Right to Health as a Fundamental Right in India: Legal Framework, Judicial Interpretation and Policy Challenges

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Abstract—**This paper examines the evolution of the right to health in India's legal system, situating it within constitutional law, judicial interpretation, and policy developments. Although the Indian Constitution does not expressly confer a fundamental right to health, Article 21's guarantee of life and liberty has been expansively interpreted to include health and medical care. Directive Principles such as Article 47 ('Duty of the State to improve public health') and Articles 39(e) and 42 further underline the State's obligation towards citizens' health. Landmark Supreme Court cases — from Rakesh Chandra Narayan v. State of Bihar (1988) and Paschim Banga Khet Mazdoor Samity v. State of WB (1996) to Consumer Education & Research Centre v. UOI (1995) — have read Article 21 to embrace healthcare, mandating emergency medical services and safe working conditions. Recent judgments, notably Sukdeb Saha v. State of Andhra Pradesh (2025), have explicitly declared mental health a fundamental right under Article 21. On the policy front, frameworks like the National Health Policy (2017) and insurance schemes (e.g., Ayushman Bharat) seek to advance universal coverage. Nevertheless, implementation lags: high out-of-pocket spending (~47% of health costs) and low public health investment hinder realization of health rights. This paper reviews literature and case law, analyses the constitutional basis and state duties, evaluates judicial mandates and health policies, and identifies persisting challenges. It concludes that recognizing health within constitutional life-rights is necessary but not sufficient: enforceable legislation, adequate resources, and accountability mechanisms are needed to translate 'rights on paper' into living realities.**

Keywords—**Right to Health; Article 21; Directive Principles; Fundamental Rights; Judicial Interpretation; Health Policy; Universal Health Coverage**

I. Introduction

Health is a cornerstone of human dignity and well-being. Globally, documents like the Universal Declaration of Human Rights (Article 25) and the International Covenant on Economic, Social and Cultural Rights (Article 12) recognize the right to health as essential. In India, however, the Constitution does not explicitly list 'health' as a fundamental right. Instead, healthcare is addressed in non-justiciable Directive Principles of State Policy (DPSPs), notably Article 47 (public health), Article 39(e) (workers' health), and Article 42 (humane work conditions). The fundamental guarantee of Article 21 — the right to life and personal liberty — has thus become the vehicle for health rights. Over four decades, the Supreme Court of India has expanded Article 21, holding that its protection of 'life' includes not mere animal existence but 'life with dignity.' This has opened the door for a 'right to health' jurisprudence under Article 21, albeit judicially created rather than constitutionally enumerated.

Yet, a tension remains between broad judicial pronouncements and practical enforcement. The Constitution's framers deliberately placed health in DPSPs as goals rather than enforceable rights. Until very

recently, India lacked a comprehensive legal right to health akin to some countries. In practice, millions of Indians face inadequate public health facilities and high out-of-pocket costs, despite courts recognizing health entitlements. This raises critical questions: What is the extent of India's 'right to health' today? How have courts interpreted the Constitution on this issue? What policies exist and how effective are they? This paper addresses these questions by outlining the legal framework (constitutional and statutory), reviewing key judgments and literature, and discussing policy measures and challenges. The analysis situates India's path in international context and suggests reforms to bridge the gap between 'rights on paper' and citizens' lived experience.

II. Review of Literature

Scholars and health advocates have long debated India's right to health. Early work noted the absence of an express constitutional right, urging reliance on Article 21. Legal commentators observe that Article 21 must be read in harmony with international norms: India has ratified treaties like ICESCR, and courts have cited Article 25 UDHR and Article 12 ICESCR to enlarge Article 21's meaning. Mathiharan (IJME) emphasizes that the Supreme Court repeatedly held health as intrinsic to life with dignity, deriving from DPSPs. At the same time, international reviews remark that India is among many nations that recognize health rights only via judicial interpretation or policy rather than explicit constitutional text.

