

THE CONSTITUTIONAL DUTY TO HEALTHCARE IN INDIA: LEGAL ARCHITECTURE, ACCOUNTABILITY AND PATHWAYS TO UNIVERSAL HEALTH COVERAGE

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ABSTRACT

Healthcare is increasingly recognised as an integral component of the right to life and human dignity under Article 21 of the Constitution, yet the translation of this judicial recognition into effective health outcomes remains inconsistent. India's health system continues to face insufficient public financing, fragmented regulation, over-reliance on private providers, and significant inter-state disparity in access and outcome. This paper examines the constitutional duty to healthcare in India through a legal and institutional lens, analysing the normative foundations of the right to health, the evolving role of the judiciary, and the adequacy of the existing legislative and policy framework in advancing Universal Health Coverage. It evaluates flagship initiatives, including the National Health Mission, Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana and the Ayushman Bharat Digital Mission, and identifies persistent accountability deficits in financing, regulation and service delivery, including in the largely unaddressed area of digital health data governance. Drawing on comparative experience from Thailand, South Africa and Brazil, the paper argues for the recognition of a legally enforceable minimum core health entitlement under Article 21. It concludes by proposing institutional and statutory reforms directed at strengthening accountability, ensuring equity, and enabling a phased but genuinely enforceable pathway toward Universal Health Coverage in India.

KEYWORDS: Universal Health Coverage; Article 21; Right to Health; Ayushman Bharat; Digital Health Governance.

1. INTRODUCTION

The constitutional vision of India places human dignity at the centre of governance, with the right to life under Article 21 serving as its cornerstone.¹ The Supreme Court has interpreted this provision expansively to include the right to health and medical care, recognising healthcare as essential to a meaningful and dignified existence.² Despite this judicial recognition, India's healthcare system continues to suffer from persistent structural deficiencies, including public health investment well below the levels national policy itself sets as targets, difficult access to services, weak regulatory mechanisms, and high out-of-pocket expenditure.³ These deficiencies raise a critical question this paper addresses directly: to what extent are India's constitutional obligations relating to healthcare actually being fulfilled in practice, rather than merely recognised in principle.⁴

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¹ India Const. art. 21.

² *Paschim Banga Khet Mazdoor Samity v. State of W.B.*, A.I.R. 1996 S.C. 2426 (India).

³ Ministry of Health & Family Welfare, Gov't of India, National Health Accounts Estimates for India 2019-20 (2022).

⁴ *Consumer Educ. & Rsch. Ctr. v. Union of India*, A.I.R. 1995 S.C. 922 (India).

India's policy discourse has progressively incorporated Universal Health Coverage as a national objective, reflected in initiatives such as Ayushman Bharat and the National Health Policy, 2017.⁵ The legal enforceability of these commitments nonetheless remains uncertain, particularly in the absence of a comprehensive statute guaranteeing healthcare as a justiciable right. This gap between healthcare policymaking and legal accountability constitutes the central challenge this paper examines.⁶

1.1 Objectives of the Study

- To examine the constitutional basis of the right to healthcare in India, with particular reference to the judicial construction of Article 21.
- To analyse the legislation, policy and regulatory instruments governing healthcare delivery in India and assess their adequacy in fulfilling constitutional obligations.
- To evaluate the judiciary's role in enforcing healthcare rights and the doctrinal tools courts have employed to balance rights protection against administrative feasibility.
- To identify implementation gaps in existing health policies, laws and schemes.
- To identify legal pathways for advancing Universal Health Coverage through enforceable standards, institutional reform and strengthened governance mechanisms.

1.2 Research Methodology

This study adopts a doctrinal methodology, analysing constitutional provisions and the judicial decisions of the Supreme Court and High Courts alongside the statutory and policy framework governing the health sector, in order to trace how the relationship between Article 21 and healthcare has been interpreted and applied. It further examines the legislative and regulatory framework governing healthcare delivery, including the Clinical Establishments (Registration and Regulation) Act, 2010, the Mental Healthcare Act, 2017, and the regulatory regimes governing medical education and professional standards, to assess their effectiveness in advancing access, quality and accountability. Health policies and government schemes, including the National Health Policy, 2017, the National Health Mission and Ayushman Bharat-PMJAY, are analysed to understand the interface between policy commitment and legal enforceability. Finally, a comparative method draws selectively on international lessons from Thailand, South Africa and Brazil to examine differing legal approaches to

⁵ Ministry of Health & Family Welfare, Gov't of India, National Health Policy 2017 (2017).

