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ACCESS TO UNIVERSAL HEALTH COVERAGE: A SOCIO-LEGAL STUDY WITH SPECIAL REFERENCE TO PRISONERS IN INDIA

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ABSTRACT

In India, the right to healthcare is constituted under Article 21 and forms an essential part of the constitutional guarantee. However, the health rights of prisoners and undertrials remain at a critical juncture, challenging human dignity and constitutional assurance. Although prisoners and undertrials are deprived of their personal liberty, and that too by procedures established by law, this does not waive their fundamental rights. Indian courts have repeatedly held that the right to life does not mean mere animal existence but life with dignity, which includes within its sphere the right to health and medical care, and that the State bears a heightened obligation towards persons in its custody. Though procedural safeguards for prisoner healthcare exist under enactments including the Bharatiya Nagarik Suraksha Sanhita, 2023, the Mental Healthcare Act, 2017 and the Prisons Act, 1894, their practical implementation remains inadequate. This paper examines Universal Health Coverage as a Sustainable Development Goal, the international human rights instruments governing healthcare standards owed to prisoners, India's constitutional provisions, national laws and policies, and the judicial approach to prisoner healthcare rights. It highlights persistent concerns including overcrowding, inadequate medical infrastructure, weak enforcement, and indifference toward prisoners' mental health, and it concludes that a dedicated legislative framework aligned with international standards, rather than continued reliance on case-by-case judicial correction, is necessary to secure dignity, equality and the rule of law in India's prison healthcare administration.

KEYWORDS: *Universal Health Coverage; Prisoners' Rights; Right to Health; Undertrial Detention; Prison Reform*

1. INTRODUCTION

The Constitution of India guarantees the right to life to every individual through Article 21, which has been interpreted to include the right to healthcare as one of its inherent components. This right does not vanish upon imprisonment; rather, it becomes more pressing once a person is in the State's custody. Incarceration waives personal liberty but not human dignity, and a person in custody is entitled to humane treatment.[1] The State is under an obligation to preserve and safeguard the physical and mental health of persons it detains.[2] This obligation acquires particular significance in India given the scale of the population it affects: with a prison system holding hundreds of thousands of

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1 Sunil Batra v. Delhi Administration, (1978) 4 S.C.C. 494 (India).

2 Charles Sobhraj v. Superintendent, Central Jail, Tihar, (1978) 4 S.C.C. 104 (India).

individuals at any given time, the overwhelming majority of whom are undertrials rather than convicted persons, the adequacy of custodial healthcare is not a marginal administrative question but a determinant of health outcomes for a substantial and continuously circulating population, one that moves between custody and the wider community and thereby links prison health conditions directly to public health outcomes beyond the prison gate.

1.1 Research Objectives

This paper seeks to introduce Universal Health Coverage under the Sustainable Development Goals; to analyse the availability of the right to healthcare to prisoners and undertrials in Indian jails; to examine the international instruments upholding healthcare rights for prisoners; to study the statutes, policies and schemes governing Indian prisons; and to identify the reforms needed in India's prison healthcare system.

1.2 Research Methodology

This study adopts a doctrinal and analytical methodology, examining the Constitution, statutes, judicial precedent and international human rights instruments relevant to custodial healthcare administration. It draws on secondary sources, including the Bharatiya Nagarik Suraksha Sanhita, 2023, the Prisons Act, 1894 and the Mental Healthcare Act, 2017, decisions of the Supreme Court and High Courts, and international instruments including the International Covenant on Civil and Political Rights and the Nelson Mandela Rules, supplemented by scholarly literature, government reports and prison statistics. The analysis is qualitative, interpreting legal provisions and case law to evaluate the scope and limitations of the custodial right to health, and incorporates a limited comparative review of selected foreign jurisdictions to identify alternative institutional models. The study is descriptive in outlining the existing legal framework and critical in evaluating systemic gaps and reform needs; no primary empirical fieldwork or interviews were conducted, and relevant empirical data on prison conditions have instead been drawn from academic and peer-reviewed publications.

