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RIGHT TO HEALTH IN INDIA

~By Paiyyavula Ramya

ABSTARCT:

This paper examines the evolution, legal framework, and practical challenges of the Right to Health in India. While the framers of the Indian Constitution initially placed health under the non-justiciable Directive Principles of State Policy (Article 47), the judiciary later used structural interpretation to link it directly to the Right to Life under Article 21. Through landmark cases like Parmanand Katara and Paschim Banga Khet Mazdoor Samity, the Supreme Court established that the state cannot cite financial limitations to deny emergency medical care, and that living with dignity inherently requires access to healthcare and a clean environment.

Despite these strong judicial rulings, a major gap persists between legal principles and real-world implementation. This paper analyses how low public spending (stuck below 2% of GDP), severe medical staff shortages, and weak rural infrastructure have created a fractured system where quality healthcare is accessible primarily to the wealthy. While initiatives like Ayushman Bharat (PM-JAY) offer financial protection for inpatient surgeries, they fail to cover daily outpatient expenses, which continue to push millions into poverty annually. The study concludes that fulfilling the Right to Health requires moving past progressive policies toward passing an enforceable Right to Health Act, raising public health spending to at least 3% of GDP, and ensuring strict executive accountability.

INTRODUCTION

Living with dignity loses its meaning when a person's body is deteriorating without access to medical assistance. Health is the most fundamental condition for any human action. It is the basic requirement upon which all other rights, such as free expression and movement, are built.

In the context of India, the situation presents a paradox. The framers of the Constitution did not explicitly include health in Part III as a Fundamental Right.[1] Instead, it was placed under the Directive Principles of State Policy,[2] which state that improving nutrition and public health is one of the primary duties of the State. However, the Indian judiciary did not allow these directives to remain merely on paper. Through years of judicial activism, the courts brought the issue of health under Article 21[3] of the Constitution, recognising it as a core part of the Right to Life. According to the Supreme Court, life without health and dignity is reduced to mere animal existence.

Despite these strong legal protections, a massive gap exists between these judicial pronouncements and the daily lives of ordinary citizens. While the courts have expanded rights to include everything from a clean environment to emergency services, the actual delivery of these services is crippled by chronic underfunding.

This failure has created a system of dual constitutionalism, where the wealthy can pay for their survival in private hospitals, while the poor are pushed deeper into poverty due to mounting medical expenses. This constitutional journey of the Right to Health, was expanded by the Supreme court in *State of Punjab v. Ram Lubhaya Bagga* or *Paschim Banga Khet Mazdoor Samity*[4] case. This paper examines the factors hindering its proper implementation. Furthermore, the paper analyses whether modern initiatives, such as Ayushman Bharat,[5] can effectively bridge this gap.

LEGAL FRAMEWORK & JUDICIAL EVOLUTION:

THE CONSTITUTIONAL EVOLUTION OF THE RIGHT TO HEALTH

The evolution of the Right to Health in India is a journey of moving from an ambiguous social objective to an imperative constitutional provision. While drafting the document, the framers refrained from incorporating health into the Fundamental Rights provided under Part III of the Constitution. Instead, the framers kept this right within the ambit of the Directive Principles of State Policy (DPSP) under Part IV, particularly Article 47.[6] This article describes the

[1] INDIA CONST. pt. III (arts. 12–35).
[2] INDIA CONST. pt. IV (arts. 36–51).
[3] INDIA CONST. art. 21.
[4] 1 S.C.R. 1120 [1998].
[5] NATIONAL HEALTH AUTHORITY, MINISTRY OF HEALTH & FAMILY WELFARE, GOV'T OF INDIA, AYUSHMAN BHARAT PRADHAN MANTRI JAN AROGYA YOJANA: OPERATIONAL GUIDELINES ON EMPANELMENT OF HOSPITALS 12 (2018).
[6] INDIA CONST. art. 47.

improvement of public health as one of the primary duties of the State. However, because this provision was part of the DPSP, it was non-justiciable in nature. Consequently, citizens had no immediate legal remedy against the State's failure to provide proper healthcare services.