⁶ World Health Organization, Universal Health Coverage (2023), available at <https://www.who.int/health-topics/universal-health-coverage>.

healthcare rights, particularly regarding statutory entitlement, minimum core obligation and the appropriate scope of judicial oversight.

2. CONCEPTUAL FRAMEWORK: HEALTH, RIGHTS AND STATE OBLIGATION

Health, as understood in contemporary public law discourse, extends beyond the mere absence of disease to encompass physical, mental and social well-being,⁷ an understanding that aligns with international human rights instruments and with the constitutional construction of the right to life. Universal Health Coverage refers to ensuring that every individual has access to basic and essential health services of adequate quality without suffering financial hardship as a consequence. While UHC is frequently framed as a policy goal, its constitutionalisation raises important questions of enforceability and prioritisation that this paper addresses throughout.

A central concept in evaluating the state's duty in healthcare is the minimum core, referring to the essential facilities of healthcare the state must guarantee immediately, regardless of resource constraints.⁸ This sits alongside the principle of progressive realisation, which acknowledges fiscal constraint while requiring the state to demonstrate continuous, non-retrogressive improvement. Although the Indian judiciary has not unequivocally adopted the minimum core doctrine by that name, courts have imbibed it indirectly into healthcare rights jurisprudence by mandating non-discriminatory access, emergency care and basic medical amenities as immediately enforceable entitlements.⁹

2.1 Historical and Policy Background

India's healthcare system has developed through a combination of constitutional objective, policy intervention and institutional planning. In the decades following independence, health was addressed primarily through a welfare-oriented state approach, though population growth and resource scarcity constrained the expansion of robust health infrastructure. The launch of the National Rural Health Mission in 2005 marked a significant shift, directing attention toward primary healthcare and the reduction of regional disparity,¹⁰ and was later merged into the National Health Mission, extending a comparable approach to urban areas.¹¹

⁷ World Health Organization, Constitution of the World Health Organization (1946).

⁸ Katharine G. Young, The Minimum Core of Economic and Social Rights, 33 *Yale J. Int'l L.* 113 (2008).

⁹ *Mohinder Singh Chawla v. Union of India*, A.I.R. 1997 S.C. 1225 (India).

¹⁰ Ministry of Health & Family Welfare, Gov't of India, National Rural Health Mission Framework for Implementation (2005).

¹¹ Ministry of Health & Family Welfare, Gov't of India, National Health Mission Framework (2013).

The National Health Policy, 2017 placed Universal Health Coverage at the centre of national health objectives, emphasising preventive care, increased public expenditure and systematic purchasing of services from the private sector.¹² Ayushman Bharat operationalised this vision through two components, Health and Wellness Centres and the insurance-based Pradhan Mantri Jan Arogya Yojana targeting secondary and tertiary care.¹³ These initiatives have achieved considerable coverage, but persistent concerns regarding supervisory oversight and quality control remain.¹⁴

The parallel growth of private healthcare provision over the past two decades has reshaped India's health system: private entry has expanded the availability of services but has also driven high out-of-pocket expenditure and inconsistent quality. This trajectory underscores the question this paper pursues throughout: whether policy-led expansion without a correspondingly robust legal foundation can fulfil the state's constitutional obligation toward healthcare.

2.2 Constitutional and Jurisprudential Foundation

The normative foundation of the right to healthcare in India derives primarily from Article 21. The judiciary has consistently held that the right to life is not confined to mere animal existence but embraces the right to live with dignity, including access to the basic amenities necessary for survival,¹⁵ healthcare being one such amenity forming a core component of the right to life. Beyond Article 21, the right to healthcare is voiced in Part IV of the Constitution: Article 38 requires the state to secure a social order founded on justice, Article 39(e) addresses the protection of workers' health, Article 41 mandates state assistance in circumstances of vulnerability including old age, sickness and unemployment, and Article 47 directs the state to improve public health and raise nutritional standards.¹⁶

Although the Directive Principles remain non-justiciable, the judiciary has used them to enlarge the substantive scope of fundamental rights in matters of health and welfare. In *Consumer Education and Research Centre v. Union of India*, the Supreme Court held that the right to health and medical care is a fundamental right under Article 21, particularly for workers exposed to occupational hazards.¹⁷ In *Mohinder Singh Chawla v. Union of India*, the Court

¹² Ministry of Health & Family Welfare, Gov't of India, National Health Policy 2017 (2017).