2. UNIVERSAL HEALTH COVERAGE AND THE VULNERABILITY OF THE PRISON POPULATION

The United Nations General Assembly adopted the Sustainable Development Goals in 2015, a set of seventeen goals succeeding the earlier Millennium Development Goals and directed at improving economic, social and environmental conditions by 2030, including reductions in gender disparity, educational deprivation and climate vulnerability.[3] Universal Health Coverage

[3] United Nations, Transforming Our World: The 2030 Agenda for Sustainable Development, G.A. Res. 70/1 (Sept. 25, 2015).

forms the third of these seventeen goals, aimed at including every individual within health coverage, providing high-quality health services, mitigating financial risk through insurance mechanisms, and ensuring access to vaccines and quality medicines for all. Achieving this goal requires particular attention to the most vulnerable sections of society, since the lower a population's socioeconomic status, the more precarious its access to basic health provision tends to be. Persons in state custody, prisoners and undertrials, constitute precisely such a vulnerable group, and the goals set under Universal Health Coverage can only be realised if this population is included within basic and advanced healthcare provision rather than treated as a residual category.[4] According to the Global Prison Trends report of 2020, approximately eleven million individuals reside in prison globally at any given time, with more than thirty million moving between prisons and their communities annually, a population whose health profile is complicated by the interaction of physical and mental disorders within a custodial environment.[5] Extending healthcare rights to prisoners comparable to those enjoyed by the community outside prison walls is not merely a matter of custodial welfare; it materially assists social rehabilitation and reintegration upon release, and its absence carries public health consequences that extend well beyond the prison gate.[6] India's own position within this global picture is significant: as one of the countries with the largest prison populations, and one in which undertrials substantially outnumber convicted persons, the country's approach to custodial healthcare bears disproportionately on the overall project of achieving Universal Health Coverage domestically, since a population this large cannot be meaningfully excluded from national health metrics without materially distorting the country's progress toward the underlying Sustainable Development Goal.

3. INTERNATIONAL INSTRUMENTS PROTECTING PRISONERS' RIGHT TO HEALTHCARE

International human rights law firmly establishes the right to healthcare of prisoners and undertrials, and states bear a non-derogable duty to uphold the human rights of persons deprived of liberty through procedures provided by law.[7] These international standards have substantially influenced constitutional interpretation and prisoners' rights jurisprudence in India, functioning less as directly enforceable domestic law and more as an interpretive resource the judiciary has repeatedly invoked when reading the content of Article 21 in the custodial context. The International Covenant on Civil and Political Rights, to

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4 Filipa Alves da Costa et al., The WHO Prison Health Framework: A Framework for Assessment of Prison Health System Performance, Eur. J. Pub. Health 565 (2022).

5 Id.

6 Abhishek Rath, Mortality Trends in Indian Prisons and Its Associated Risk Factors, Indian J. Cmty. Med. 49 (2024).

7 Universal Declaration of Human Rights art. 1, G.A. Res. 217 (III) A (Dec. 10, 1948).

which India is a signatory and state party, requires under Article 10(1) that all persons deprived of liberty be treated with humanity and respect for inherent human dignity.[8] The Human Rights Committee has clarified that this duty encompasses timely medical attention and protection against health risks arising from detention itself.[9] The United Nations Standard Minimum Rules for the Treatment of Prisoners, commonly known as the Nelson Mandela Rules, direct that the level of healthcare accessible to prisoners should be equivalent to that available to the community at large, with particular emphasis on qualified medical professionals, effective medical services, mental healthcare, preventive treatment and emergency intervention; the Rules further provide that the absence of required medical treatment amounts to cruel, degrading and inhuman treatment.[10] These provisions matter beyond their persuasive doctrinal value because they establish a concrete benchmark, the "principle of equivalence" between custodial and community healthcare, against which India's own statutory and administrative framework, reviewed in Part 4, can be directly measured.