Parmar and Wahi (Harvard, 2011) chronicled litigation of health rights in India, noting both bold judgments and implementation gaps. More recent analyses note a 'dualistic' approach: the courts have generated an expanding catalogue of socio-economic rights (health, water, environment), but these often remain unenforced due to resource constraints. The East Asia Forum review (2020) argues India needs explicit health rights legislation to make judicial remedies viable. Empirical public health literature highlights India's structural challenges: low public spending, high out-of-pocket payments (~47% of total health expenditure in 2019–20), and inequitable access. Studies on mental health policy have pointed out that despite schemes and a mental health law, India has only ~0.8 psychiatrists per 100,000 people and less than 1% of health budget for mental healthcare.

Others critique that although draft 'Health Acts' have been proposed, constitutional reform remains elusive, leaving health obligations vulnerable to political will. In sum, the literature paints a picture of aspirational legal recognition of health rights, countered by pragmatic obstacles, thus framing the need to analyze both doctrinal law and policy implementation. This paper builds on these analyses by systematically reviewing constitutional sources, case law, and policy to assess where India stands on health rights.

III. Research Methodology

This study employs a doctrinal legal research methodology combined with policy analysis. Primary sources include the Indian Constitution, major Supreme Court judgments, statutory texts (such as public health laws and policies), and government reports. We examined cases and statutes via legal databases (Indiankanoon, judis.nic.in, and law reports). Secondary sources include scholarly articles, government policy documents (e.g., National Health Policy 2017), WHO/World Bank data, and news analyses. Key Supreme Court cases were identified through legal search. We supplemented legal research with reviews of health sector analyses to capture policy context. Citations are drawn from authoritative sources: constitutional provisions from official texts, case law from judgments or reputable digests, and policy details from official publications or international organizations. This combined doctrinal and empirical approach ensures coverage of legal principles as well as real-world health system indicators.

IV. Constitutional and International Framework

The Indian Constitution, while not explicitly guaranteeing a right to health, embeds health-related duties in both Fundamental Rights and Directive Principles. The most pivotal provision is Article 21, which guarantees 'protection of life and personal liberty' to all persons. The Supreme Court has held that Article 21 safeguards the right to life with dignity, going beyond mere survival. In multiple judgments, the Court interpreted this dignity as embracing health. A leading medical ethics analysis notes: 'Article 21 guarantees protection of life... The Supreme Court has held that the right to live with human dignity… includes protection of health.' The Court has applied Article 21 to require states to provide timely medical treatment.

Directive Principles reinforce health obligations. Article 47 directs: 'The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.' Article 39(e) specifically mandates measures to protect 'the health and strength of workers, men and women, and the tender age of children from abuse.' Article 42 obliges provision of just and humane work conditions and maternity relief. Courts have often cited these DPSPs to interpret Article 21. For example, in Consumer Education Centre, the Court cited Articles 38, 39(e), 42 and others to underline a constitutional scheme favoring health and welfare.

On the international plane, India is a signatory to ICESCR (Article 12 recognizes health) and has enacted the Protection of Human Rights Act 1993 recognizing international human rights norms. The Supreme Court has stated that Article 21 must be read in consonance with international covenants. Thus, while no express right to health exists, the combined constitutional scheme — the sweeping language of Article 21 and supportive directives — provides a potent foundation for a legal right to health, as courts have repeatedly affirmed.

V. Judicial Interpretation and Key Case Law

Over decades, India's courts have gradually expanded health-related rights through case law. One of the early significant interventions came in Rakesh Chandra Narayan v. State of Bihar (1989) 3 SCC 485, where the Supreme Court addressed the inhuman conditions prevailing in a mental asylum in Ranchi. The Court treated the matter as one involving violation of Article 21 and held that the State, as a welfare entity, has a constitutional obligation to provide adequate medical care to those under its custody. The judgment emphasized that failure to maintain humane conditions in mental health institutions amounted to a violation of the right to live with dignity under Article 21.