¹³ National Health Authority, Gov't of India, Ayushman Bharat PMJAY Scheme Overview (2023).

¹⁴ Abhay Shukla et al., High Level of Private Health Care in India: Implications for Universal Health Coverage, 34 Health Pol'y & Plan. 235 (2019).

¹⁵ Francis Coralie Mullin v. Administrator, Union Territory of Delhi, A.I.R. 1981 S.C. 746 (India).

¹⁶ India Const. arts. 38, 39(e), 41, 47.

¹⁷ Consumer Education and Research Centre v. Union of India, A.I.R. 1995 S.C. 922 (India).

held that the right to life includes the right to medical treatment,¹⁸ a position strengthened in *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, which held the state accountable for failure to provide timely emergency medical treatment and made clear that financial constraint cannot justify the denial of basic healthcare.¹⁹ Doctrinal debate nonetheless persists regarding the proper limits of judicial intervention in socio-economic rights: critics argue that without judicial scrutiny, constitutional guarantees risk becoming illusory,²⁰ while courts have generally adopted a middle path, imposing health obligations on the state while leaving questions of policy design and fund allocation to executive discretion. This balance between legislative framework and judicial enforcement forms the normative basis against which the remainder of this paper examines whether India's healthcare governance adequately reflects its constitutional commitments.

2.3 The Doctrinal Limits of Article 21 Health Jurisprudence

The judicial recognition traced above operates within identifiable doctrinal limits that matter considerably for the reform this paper proposes. Courts have proven willing to intervene decisively where the state's failure is acute and individualised, such as the denial of emergency treatment to an identifiable patient, but have shown far greater reluctance to prescribe the systemic resource allocation choices that would be necessary to prevent such failures from recurring at scale. This asymmetry reflects a defensible institutional caution about the judiciary's competence to manage complex budgetary trade-offs, but it also means that Article 21 healthcare jurisprudence, however doctrinally expansive in principle, has developed primarily as a jurisprudence of individual remedy rather than one of systemic entitlement. The distinction matters because a right vindicated only after an individual has suffered demonstrable harm provides considerably weaker protection than a right that structures healthcare delivery prospectively, and it is precisely this gap between remedial and preventive protection that the minimum core framework discussed above is best positioned to close.

3. THE LEGISLATIVE AND REGULATORY ARCHITECTURE GOVERNING HEALTHCARE

The legislative and regulatory framework governing healthcare in India is fragmented and multi-layered, comprising central and state enactments, delegated legislation, and executive schemes and policies.²¹ Unlike jurisdictions that have enacted healthcare as a comprehensive statutory right, India lacks any

¹⁸ Mohinder Singh Chawla v. Union of India, A.I.R. 1997 S.C. 1225 (India).

¹⁹ Paschim Banga Khet Mazdoor Samity v. State of W.B., A.I.R. 1996 S.C. 2426 (India).

²⁰ Upendra Baxi, The Right to Health and the Right to Life, 4 Sup. Ct. Cases J. 1 (1996).

²¹ Frank J. Chaloupka et al., Health Policy and Governance in Comparative Perspective, 41 J. Health Pol. 220 (2016).

such unifying statute; its healthcare legislation is instead either policy-driven or confined to specific sectors.

3.1 Sector-Specific Legislation and Its Limitations

India possesses no all-encompassing law guaranteeing a right to health at the central level. Its legal framework instead spans numerous enactments addressing specific aspects of healthcare: professional regulation, public health emergencies, mental health, patient rights and disease control.²² The Epidemic Diseases Act, 1897, among the earliest such legislation, authorises government to take special measures to check the outbreak of epidemic disease,²³ but is widely criticised as obsolete, ambiguous and silent on patient rights and procedural safeguards. The Drugs and Cosmetics Act, 1940, a sector-specific regulatory statute governing the manufacture, sale and distribution of medical devices and drugs,²⁴ indirectly secures the right to health by ensuring quality standards, though weak enforcement, regulatory capture and uneven state-level implementation have permitted the circulation of substandard or counterfeit medicines, posing serious risk to public health.