The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment similarly treats the withholding of serious medical care as an affront to human dignity, and although India is not a state party to this Convention, its provisions carry persuasive weight in interpreting the Indian Constitution.[11] The United Nations Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment further recognises a right to medical examination and treatment when needed, and the World Health Organization has emphasised that safeguarding prisoner health is a necessary element of public health more broadly, since neglect within custodial settings carries consequences extending well beyond the prison itself.[12] Read together, these instruments converge on three recurring themes that the remainder of this paper uses as an analytical benchmark: equivalence between custodial and community healthcare standards, the non-derogability of the underlying duty regardless of the reason for detention, and the recognition that custodial health neglect generates externalities for public health at large. Notwithstanding India's engagement with these international instruments, the

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8 International Covenant on Civil and Political Rights art. 10(1), Dec. 16, 1966, 999 U.N.T.S. 171.

9 Human Rights Committee, General Comment No. 21: Humane Treatment of Persons Deprived of Their Liberty, ¶ 3, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (1992).

10 U.N. Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), G.A. Res. 70/175, rr. 24-35, 43 (Dec. 17, 2015).

11 Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. 16, Dec. 10, 1984, 1465 U.N.T.S. 85.

12 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment princ. 24, G.A. Res. 43/173 (Dec. 9, 1988); World Health Org., Prisons and Health 3-5 (2014).

gap between their normative content and the ground reality of Indian prisons remains stark, a gap the following sections examine in detail.

4. NATIONAL LEGAL FRAMEWORK GOVERNING PRISONERS' AND UNDERTRIALS' HEALTHCARE RIGHTS

4.1 Constitutional Provisions

Article 21 of the Constitution guarantees the right to life and personal liberty and has been expansively interpreted by the judiciary to include the right to health and medical care.[13] The Supreme Court has consistently held that the State's duty to protect life extends with particular force to persons in custody, who are entirely dependent on prison administration for their healthcare needs, and that deprivation of liberty does not authorise the State to deprive prisoners of their right to live with dignity, which necessarily includes access to adequate medical treatment.[14] This constitutional foundation is significant precisely because it does not depend on any specific statutory enactment; it operates as an independent, judicially enforceable guarantee that survives regardless of the adequacy or inadequacy of the statutory schemes discussed below, supplying the baseline against which every subordinate statute and administrative instrument governing prison healthcare must ultimately be tested. The Directive Principles of State Policy reinforce this responsibility: Article 39(e) directs the State to safeguard the health and strength of workers, Article 41 requires support for persons facing sickness or disability, and Article 47 casts a broader duty on the State to improve public health; although these provisions are not directly enforceable, they inform judicial interpretation of fundamental rights and the formation of prison healthcare policy.[15]

4.2 Bharatiya Nagarik Suraksha Sanhita, 2023

The Bharatiya Nagarik Suraksha Sanhita, which replaced the Code of Criminal Procedure, 1973, contains provisions protecting the health of detained persons and undertrials at the point of arrest. Section 43 requires that an arrested individual undergo medical examination shortly after arrest to detect injuries or health conditions at an early stage, while Section 54 grants the arrested individual the option to request examination by a registered medical practitioner, functioning as a safeguard against custodial abuse.[16] Section 183 permits investigating authorities to direct medical examination of an accused where necessary for investigation, subject to the requirement that it be

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13 The Constitution of India, 1950, art. 21.

14 State of Punjab v. Mohinder Singh Chawla, (1997) 2 S.C.C. 83 (India); Sunil Batra v. Delhi Administration, (1978) 4 S.C.C. 494 (India).

15 The Constitution of India, 1950, arts. 39(e), 41, 47; Bandhua Mukti Morcha v. Union of India, (1984) 3 S.C.C. 161 (India).