The true transformation came with the advent of an ambitious Indian experiment of judicial activism. Through this movement, the Supreme Court declared that the promises contained in the Constitution should not remain merely symbolic. In the landmark case of *Bandhua Mukti Morcha v. Union of India*,[7] the Court declared that the government cannot use the unenforceable character of Directive Principles as an excuse to shirk its baseline duties. The judiciary created a direct link between Part IV and Part III, ruling that without the right to live with human dignity, the Right to Life mentioned in Article 21 loses all meaning. This landmark clarification established that the term life does not signify bare animal existence, but that sound health forms the very foundation of all human activity. The same was also the outcome of *Paschim Banga Khet Mazdoor Samity* case.

This doctrine found immediate application in the area of emergency medical treatment. For many years, an unfortunate system of legal formalities existed, wherein doctors routinely refused to provide treatment to accident victims until an official police report was filed. This practice was dismantled by the Supreme Court in the case of *Parmanand Katara v. Union of India*.[8] The Court made it clear that the State's responsibility to protect life takes precedence over any procedural difficulties. It was explicitly clarified that all doctors, whether in government or private hospitals, bear a solemn professional responsibility to render immediate emergency medical aid. 1989 (4) SCC 286

This duty was further reinforced in the case of *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*.[9] In this instance, an injured farmer was denied admission by seven state-run hospitals on the grounds that no beds were available. The Supreme Court found that the denial of timely emergency services constituted a direct infringement of the Right to Life under Article 21. Most importantly, the ruling reiterated that the State cannot claim a lack of finances or resources as a valid reason for being unable to perform this life-saving duty.

In addition to hospital care, the courts realized that individual health is impossible without a safe environment. Through the case of *Subhash Kumar v. State of Bihar*[10] and various

[7] AIR 1984 SC 802.
[8] 1989 (4) SCC 286.
[9] 1 S.C.R. 1120 [1998].
[10] 1991 SCR (1) 5.

litigations filed by M.C. Mehta, the Supreme Court interpreted the concept of health to include access to clean air and water. This expansion was based on the understanding that industrial pollution acts as a direct barrier to the social justice aspect of the rule of law. These judgments highlighted the environmental dimension of health, emphasizing that disease prevention begins with sanitary conditions. By holding municipalities and industries legally accountable for wastewater and emissions, the judiciary effectively integrated healthcare with environmental law.

However, despite this impressive judicial interpretation, a widening gap persists between the orders issued by the Supreme Court and the actual living conditions in Indian villages. This reality demonstrates that recognizing a right in a courtroom does not automatically translate to providing it on the ground.

STATUTORY PROTECTIONS AND POLICIES:

STATUTORY REGULATORY FRAMEWORKS AND PUBLIC POLICY INITIATIVES

To convert the Right to Health from a judicially mandated obligation into a tangible reality at the grassroots level, the Indian government must shift its focus from merely promising health to actively regulating it. A key legislative initiative in this direction is the Clinical Establishments (Registration and Regulation) Act, 2010[11]. For decades, the healthcare sector in India, where a substantial 80% of all curative medical services are provided by the private sector—operated with minimal oversight.[12] Through this Act, the government attempted to step in as a strict regulator, establishing benchmarks for physical infrastructure and professional conduct. This regulatory shift directly addresses the quality factor within the internationally recognised healthcare framework of Availability, Accessibility, Acceptability, and Quality (AAAQ), ensuring that patients receive ethical medical care in exchange for financial expenditure.

Simultaneously, a significant shift has occurred in how the state perceives the very definition of health. Health is no longer viewed merely as the physical functioning of the human body, but as a holistic state encompassing mental well-being. Aligning with the World Health Organisation's definition of health as complete physical, mental, and social well-being, the

[11] Clinical Establishments (Registration and Regulation) Act, No. 23 of 2010.
[12] Arun K. Aggarwal, *Strengthening Health Care System in India: Is Privatization the Only Answer?*, 33(2) INDIAN J. CMTY. MED. 69, 69–70 (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2784627/.

Parliament enacted the Mental Healthcare Act, 2017.[13] Here again, the role of the judiciary has been highly significant in declaring that the Right to Health under Article 21 encompasses mental health. Consequently, state programs such as the National Tele-Mental Health Programme[14] operate on the principle that human dignity cannot be achieved without addressing psychological disorders and providing accessible mental healthcare.