Professional conduct and standards are governed by the National Medical Commission Act, 2019, which replaced the Medical Council of India and seeks to regulate medical education, professional ethics and the availability of qualified professionals,²⁵ though grey areas remain regarding institutional autonomy, transparency and the adequacy of the disciplinary framework, particularly in the redressal of patient grievances and medical negligence claims. The Clinical Establishments (Registration and Regulation) Act, 2010 attempts to standardise healthcare services across the public and private sectors by mandating registration and prescribing minimum standards of amenities and services,²⁶ but its impact is narrowed by incomplete state-level adoption and weak enforcement, creating regulatory gaps that are especially consequential in the rapidly expanding private healthcare sector. The Mental Healthcare Act, 2017 marked a significant legislative development by explicitly recognising the right to mental healthcare as a statutory entitlement and incorporating principles of autonomy and informed consent consistent with international human rights standards,²⁷ though a shortage of infrastructure, funding and trained professionals continues to hamper its implementation in practice.

²² Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* (2d ed. 2008).

²³ Epidemic Diseases Act, No. 3 of 1897 (India).

²⁴ Drugs and Cosmetics Act, No. 23 of 1940 (India).

²⁵ National Medical Commission Act, No. 30 of 2019 (India).

²⁶ Clinical Establishments (Registration and Regulation) Act, No. 23 of 2010 (India).

²⁷ Mental Healthcare Act, No. 10 of 2017 (India).

3.2 Health-Related Policy Instruments

The National Health Policy, 2017 functions as an umbrella policy explicitly advocating Universal Health Coverage and emphasising preventive care, increased public health spending and systematic purchasing of services from both public and private providers,²⁸ but it creates no enforceable right or binding obligation, its implementation depending entirely on executive will and inter-governmental coordination. The National Health Mission aims to strengthen public health infrastructure at the primary and secondary levels and has improved maternal and child health indicators,²⁹ but its efficacy is constrained by uneven implementation across states and limited financial allocation, with the absence of statutory backing further weakening accountability. Ayushman Bharat-PMJAY represents a significant step toward insurance-based healthcare, aiming to reduce catastrophic health spending through coverage of secondary and tertiary care,³⁰ yet concerns persist regarding claim denial, erroneous enrolment, limited coverage of outpatient care and inadequate regulation of empanelled private hospitals,³¹ raising a question this paper addresses squarely in Section 5: whether insurance-led models can substitute for robust public provisioning in fulfilling the state's constitutional health obligations. The aggregate effect of this fragmented legislative architecture is a system in which responsibility is diffused and accountability correspondingly diluted, a structural problem calling for the re-examination of statutory design this paper undertakes in its recommendations.

3.3 The Consequences of Fragmentation for Constitutional Enforcement

The fragmentation documented above is not merely an administrative inconvenience; it has direct constitutional consequence for how Article 21's healthcare guarantee can actually be enforced. Where a single comprehensive statute defines the right to health, as in the comparative jurisdictions examined in Section 7 below, a litigant seeking to vindicate that right has a clear statutory text against which to test executive conduct. Where the framework is instead distributed across a dozen sector-specific statutes, none of which was drafted with constitutional health entitlement as its organising purpose, courts are left to construct the content of the right almost entirely from first constitutional principle, case by case. This is precisely the dynamic Section 2 above identifies as producing a jurisprudence of individual remedy rather than systemic entitlement, and it supplies the strongest institutional argument for the unified statutory framework this paper's recommendations in Section 8 propose.

²⁸ Ministry of Health & Family Welfare, Gov't of India, National Health Policy 2017 (2017).

²⁹ Ministry of Health & Family Welfare, Gov't of India, National Health Mission Framework (2013).

³⁰ National Health Authority, Gov't of India, PMJAY Operational Guidelines (2022).

³¹ Centre for Policy Research, Ayushman Bharat and Health Insurance in India: An Assessment (2021).

4. DIGITAL HEALTH GOVERNANCE AND THE FINANCING OF UHC

4.1 Digital Health and Data Governance

The digital transformation of healthcare has become a core component of India's strategy for improving access and efficiency. The Ayushman Bharat Digital Mission, successor to the National Digital Health Mission, seeks to build an integrated digital ecosystem for health through unique health identifiers and online service delivery platforms.³² While digital health promises to address systemic inefficiency, it raises intricate concerns regarding privacy, consent, data security and accountability that existing law addresses only partially.