16 The Bharatiya Nagarik Suraksha Sanhita, No. 46 of 2023, §§ 43, 54 (India).

conducted lawfully and humanely.[17] These provisions demonstrate that the law recognises the importance of medical care in custody, but the Sanhita's focus on the pre-trial and investigation stage means it does not comprehensively address the ongoing healthcare needs of prisoners across long periods of incarceration, particularly in overcrowded facilities. The structural limitation here is temporal rather than substantive: the Sanhita's healthcare provisions are triggered by the act of arrest itself and are largely exhausted once the initial examination has occurred, leaving the entire subsequent period of pre-trial or post-conviction custody, often extending for years given the undertrial detention patterns discussed in Part 7, without a comparable statutory healthcare mandate.

4.3 Prisons Act, 1894

The Prisons Act, 1894, a colonial-era statute, remains the principal legislation governing prisoner administration in India despite its evident obsolescence. Sections 37 to 39 address the appointment of medical officers, the operation of prison hospitals, and the treatment of sick prisoners.[18] The Act, however, reflects a colonial emphasis on discipline over rehabilitation or healthcare rights, and it establishes no clear standards for mental healthcare, preventive care, or accountability for medical neglect. Because this outdated framework remains the operative statute, healthcare provision in prisons varies widely across states, and in the absence of a modern, rights-based law, medical care remains largely discretionary and uneven. The persistence of an 1894 statute as the operative legal framework for prison healthcare a century and a quarter after its enactment is itself a telling indicator of the broader legislative neglect this paper documents: successive governments have amended, replaced or supplemented virtually every other major branch of Indian criminal law in the period since independence, from the enactment of the Bharatiya Nagarik Suraksha Sanhita discussed above to the wholesale replacement of the Indian Penal Code, yet the Prisons Act has never received comparable legislative attention notwithstanding repeated judicial criticism of its inadequacy.

4.4 Model Prison Manual, 2016

The Model Prison Manual, issued by the Ministry of Home Affairs in 2016, recommends regular medical check-ups, mental health assessment, referral to outside hospitals, and special care for vulnerable prisoners including undertrials, and it acknowledges mental illness as a serious concern warranting integrated psychiatric services.[19] The Manual, however, is purely advisory and

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17 The Bharatiya Nagarik Suraksha Sanhita, No. 46 of 2023, § 183 (India).

18 The Prisons Act, No. 9 of 1894, §§ 37-39 (India).

19 Ministry of Home Affairs, Model Prison Manual 2016, ch. VII (India).

carries no binding force; its adoption varies substantially across states, limiting its capacity to secure uniform healthcare standards.[20]

4.5 Mental Healthcare Act, 2017

The Mental Healthcare Act represents a significant advance from aspirational policy toward rights-based statutory norms. Section 103 provides that a person with mental illness who is in custody is entitled to treatment in government medical institutions and other mental healthcare facilities, and the Act further embeds dignity and non-discrimination through its requirement of informed consent.[21] Notwithstanding this statutory architecture, implementing infrastructure remains rudimentary: a chronic shortage of psychiatrists and allied professionals means regular screening rarely occurs in practice, and no structured rehabilitation or reformative procedure has emerged to fill the space the statutes and rules leave open.[22] Taken together, the legislative landscape governing prison healthcare is fragmented, outdated and weakly enforced: the Sanhita addresses healthcare only at the point of arrest and investigation, the Prisons Act reflects nineteenth-century priorities rather than contemporary health standards, and the absence of a well-defined, enforceable healthcare law constitutes a critical gap that judicial intervention alone cannot close.

