currently show three simultaneous trauma challenges: road trauma levels, vulnerable road user deaths, and compensation delays.

10. Scale of Harm and Vulnerable Road Users

The burden remains extreme. The Ministry of Road Transport and Highways reported a total of 480,583 accidents, with 172,890 resulting injuries and deaths. The year 2023 showed a continuation of the post Covid-19 growth trend in the total number of accidents (MoRTH, 2025). Figure 2 attempts to highlight a further significant trend, that the concentration of fatal outcomes is high for two-wheeler riders and pedestrians, and that fatal outcomes are not uniformly distributed among road users. Similar observations of the concentration of road injury risk in India due to exposure, vulnerability in road infrastructure, and inadequate protection for non-motorized road users can be found in Dandona et al. (2006) and Hsiao et al. (2013).

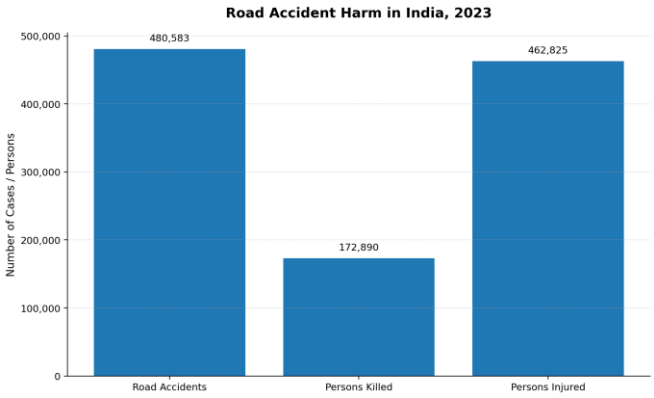

Figure 2. Road accidents, deaths, and injuries in India, 2023.

Source: Ministry of Road Transport and Highways (2025).

There are legal repercussions from this distribution. Losses from victims in informal employment, unpaid caregivers, older dependants, and those who lose the capacity to function fully but not at all, are likely to be underestimated from a compensation framework that uses standardized losses from income. Dindi et al. (2019) argues that in the Indian context, road safety policies are more likely to view

accidents from an engineering or enforcement perspective, while the negative impacts of road accidents are mostly borne by the socially vulnerable. A compensation framework must, therefore, be constructed in such a way that it takes both legal frameworks, and the visibility of losses, into account.

11. Claims Delay, Settlement Backlog, and the Cost of Waiting

Delays in processing of claims are no longer anecdotal but have been documented by an official, annual, national-level report. In a 2026 parliamentary session, claims against third-party motor insurance for the financial year 2024-25 stood at 1,073,020, with a recorded outstanding amount of Rs. 96,257.12 crore. Similar figures for the previous two financial years were reported. Delays are attributed to late reports of accidents, First Information Reports that are incomplete, delays in the preparation of final reports, delayed medical reports, and prolonged treatment of victims. Figure 3 aims to show these trends as a claims and stress visualization tool.

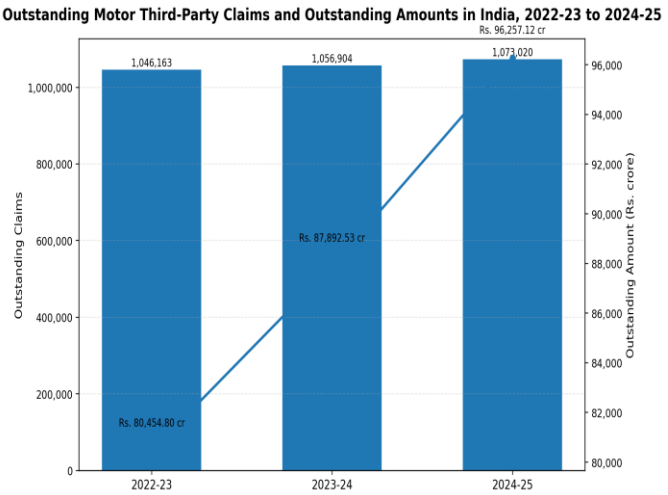

Figure 3. Outstanding motor third-party claims and outstanding amounts in India, 2022-23 to 2024-25.

Source: Rajya Sabha (2026).

Delay constitutes a more substantive loss than mere inconvenience. Many claimants are dealing with additional disability, funeral expenses, debt, and loss of income, thus procedural delays impact both the real cost of compensation and increase the pressure to accept a settlement before the case is resolved. Cane and Goudkamp (2018), restating Atiyah, point out that the worth of a compensation scheme must include its speed and administrative ease. In India, the persistence of large disgruntling claims is indicative of the gap between welfare goals and the actual capabilities of existing institutions.