The collection and processing of health data engages the right to privacy, recognised as a fundamental right under Article 21 in *Justice K.S. Puttaswamy v. Union of India*³³. Health data comprises particularly sensitive personal information, and its misuse risks a serious erosion of patient autonomy, yet India presently lacks a dedicated statutory framework for health data protection specifically; digital health platforms instead operate under executive policy and technical standards lacking enforceability and clear remedies for personal data breaches.³⁴

The consent mechanism operating within the digital health ecosystem suffers from significant informational asymmetry, since an individual may not fully comprehend the scope or consequences of sharing health data, and the absence of standardised rules governing informed consent and data minimisation weakens legal accountability considerably. The Digital Personal Data Protection Act, 2023 recognises health data as sensitive personal data, but grants government considerable latitude to use such data for research or during epidemic outbreaks and permits sharing with third-party vendors, including in circumstances that may result in cross-border data transfer.³⁵ In the continuing absence of legislative clarity specific to health data, courts may increasingly be called upon to adjudicate disputes arising from digital health governance, underscoring the need for a dedicated statutory framework integrating digital health initiatives with constitutional safeguards, so that technological advancement does not come at the expense of fundamental rights.

³² National Health Authority, Gov't of India, Ayushman Bharat Digital Mission Strategy Overview (2021).

³³ Justice K.S. Puttaswamy v. Union of India, A.I.R. 2017 S.C. 4161 (India).

³⁴ Arghya Sengupta & Vidushi Marda, Health Data Governance in India: Legal Gaps and Institutional Design, 15 NUJS L. Rev. 45 (2022).

³⁵ Digital Personal Data Protection Act, No. 22 of 2023 (India); JSA Prism, Digital Personal Data Protection Act 2023: Implications for Health Data (2023).

4.2 Financing Universal Health Coverage

Adequate public financing constitutes the backbone of effective UHC implementation. India's public health expenditure has remained persistently below global benchmarks, driving high out-of-pocket expenditure and consequent financial hardship.³⁶ Despite repeated policy commitment to increased public spending, actual budgetary allocation continues to fall short of the targets national health policy itself articulates.³⁷ The Parliamentary Standing Committee on Health and Family Welfare (2022-23) noted that India ranks 176th of 196 countries by the percentage of current health expenditure paid out of pocket, with India's out-of-pocket expenditure standing at 54.78 per cent in 2019, compared with 11.03 per cent in the United States and 17.01 per cent in the United Kingdom in the same year.³⁸

Insurance-based schemes such as PMJAY have been promoted as a mechanism for bridging financing gaps and protecting households from catastrophic health expenditure.³⁹ While such schemes have extended coverage for hospitalisation, they do not address the full spectrum of healthcare need, particularly outpatient care and preventive services, and insurance-led models risk entrenching private sector dominance unless matched by robust regulation and continued public provisioning. A legally grounded approach to health financing would involve statutory commitment to minimum public health expenditure, phased targets and transparent reporting obligations, measures that would improve fiscal accountability while preserving legislative discretion over the specific means of implementation, and aligning financial design with constitutional obligation is accordingly essential to the sustainable realisation of healthcare rights.

The digital health governance gap and the financing gap examined in this section are, on closer analysis, connected rather than independent problems. As enrolment, claims processing and provider empanelment under PMJAY and comparable schemes increasingly migrate onto digital platforms built under the Ayushman Bharat Digital Mission, the absence of a dedicated health data protection statute described above compounds the financing accountability problem: erroneous or fraudulent claims, discussed further in Section 6, are considerably harder to audit and correct where the underlying data governance framework itself lacks clear standards for accuracy, correction and accountability. A reform agenda addressing financing alone, without corresponding attention to the digital infrastructure through which that

³⁶ World Health Organization, Global Health Expenditure Database (2023).

³⁷ Ministry of Health & Family Welfare, Gov't of India, National Health Policy 2017, Financing Targets (2017).

³⁸ Rajya Sabha, Standing Committee on Health and Family Welfare, 139th Report (2022-23).

³⁹ National Health Authority, Gov't of India, PMJAY Annual Report 2022-23 (2023).

financing is now largely administered, would accordingly address only half of the accountability deficit this paper identifies.