Despite these legislative advancements, the financial cost of medical care remains a severe barrier to social justice. Annually, out-of-pocket medical expenses push approximately 60 million people below the poverty line, creating a destructive poverty trap for vulnerable families.[15] To mitigate this systemic crisis, the government introduced the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY), designed as a financial shield for roughly 500 million vulnerable citizens.[16] This scheme provides eligible families with health insurance coverage of up to ₹5 lakh per year for secondary and tertiary hospitalization. Furthermore, the model circumvents the challenges of overburdened public hospital infrastructure by allowing impoverished patients to access empanelled private healthcare facilities free of charge.

However, implementation data indicates that Ayushman Bharat is not a comprehensive solution. While the scheme functions effectively for major surgeries, its impact on daily public health remains somewhat limited because it is primarily designed to cover inpatient hospitalisation. Consequently, it fails to address outpatient department (OPD) care, which includes the ongoing daily medication expenses required for chronic conditions such as hypertension and diabetes. Furthermore, auditing reports have revealed instances of institutional fraud, where certain private hospitals have exploited the insurance system for financial gain at the taxpayers' expense. To narrow the persistent gap between constitutional ideals and the daily realities of citizens, the state must look beyond insurance coverage and establish an integrated, accountable framework that structurally guarantees the Right to Health.

ANALYSIS:

[13] Mental Healthcare Act, No. 10 of 2017.
[14] NATIONAL HEALTH SYSTEMS RESOURCE CENTRE, MINISTRY OF HEALTH & FAMILY WELFARE, GOV'T OF INDIA, OPERATIONAL GUIDELINES: THE NATIONAL TELE MENTAL HEALTH PROGRAMME OF INDIA 4 (2022).
[15] Neymat Chadha & Jenny Susan John, *The Indian Healthcare System and Right to Health*, SOCIAL AND POLITICAL RESEARCH FOUNDATION 1 (2020).
[16] NATIONAL HEALTH AUTHORITY, *supra* note 5.

IMPLEMENTATION GAPS AND SYSTEMIC CHALLENGES IN REALIZING THE RIGHT TO HEALTH

While the courts in India have succeeded in declaring the importance of good health as an essential prerequisite for leading a dignified life, the reality faced by the common citizen remains one of under-resourced medical centres and institutional disappointment. The most apparent cause of this systemic failure is insufficient budgetary allocation. Public healthcare spending in India remains very low, stuck between 1.6% and 1.9% of GDP, which means the government missed its own goal of reaching 2.5% by 2025. This funding has not kept up with our country's economic growth and is far below the 4% to 5% global standard needed for a strong healthcare system.[17] Due to this budgetary inadequacy, public healthcare centres frequently face a dearth of basic necessities, including safe drinking water, functional sanitation facilities, and consistent electricity supplies. Most critically, this financial deficit has resulted in an acute shortage of qualified personnel, leaving thousands of posts for specialist doctors and healthcare workers vacant across the country.

This shortage of resources has institutionalised a highly fractured, dual-tiered healthcare system, wherein an individual's access to medical care depends entirely on geographic location and purchasing power. In rural settings, the structural deficit is severe, public data indicates a shortfall of roughly 31 percent for Primary Health Centres (PHCs) and a 25 percent deficit for sub-centres. However, the statistic that highlights the depth of this infrastructure crisis most clearly is India's average of approximately 0.7 hospital beds per 1,000 people, which represents one of the lowest ratios among the world's major economies. For the nearly 70 percent of the Indian population residing in rural areas, many of whom face barriers of illiteracy and a lack of awareness regarding their fundamental right to medical care, the public health safety net remains largely inaccessible.[18]

In instances where medical care is available, it is frequently delivered at a cost that causes financial ruin. Because public facilities are overstretched and underfunded, over 80 percent of curative medical treatment in India takes place within the private sector, where services are significantly more expensive. For example, complex interventions like cardiovascular surgeries in private institutions can cost up to eight times more than the same procedures in public hospitals. Annually, this financial burden creates a severe poverty trap, forcing an estimated 60

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[17] MINISTRY OF FINANCE, GOV'T OF INDIA, ECONOMIC SURVEY 2023-24, at 254–56; MINISTRY OF HEALTH & FAMILY WELFARE, GOV'T OF INDIA, NATIONAL HEALTH POLICY 2017.