5. JUDICIAL DECISIONS UPHOLDING HEALTHCARE RIGHTS OF PRISONERS AND UNDERTRIALS

The Indian judiciary has been instrumental in both identifying and, where legislation has fallen short, substantively implementing the healthcare rights of prisoners and undertrials through expansive interpretation of Article 21. In Sunil Batra v. Delhi Administration, the Supreme Court established that a prisoner does not lose fundamental rights upon incarceration, and that prison officials must operate within constitutional limits and treat inmates humanely, a holding that laid the doctrinal foundation for treating healthcare as an integral component of prisoners' Article 21 rights.[23] In Parmanand Katara v. Union of India, decided outside the prison context but subsequently applied repeatedly to custodial situations, the Court held that the right to life encompasses a right to emergency medical treatment that cannot be postponed for procedural formality, prioritising the preservation of human life above administrative process.[24] In Hussainara Khatoon v. State of Bihar, the Court confronted the

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20 Id. 7.07-7.12.

21 The Mental Healthcare Act, No. 10 of 2017, § 103 (India).

22 Commonwealth Human Rights Initiative, Barred and Beyond: Mental Health and India's Prisons (2020).

23 Sunil Batra v. Delhi Administration, (1978) 4 S.C.C. 494 (India).

24 Parmanand Katara v. Union of India, (1989) 4 S.C.C. 286 (India).

reality of undertrials languishing in jail for years under inhuman conditions, holding that prolonged detention without trial offends Article 21 and reminding the State of its obligation to preserve dignity and wellbeing even where the case's primary focus was the right to a speedy trial.[25] In State of Punjab v. Mohinder Singh Chawla, the Court confirmed that the right to health falls squarely within Article 21, holding that refusal to treat a person in need of medical assistance is equivalent to a violation of the right to life, a principle subsequently applied to affirm that prisoners, being entirely within State control, cannot be denied medical treatment.[26]

A significant institutional shift followed in Re-Inhuman Conditions in 1382 Prisons, in which the Supreme Court took suo motu notice of deplorable prison conditions nationally, addressing overcrowding, doctor shortages, inadequate medical facilities and neglect of mental health, and directing states to enhance medical facilities and provide regular check-ups, a decision that publicly acknowledged prison healthcare in India as suffering a systemic breakdown rather than isolated failures.[27] This shift from adjudicating individual grievances to supervising systemic conditions nationally mirrors a pattern visible elsewhere in Indian public interest litigation, in which the Supreme Court, confronted with evidence that individual case-by-case remedies were failing to produce durable change, assumed a continuing supervisory jurisdiction over an entire institutional sector, a jurisdiction the Court has exercised only intermittently in the prison healthcare context and with limited durable effect, as the persistence of the underlying conditions documented in Part 7 demonstrates. The question of custodial deaths and medical neglect was addressed in In Re: Death of Prisoners, where the Court held that the State cannot avoid constitutional liability, including compensation, where the absence of timely medical assistance results in death in custody.[28] High Courts have supplemented this jurisprudence: the Delhi High Court in Court on Its Own Motion v. State emphasised that jail authorities must ensure inmates receive immediate medical assistance, and the Bombay High Court has similarly held that withholding medical care from prisoners violates Article 21 and warrants judicial intervention.[29]

These decisions leave little doubt that prison healthcare is a matter of constitutional entitlement rather than administrative discretion; yet the recurrence of substantially similar litigation over decades, from Sunil Batra in 1978 through In Re: Death of Prisoners in 2020, demonstrates that prison

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25 Hussainara Khatoon (I) v. State of Bihar, (1980) 1 S.C.C. 81 (India).

26 State of Punjab v. Mohinder Singh Chawla, (1997) 2 S.C.C. 83 (India).

27 Re-Inhuman Conditions in 1382 Prisons, (2016) 3 S.C.C. 700 (India).

28 In Re: Death of Prisoners, (2020) 3 S.C.C. 145 (India).

29 Court on Its Own Motion v. State, 2014 SCC OnLine Del 1449 (India); Prafull Goradia v. State of Maharashtra, 2016 SCC OnLine Bom 8719 (India).

authorities continue to fall short of these standards, suggesting that structural legislative reform, rather than continued case-by-case judicial correction, is now required. The pattern across this body of case law is itself instructive: each decision responds to a specific, often egregious set of facts, a death in custody, a documented instance of neglect, a suo motu inquiry prompted by media reporting, rather than to a systemic audit of prison healthcare conducted independently of litigation. This reactive posture, however doctrinally sound, cannot by itself guarantee that the standards articulated in one case are consistently applied across India's more than one thousand prison facilities, a structural limitation that only comprehensive legislation of the kind proposed in Part 7 can meaningfully address.