5. ACCESS, HUMAN RESOURCES AND PRIVATE SECTOR ACCOUNTABILITY

5.1 Access, Equity and Human Resources for Health

Equitable access to healthcare remains a major challenge within India's health system, driven by regional disparity, disparity among socio-economic groups, and a persistent rural-urban divide in the availability of healthcare professionals, infrastructure and essential services.⁴⁰ Human resources constitute a critical determinant of accessible and quality healthcare, and despite an overall increase in the number of medical professionals nationally, shortages persist acutely in rural and underserved areas.⁴¹ India's doctor-to-population ratio, at approximately 1:811, compares reasonably with international benchmarks, but its nurse-to-population ratio, at roughly 1.7 per 1,000 population, remains considerably below the levels developed health systems display.⁴²

Existing workforce deployment policy relies heavily on contractual appointment and short-term incentive, neither of which supports long-term retention in underserved regions. Article 14 mandates equality before law, and Article 21 requires that access to healthcare be non-discriminatory; judicial decisions have accordingly held that denying healthcare facilities on arbitrary or unreasonable grounds violates constitutional guarantee.⁴³ Structural disparity driven by geography, social status and income nonetheless continues to shape health outcomes in ways formal non-discrimination doctrine does not, by itself, correct.

5.2 Quality of Care and Private Sector Accountability

Quality of care forms a major component of the constitutional right to health; access to healthcare without adherence to ethical medical practice and adequate safety standards cannot meaningfully satisfy the constitutional objective.⁴⁴ Quality regulation in India is complicated by the substantial role private providers play, accounting for a significant share of both in-patient and out-patient service delivery.⁴⁵ The Clinical Establishments Act, 2010 specifies minimum standards for healthcare facilities, human resources and record-

⁴⁰ NITI Aayog, *Healthy States, Progressive India* (2019).

⁴¹ World Health Organization, *Human Resources for Health: India Country Profile* (2021).

⁴² Express Healthcare, *Is India's Healthcare Gap About Doctors, or About Nurses?* (2022).

⁴³ *State of Punjab v. Mohinder Singh Chawla*, A.I.R. 1997 S.C. 1225 (India).

⁴⁴ India Const. art. 21.

⁴⁵ Sunil Nandraj et al., *Private Health Sector in India*, 49 *Econ. & Pol. Wkly.* 15 (2014).

keeping,⁴⁶ but incomplete state adoption and weak implementation have limited its regulatory impact, and compliance, where it exists, is frequently procedural rather than substantive. The National Medical Commission Act, 2019 provides for professional accountability through disciplinary action,⁴⁷ though the primary public remedy for deficient quality of care, medical negligence litigation under tort law, remains time-consuming and costly for the ordinary patient.

Holding the extensive private health sector accountable under state-funded schemes such as PMJAY presents an enduring challenge. Empanelment norms, standard treatment guidelines and anti-fraud measures exist but are unevenly enforced,⁴⁸ and documented instances of overbilling, denial of service and medically unnecessary costly procedures indicate significant regulatory gaps, with the absence of statutory penalties and transparent audit mechanisms weakening deterrence and undermining public trust. Courts have recognised that where private entities perform public functions or operate under state-funded schemes, they remain subject to constitutional objectives,⁴⁹ meaning that a failure to regulate private healthcare effectively may amount to indirect state responsibility, strengthening the case for the independent oversight and enforceable quality standards this paper's recommendations propose.

The human resource shortages and private sector accountability gaps examined in this section are mutually reinforcing rather than separate problems. Where public facilities are understaffed and under-equipped, patients are pushed toward private providers regardless of cost, a dynamic that both drives the high out-of-pocket expenditure documented in Section 4 above and weakens the state's practical leverage over private sector quality, since a regulatory regime that threatens to close or restrict a private facility on which a community has become the primary source of care carries a political and public health cost regulators are reluctant to bear. Breaking this cycle requires simultaneous investment in public capacity and stronger private regulation, since either measure pursued alone risks leaving patients with no better alternative than tolerating the very deficiencies the reform was meant to correct.

6. FAILURE MODES AND THE EMPIRICAL CASE FOR LEGAL REFORM

Despite constitutional commitment and an array of schemes and policies, recurring failures in healthcare delivery reveal the limits of the existing legal and institutional framework, and examining these failures directly highlights the disparity between legal guarantee and ground reality.

⁴⁶ Clinical Establishments (Registration and Regulation) Act, No. 23 of 2010, § 12 (India).

⁴⁷ National Medical Commission Act, No. 30 of 2019 (India).

⁴⁸ National Health Authority, PMJAY Anti-Fraud Guidelines (2021).

⁴⁹ *Zee Telefilms Ltd. v. Union of India*, A.I.R. 2005 S.C. 2677 (India).