12. The Rehabilitation Gap

The largest structural gap in the current system lies between emergency response and long-term rehabilitation. Even if the first response is adequate, many victims still have to cope with disrupted rehabilitation services in the form of fragmented, insufficient services for physiotherapy, replacement of assistive devices, inaccessible social infrastructure, and uncertain and inadequate finance for future needs of care. Although the law has become more sensitive to catastrophic injuries, the extent of social change has been limited. Both *T. Rajamoni v. The Manager, Oriental Insurance Company Limited* (2025) and *Prahlad Sahai v. Haryana Roadways* (2026) have stipulated that the determination of the value of serious injuries should account not only loss of earnings but also the unending need for replacement of prosthetic devices.

Criminal justice reforms based on a stronger rights-based approach would view treatment, rehabilitation, and even compensation, as part of the

same process rather than as disconnected administrative tasks. The World Bank (2022) says that economically weaker families disproportionately suffer the most because of the fatal consequences of road crashes. Thomas et al. (2024) show that injury costs can disrupt family income and increase household vulnerability. Additionally, undercompensating victims of road crashes who survive is a social exclusion problem and a private wrong. Indian law has made advances to this understanding, yet it is not completely embraced and formalized.

13. Conclusion

Indian law on road accidents has made noteworthy advances in the understanding that the legal needs of road accident victims begin the moment the crash occurs, carry through the emergency phase of injury stabilization, and end when the victim receives a monetary award commensurate with the evidence of long-term victimization.

This change is evident in how Article 21 interacts with the statutory changes in Sections 161, 162, 164, and 164B of the 1988 Motor Vehicles Act, and the recent Supreme Court rulings concerning future prospects, disability, prosthesis, and non-deduction of Personal Mediclaim coverage. The right to emergency assistance is more robust in theory than in practice at the district level, and just compensation is eroded by a backlog of cases, delays in documentation, and the constant undervaluation of rehabilitation expenses. A truly victim-oriented approach would integrate treatment and compensation as linked facets of accident justice, instead of considering them as separate bureaucratic elements.

14. Suggestions

The issues discussed above call for reforms that are doctrinally modest but institutionally consequential:

1. Mandate district-level treatment audits: Each district ought to disclose quarterly statistics on admissions, refusals, referral wait times, and reimbursement pertaining to the cashless treatment framework. Disclosure of this information would allow for section 162 to be a live right as opposed to a potentially notified scheme.
2. Integrate hospital and claims data: The Detailed Electronic Accident Reports should be integrated with hospital discharge summaries and disability certificates, and police depositories by means of a unified accident identifier. This would minimize the duplication of documents and eliminate delays during tribunal processes.
3. Revise fixed statutory sums periodically: Compensation for no-fault and hit-and-run incidents should not rely on sporadic attention from legislators. Instead, a planned, scheduled, inflation-based assessment should be established. Due to the high cost of treatment, fixed legislative relief quickly loses its practical value, making regular updates a necessity.
4. Create rehabilitation-specific award guidelines: It would be beneficial for the tribunals to have better structured guidance to inform them of the costs concerning prosthetic replacement, assisted care, cognitive injury, and long-term physiotherapy. This would assist in

administering better compensation for catastrophic injury cases and promote better consistency across tribunals.

5. Strengthen emergency referral accountability: In situations where a hospital is unable to take on road accident victims, health authorities should create required protocols to facilitate escalation to other hospitals. The right to treatment becomes meaningless if there is ambiguity about who is responsible for the at times critical, and life-saving, task of transferring the patient.
6. Time-limit insurer response stages: There should be legally binding deadlines imposed on insurers by the relevant authorities to determine liability and process awards or approved settlements. Systematic disincentives which include substantial graded interest for delays should be implemented. This may include a substantial minimum interest per day which would force a change in the culture of the industry.
7. Expand legal recognition of informal loss: The compensation framework should address the loss of functional units and the informal economic system due to the unpaid care work and domestic responsibilities. These losses are real and economically significant, even if they are neglected in traditional income-based assessments.
8. Protect Good Samaritan participation: The good samaritan model should be complemented with active measures at the operational enforcement level against police and hospital behavior that works to actively discourage bystanders from helping injured persons. It is both rewarding and a constructive deterrent against harassment that builds public confidence.
9. Develop specialised disability assessment panels: Medical boards constituted for serious accident cases need not be restricted to impairment percentage, but should focus on rehabilitation. It is crucial to account for functional disability when assessing the continuing hardship of loss of earnings and future earnings potential.
10. Promote pre-trial settlement with safeguards: Voluntary settlement is informed and not motivated by financial need. It is necessary for quick relief. It is proposed to improve Lok Adalat and pre-trial settlement, only extending them to cases where claimants can obtain access to the complete set of documents and a realistic assessment of the loss.

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