6. COMPARATIVE PERSPECTIVE

A comparative review of other jurisdictions shows that several countries have developed clearer statutory frameworks governing prisoner healthcare than India presently possesses. In the United States, the Eighth Amendment's prohibition on cruel and unusual punishment has been interpreted by the Supreme Court in Estelle v. Gamble to render "deliberate indifference" to a prisoner's serious medical needs a constitutional violation, a standard triggered whenever the state neglects urgent medical intervention and enforced through direct state accountability.[30] The deliberate-indifference standard is narrower in one respect than the approach Indian courts have taken under Article 21, since it requires a showing of the custodial authority's subjective awareness of the medical need and a conscious disregard of it, rather than the more open-ended dignity-based reasoning of Sunil Batra and its progeny; yet it compensates for this narrower liability standard with considerably more extensive federal civil rights litigation infrastructure through which prisoners can vindicate the right, including damages actions under federal civil rights statutes that supply a remedy Indian prisoners largely lack outside the constitutional compensation jurisprudence discussed in Part 5.

In the United Kingdom, the National Health Service Act, 1948 extends comprehensive healthcare coverage to the general public, including prisoners, reducing the fragmentation that characterises the Indian framework and preserving medical professionals' clinical autonomy; the scheme is funded through general taxation and national insurance contributions and provides free care irrespective of nationality.[31] The British model's principal advantage over the Indian framework lies in institutional integration: because prison healthcare in England and Wales is commissioned and delivered through the same

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30 Estelle v. Gamble, 429 U.S. 97 (1976).

31 Nat'l Health Serv., Healthcare in Prisons Programme (UK); Jake Phillips, Delivering Healthcare in UK Prisons: Challenges and Opportunities, 59(3) Brit. J. Criminology 601 (2019).

National Health Service structure that serves the general public, rather than through a separate prison medical service answerable to correctional authorities, continuity of care persists across the transition into and out of custody in a manner the Indian system, structured around jail-specific medical officers with no integration into the wider public health system, does not replicate. Norway offers a still more integrated model, applying the "principle of equivalence," under which prison inmates are treated as equal to the general population for healthcare purposes, with prisoner healthcare placed under the jurisdiction of the Ministry of Health rather than prison administration, insulating medical decision-making from custodial authority.[32] The Norwegian approach is instructive precisely because it removes the structural conflict of interest inherent in a model, such as India's, where the same institution responsible for security and discipline within a prison is also responsible for assessing and meeting the medical needs of the persons it confines, a conflict that recurs throughout the case law reviewed in Part 5 in the form of delayed referrals, under-reported symptoms, and administrative resistance to costly external treatment.

India's approach, by contrast, remains almost entirely judicially constructed, resting on the courts' expansive interpretation of Article 21 rather than on any comparably robust statutory architecture; while Indian courts have consistently upheld the principle of prisoner healthcare, the resulting right remains an abstract constitutional guarantee whose enforcement depends on litigation rather than a settled institutional framework of the kind the American, British and Norwegian models each supply in different ways. None of these three comparators is presented here as directly transplantable; each reflects institutional and fiscal conditions, a comprehensive national health service in the British case, a well-resourced federal civil rights litigation infrastructure in the American case, and a small, well-funded welfare state in the Norwegian case, that India's own reform trajectory would need to adapt rather than import wholesale. What the comparison does demonstrate is that a range of institutional architectures, from litigation-driven constitutional accountability to fully integrated national health service delivery, can in principle deliver the "principle of equivalence" the Nelson Mandela Rules articulate, and that India's presently fragmented, jail-specific medical administration represents neither the litigation-intensive nor the integrated-service end of this spectrum, but rather an underdeveloped position that borrows the constitutional rhetoric of the American model without either its litigation infrastructure or the institutional integration the British and Norwegian models supply.