One significant, recurring failure mode is the denial of emergency medical care by both public and private hospitals. Courts have repeatedly affirmed that refusing emergency care violates Article 21 irrespective of a patient's financial capacity,⁵⁰ yet delayed admission, referral without stabilisation, and insistence on lump-sum payment before treatment continue to be documented. A second recurring failure mode concerns publicly funded insurance schemes such as PMJAY, where reports of informal payment demands, claim denial, fraudulent accounts created by hospital authorities, overcharging, and exclusion of eligible beneficiaries raise sustained questions about the schemes' transparency and accountability;⁵¹ grievance redressal mechanisms exist in principle, but their efficacy is hampered by procedural complexity and low beneficiary awareness, undermining the financial protection the scheme is designed to provide.

Public health failures are also evident in episodes of institutional negligence, including mass sterilisation programmes where lapses in quality control and oversight have resulted in fatality.⁵² The judiciary has responded to such episodes by awarding monetary compensation and issuing corrective directions, but systemic reform addressing the underlying causes has largely remained aspirational. These case studies demonstrate that constitutional remedies, while indispensable, tend to be reactive and individualised: without institutional reform addressing regulatory capacity, enforcement and accountability directly, judicial intervention risks becoming an episodic response to failure rather than a driver of systemic change.

An empirical mapping of where legal intervention is most urgently needed confirms this pattern. High out-of-pocket expenditure remains the defining feature of financial hardship within the Indian health system, pushing vulnerable households toward poverty and reflecting continuing gaps in public provisioning and regulatory oversight.⁵³ Infrastructure shortages compound this difficulty: bed density in India's public hospitals remains low by international benchmark, with pronounced rural-urban disparity, and primary healthcare facilities, which form the backbone of preventive and promotive care, frequently suffer from inadequate staffing, poor equipment and limited diagnostic capacity.⁵⁴ Large segments of the population remain without coverage for diagnostics, outpatient services and medicines, which together constitute a significant share of health-related expenditure, and uneven scheme implementation together with exclusion error continues to limit the effectiveness of insurance as a genuine safety net.⁵⁵ These structural deficits,

⁵⁰ *Parmanand Katara v. Union of India*, A.I.R. 1989 S.C. 2039 (India).

⁵¹ Centre for Policy Research, *Evaluating PMJAY Implementation: Gaps and Grievances* (2022).

⁵² *Devika Biswas v. Union of India*, A.I.R. 2016 S.C. 366 (India).

⁵³ World Bank, *Out-of-Pocket Expenditure (% of Current Health Expenditure): India* (2023).

⁵⁴ NITI Aayog, *Health Systems for a New India: Building Blocks* (2019).

⁵⁵ Nat'l Sample Survey Office, Gov't of India, *Health in India, NSS 75th Round* (2019).

taken together, confirm that the law must move beyond the declaratory recognition of rights toward defining concrete minimum entitlements, accountability benchmarks and institutional responsibility if Article 21's healthcare guarantee is to have practical rather than merely doctrinal effect.

7. COMPARATIVE EXPERIENCE: THAILAND, SOUTH AFRICA AND BRAZIL

Comparative constitutional and policy experience offers valuable insight into how statutory design can advance Universal Health Coverage. Several jurisdictions have adopted statutory or constitutional approaches that clarify state obligation while preserving flexibility in implementation, and their experience bears directly on the reform this paper proposes.

Thailand's National Health Security Act supplies a notable model of statutorily guaranteed Universal Health Coverage, promising access to a defined package of essential health services through legislation that provides for enhanced accountability, transparency and public participation, while retaining judicial review to address enforcement failure.⁵⁶ This model demonstrates the legislative clarity a defined statutory entitlement can achieve, in clear contrast to India's fragmented, policy-driven approach. South Africa's constitutional jurisprudence offers a different model, with courts emphasising reasonableness and progressive realisation over immediate universal entitlement to all forms of care.⁵⁷ This preserves executive discretion over resource allocation but has correspondingly limited the enforceability of concrete minimum standards, illustrating both the strengths and the limitations of a judicially managed, rather than statutorily defined, approach to socio-economic rights.

Brazil's experience offers a cautionary contrast. Extensive judicial intervention in individual health rights claims, with courts frequently ordering the provision of specific treatments to individual litigants, has produced inequitable resource allocation and disrupted systemic health planning.⁵⁸ The Brazilian experience demonstrates that judicial enforcement of health rights, if confined to individualised, treatment-specific litigation rather than anchored in systemic minimum standards, can itself become a source of inequity rather than a corrective to it.