[18] MINISTRY OF HEALTH & FAMILY WELFARE, GOV'T OF INDIA, RURAL HEALTH STATISTICS 2021-22, at 45–48; *WORLD* BANK, *Hospital Beds (per 1,000 People) - India*, https://data.worldbank.org/indicator/SH.MED.BEDS.ZS.

million Indians into poverty solely to meet emergency medical expenses. Although policy initiatives such as Ayushman Bharat are aimed at serving as a protective mechanism against these shocks, their scope is structurally limited to inpatient hospital admissions. Consequently, the scheme fails to insulate families from the high cumulative costs of outpatient department (OPD) care and daily medication required for chronic illnesses.

Furthermore, a fundamental policy dilemma persists regarding the commercialization of the healthcare industry versus the constitutional obligation to ensure public well-being. Although the judicial expansion of Article 21 dictates that the Right to Life inherently encompasses the right to clean air and water, environmental degradation remains a severe public health hazard. Ambient air pollution contributes to approximately 11 percent of premature deaths among individuals under the age of 70.[19] When the judiciary has ordered the regulation or closure of polluting industries to protect public health, state enforcement mechanisms have frequently prioritised industrial and economic development over environmental compliance.

Perhaps the most significant barrier to universal care is embedded within the state's own policy framework. The National Health Policy openly declined to declare the Right to Health as a justiciable, legally binding right. The state's policy position maintains that extensive physical infrastructure must be constructed before an enforceable health right can be universally guaranteed to all citizens. By treating health as a progressive target to be realised only in the future, the statutory framework leaves millions of citizens currently living below the poverty line without immediate legal recourse, reinforcing the deep divide between constitutional ideals and real-world implementation.

SUGGESTIONS AND CONCLUSION:

The history of the Right to Health in India reflects high aspirations contrasted against a stark institutional reality. While the judicial community has brilliantly interpreted the notion of the Right to Life under Article 21, declaring that such a right is undermined when individuals suffer from illness without access to medical services, the system remains constrained by symbolic constitutionalism. Under this dynamic, rights exist primarily on paper until a vulnerable family finds itself in dire need of emergency hospital care. The COVID-19 crisis clearly demonstrated that while all individuals are theoretically treated equally by the law, real-world survival

[19] HEALTH EFFECTS INSTITUTE & WORLD HEALTH ORGANIZATION, *State of Global Air: Global Burden of Disease Study*, https://www.stateofglobalair.org/.

frequently depends on personal financial resources. Today, the healthcare landscape is characterised by deep inequalities, highlighted by a structural deficit of over 30 percent in rural health institutions and a high volume of vacant positions for medical professionals.[20]

To reform this fractured system, state action must move beyond the rhetoric of health rights toward the strict enforcement of public health laws. First, the legislature should introduce and pass a comprehensive "Right to Health Act", making health an explicitly justiciable right. It is problematic to perpetually delay the fulfilment of fundamental health rights under the premise that infrastructure must be fully mature before these rights can be legally exercised, as suggested in the National Health Policy 2017.[21]

Second, the State must increase public expenditure on healthcare to a minimum of 3 percent of the national GDP. This targeted investment would expand critical bed capacity and structurally reduce out-of-pocket expenses, mitigating the financial shocks that push approximately 60 million citizens into poverty each year. Finally, a well-empowered National Medical Commission, paired with stronger statutory regulations for private clinics, is required to ensure medical quality and ethical practices for the entire public, rather than just a privileged minority.

Ultimately, good health forms the very essence of a dignified life, without which no citizen can effectively work, learn, or participate in the democratic process. While the judicial branch has served as the primary catalyst for the expansion of constitutional rights, the courts lack the executive power to construct clinics or deploy nursing staff. The efficacy of Article 21 ultimately depends on whether the executive and legislative branches fulfil their primary responsibilities to turn these legal protections into a reality. Continuous public accountability and structural reform remain the only viable solutions to ensure that the Right to Health belongs to all citizens, rather than a select few.

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[20] MINISTRY OF HEALTH & FAMILY WELFARE, GOV'T OF INDIA, RURAL HEALTH STATISTICS 2021-22.

[21] MINISTRY OF HEALTH & FAMILY WELFARE, GOV'T OF INDIA, NATIONAL HEALTH POLICY 2017.