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32 Merete Berg Nesset et al., Healthcare Help-Seeking Behavior Among Prisoners in Norway, 11 BMC Health Servs. Rsch. (2011).

7. REFORMS NEEDED TO STRENGTHEN HEALTHCARE RIGHTS OF PRISONERS AND UNDERTRIALS

Despite constitutional guarantees, statutory provisions and sustained judicial intervention, healthcare in Indian prisons continues to suffer structural and systemic deficiencies. Empirical data confirm the severity of the problem: National Crime Records Bureau data show Indian prisons consistently operating above 115 per cent occupancy, with undertrials constituting nearly three-quarters of the total prison population, and the India Justice Report 2025 records that 176 jails operate at over 200 per cent occupancy, twelve prisons at over 400 per cent, and only 68 per cent of the prison population has access to adequate sleeping space.[33] These figures are not merely descriptive background; they establish the operational constraints within which any prison healthcare reform must function, since overcrowding of this magnitude directly undermines even a well-designed statutory healthcare mandate by overwhelming whatever medical infrastructure and personnel a given facility possesses. Eight reforms follow from this analysis.

First, Parliament should enact comprehensive prison healthcare legislation to replace the fragmented and obsolete framework presently in force; a modern statute should define minimum healthcare standards, mandate periodic health screening, ensure continuity of care, prescribe accountability mechanisms for medical negligence, address mental health specifically, and align with international standards such as the Nelson Mandela Rules, treating healthcare as a legal entitlement of prisoners rather than an administrative privilege.[34] Such legislation would supply exactly the institutional anchor the comparative review in Part 6 shows India presently lacks, converting the currently litigation-dependent constitutional guarantee into a directly enforceable statutory entitlement with defined standards against which compliance could be measured independently of individual case litigation.

Second, the existing safeguards under the Bharatiya Nagarik Suraksha Sanhita require stronger implementation: police personnel should be sensitised and held accountable for compliance with the medical examination provisions in Sections 43 and 54, which presently suffer from arbitrary and inconsistent enforcement.[35] Third, overcrowding and prolonged undertrial detention, which the India Justice Report 2025 projects will push the prison population to 6.8 lakh inmates by 2030, must be addressed through faithful implementation of the principle that bail is the rule and jail the exception, and through consistent

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33 Nat'l Crime Records Bureau, Prison Statistics India 2022, ch. 2 (Ministry of Home Affairs 2023); India Justice Report 2025.

34 The Prisons Act, No. 9 of 1894 (India); U.N. Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), G.A. Res. 70/175 (Dec. 17, 2015).

35 The Bharatiya Nagarik Suraksha Sanhita, No. 46 of 2023, §§ 43, 54 (India).

application of the guidelines on undertrial detention laid down in Hussainara Khatoon.[36] Addressing overcrowding is, on the analysis presented throughout this paper, not merely a criminal justice reform adjacent to healthcare policy but a precondition for the success of any healthcare-specific reform, since no plausible increase in medical staffing or infrastructure can keep pace with a prison population continuing to grow at the rate current projections indicate.