Read together, these comparative experiences suggest that India would benefit from a hybrid approach combining statutory definition of minimum entitlements, following the Thai model, with judicial oversight focused on systemic compliance rather than individualised treatment orders, avoiding the

⁵⁶ National Health Security Act, B.E. 2545 (2002) (Thai.).

⁵⁷ *Soobramoney v. Minister of Health (KwaZulu-Natal)*, 1998 (1) S.A. 765 (CC) (S. Afr.).

⁵⁸ Octavio Luiz Motta Ferraz, *The Right to Health in the Courts of Brazil: Worsening Health Inequities?*, 11 *Health & Hum. Rts.* 33 (2009).

distributive distortion the Brazilian experience illustrates. International practice thus reinforces the case this paper advances: that a prudently designed legal architecture, balancing rights enforcement against administrative coherence, is both achievable and necessary.

The three comparative models surveyed above map onto a broader typology worth making explicit: Thailand represents a legislative-primacy model in which the content of the right is fixed largely by statute and courts play a supporting enforcement role; South Africa represents a judicial-deference model in which courts define the standard of state conduct, reasonableness, but decline to specify the substantive content of the entitlement itself; and Brazil represents what might be termed a judicial-substitution model, in which courts effectively make individualised resource allocation decisions that a legislature or executive agency would ordinarily make. India's present healthcare jurisprudence, examined in Sections 2 and 6 of this paper, resembles the Brazilian model far more closely than either of the other two, notwithstanding that Indian courts have not embraced individualised treatment litigation on anything like the Brazilian scale: the underlying structural problem, a judiciary supplying doctrine in the absence of legislative content, is the same. The reform this paper proposes is, in substance, a proposal to move India from its current position toward the Thai model, using statutory definition to supply the content Indian courts have so far had to construct themselves.

8. INSTITUTIONAL REFORM AND CONCLUSION

8.1 Institutional Reforms and Implementation Pathways

At the institutional level, establishing dedicated health accountability forums, including district-level health ombudsmen and autonomous regulatory authorities, would strengthen grievance redressal and improve the accessibility of remedies.⁵⁹ These forums should be empowered to monitor compliance with minimum standards and to recommend corrective measures where grievances arise. A unified regulatory framework integrating licensing, registration, empanelment and quality audit would further improve transparency and inter-agency coordination, addressing the fragmentation Section 3 of this paper documents.

From a legal design perspective, statutory and policy recognition of minimum healthcare entitlements and binding treatment standards would supply a robust foundation for accountability, shifting healthcare governance from discretionary welfare provision toward rights-based administration.⁶⁰

⁵⁹ Law Commission of India, *Assessment of Statutory Frameworks for Health Rights Enforcement*, Report No. 279 (2022).

⁶⁰ World Health Organization, *Health Systems Governance for Universal Health Coverage* (2022).

Implementation should proceed through a phased roadmap: strengthening primary-level healthcare first, prioritising increased public health expenditure, and extending regulation to private providers operating under state-funded schemes, with pilot implementation in selected regions, supported by transparent monitoring indicators, permitting adaptive learning while maintaining fidelity to the constitutional standard this paper has traced throughout.

8.2 Conclusion

The constitutional duty to healthcare in India is firmly grounded in Article 21 and reinforced by judicial construction, policy commitment and international obligation. Yet the persistence of access gaps, regulatory failure and financing constraint, documented throughout this paper, reveals a significant disconnect between constitutional promise and institutional practice. Courts have played an indispensable role in recognising healthcare as a fundamental right, but judicial intervention alone, as the comparative experience of Brazil in particular demonstrates, cannot ensure the comprehensive realisation of that right.

This paper has argued that the next phase of constitutional development must move beyond recognition toward implementation and operationalisation. Defining a minimum core of healthcare entitlement, strengthening the legislative and regulatory framework Section 3 identifies as fragmented, and embedding accountability within health governance institutions along the lines Section 8.1 proposes are the essential steps toward that goal. Law, deployed as an enabling and coordinating instrument rather than a purely declaratory one, can reconcile the rights-based imperative Article 21 establishes with the administrative realism effective implementation requires. Advancing Universal Health Coverage in India therefore requires not merely policy ambition but constitutional discipline, legal clarity and sustained institutional commitment.