Fourth, mental healthcare services require substantial integration: a 2021 NIMHANS study found that between twenty-three and eighty-two per cent of prisoners across various state prisons suffered some form of mental illness during the period from 2011 to 2014, and despite the Mental Healthcare Act's statutory framework, the shortage of qualified mental health professionals in prisons remains acute, warranting regular mental health camps and an adequately staffed, professionally qualified cadre of prison mental health personnel.[37] Fifth, prison medical officers should be granted autonomous administrative status independent of jail authorities, following the Norwegian model of placing prison health services under the Ministry of Health rather than correctional administration, since subordination to jail authorities has historically diminished both the objectivity and accountability of prison medical practice.[38] Sixth, sustained training and sensitisation of police personnel, jail authorities and medical staff on medical ethics and prisoners' rights should accompany a broader shift from a punitive to a rehabilitative institutional culture.[39] Seventh, courts should institutionalise periodic medical review for undertrials, requiring mandatory medical reports in cases of prolonged detention, factoring continued incarceration's health impact into bail determinations, and giving particular attention to elderly, disabled and chronically ill prisoners, aligning procedural justice with substantive healthcare protection as contemplated in Hussainara Khatoon.[40] Eighth, India's domestic framework should be more closely harmonised with international standards including the Nelson Mandela Rules, with judicial application of these norms supplemented by legislative and executive action to ensure consistent implementation across states.[41] Taken together, these eight reforms address the problem at each of the levels this paper has examined, constitutional interpretation, statutory design, institutional administration and judicial

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36 Hussainara Khatoon (I) v. State of Bihar, (1980) 1 S.C.C. 81 (India); India Justice Report 2025.

37 Commonwealth Human Rights Initiative, Barred and Beyond: Mental Health and India's Prisons (2020).

38 Merete Berg Nesset et al., Healthcare Help-Seeking Behavior Among Prisoners in Norway, 11 BMC Health Servs. Rsch. (2011).

39 Sunil Batra v. Delhi Administration, (1978) 4 S.C.C. 494 (India).

40 Hussainara Khatoon (I) v. State of Bihar, (1980) 1 S.C.C. 81 (India).

41 U.N. Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), G.A. Res. 70/175 (Dec. 17, 2015).

enforcement, reflecting the conclusion that no single intervention, however well designed, can substitute for coordinated action across all four.

8. CONCLUSION

The human right to health of inmates and undertrials in India is deeply entrenched in constitutional text, statutory provision and the human rights norms the judiciary has consistently upheld. The Supreme Court's rulings make clear that imprisonment does not extinguish basic rights, and that the State's responsibility toward persons in its custody is heightened rather than diminished by their loss of liberty. Nevertheless, overcrowded prisons, inadequate medical infrastructure, an insufficient supply of qualified medical personnel, and weak accountability mechanisms continue to undermine these constitutional assurances in practice. Healthcare in prison is not merely an administrative concern but a matter of constitutional morality: a democratic society committed to human dignity cannot treat suffering, untreated illness or preventable death as an ordinary incident of incarceration. Improving prison healthcare will require new legislation, genuine administrative capacity, continued judicial oversight, and a wider societal recognition that prisoners and undertrials remain rights-bearing persons notwithstanding their custodial status; conversely, continued negligence in prison healthcare administration steadily erodes the legitimacy of the constitutional order itself.

The comparative analysis in Part 6 makes clear that India need not invent an entirely novel institutional model to close this gap; each of the three comparator jurisdictions offers a distinct, workable template, litigation-driven constitutional accountability, integrated national health service delivery, or ministry-based clinical independence, any of which India's own reform trajectory could adapt to its constitutional and administrative circumstances. What the analysis in this paper demonstrates most clearly, however, is that India's present position combines the weaknesses rather than the strengths of these available models: a constitutional guarantee robust in judicial rhetoric but dependent on sporadic litigation for enforcement, a statutory framework fragmented across an obsolete colonial statute and narrowly targeted contemporary provisions, and an administrative structure that subordinates medical judgment to custodial authority rather than insulating it. Universal Health Coverage, as a global development goal, cannot be meaningfully achieved while a substantial and disproportionately disadvantaged segment of the population, the incarcerated, remains excluded in practice from the healthcare guarantees the Constitution promises them. Realising India's commitment to this Sustainable Development Goal therefore requires treating prison healthcare reform not as a peripheral administrative matter but as a central test of the State's constitutional commitment to dignity, equality and the rule of law.

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