The landmark decision in Paschim Banga Khet Mazdoor Samity v. State of West Bengal (1996) 4 SCC 37 is widely regarded as a foundational authority on the right to emergency medical care. The Court held that denial of timely treatment violates Article 21 and affirmed the State's obligation to provide adequate medical facilities irrespective of financial constraints. The Court directed State governments to ensure effective emergency medical services and hospitals, making it clear that healthcare deficiencies violate Article 21.

In Consumer Education & Research Centre v. Union of India (1995) 3 SCC 42, the Supreme Court addressed occupational health hazards faced by workers exposed to asbestos and explicitly held that the right to health and medical care is a fundamental right under Article 21. The Court read Directive Principles into enforceable rights, strengthening workplace health protections. It imposed duties on industries and interpreted Article 21 to cover workplace health and preventive measures. This case explicitly linked Article 21 to occupational health, echoing DPSPs on workers.

The position was reaffirmed in State of Punjab v. Mohinder Singh Chawla (1997) 2 SCC 83, where the Supreme Court held that the right to health is integral to the right to life and imposed constitutional obligations upon the State to provide healthcare facilities. Earlier public interest litigations such as Bandhua Mukti Morcha v. Union of India (1984) 3 SCC 161 contributed indirectly to health jurisprudence by recognizing humane working conditions and protection of health as part of dignified life. Similarly, in Vincent Panikurlangara v. Union of India (1987) 2 SCC 165, the Court acknowledged that improvement of public health is a constitutional obligation flowing from Article 21 read with Article 47.

In Parmanand Katara v. Union of India (1989) 4 SCC 286, the Court emphasized that preservation of human life is paramount and imposed a duty upon all doctors, whether in government or private hospitals, to provide immediate emergency medical aid. This duty-based ruling effectively creates a right for patients to receive emergency treatment. Together, these decisions weave a doctrinal principle that the expression life assured in Art. 21 has a much wider meaning which includes hygienic conditions in the workplace and extends to health care and preservation of life.

More recently, the Court expanded health jurisprudence to include privacy, dignity, and autonomy in medical contexts. In Common Cause v. Union of India (2018) 5 SCC 1, the Constitution Bench recognized dignity in death and patient autonomy as elements of Article 21, influencing medical consent and end-of-life care. In a significant contemporary development, the Supreme Court in Sukdeb Saha v. State of Andhra Pradesh (2025) explicitly recognized mental health as an integral component of the right to life under

Article 21 and directed institutions to implement structured mental health support mechanisms. The Court issued mandatory guidelines for schools to address student mental wellbeing, including mandating counsellors and anti-bullying policies. By explicitly elevating mental health to constitutional status, the Court reinforced that health includes psychological well-being, not just physical survival.

In sum, judicial interpretation in India has progressively recognized health as part of the fundamental right to life. Courts have cited both constitutional text and external law (ICESCR, WHO provisions) to justify this expansion. However, judgments typically stop short of prescribing specific entitlements, leaving follow-up action to the executive. Nonetheless, these case laws create a legal framework where denial of basic healthcare services can be challenged as a violation of Article 21.

VI. Policy and Legislative Frameworks

Alongside the judiciary, the legislature and executive have laid out policy commitments toward health, albeit largely as aspirational or programmatic goals rather than enforceable rights. The National Health Policy (NHP) 2017 is the principal guiding document. It declares as its goal 'the attainment of the highest possible level of health and well-being for all at all ages… through universal access to good quality health care services without anyone having to face financial hardship.' NHP 2017 emphasizes preventive care, primary health, and equity. It sets quantitative targets and calls for raising public health expenditure. Notably, NHP 2017 aligns with Sustainable Development Goals and envisions health as a priority but stops short of any legal guarantee.

The Government has also launched large-scale schemes aimed at expanding coverage. Ayushman Bharat, introduced in 2018, is a flagship universal health coverage program. It has two pillars: (a) Pradhan Mantri Jan Arogya Yojana (PMJAY), a health insurance scheme providing up to ₹500,000 per family per year for secondary/tertiary care, initially covering approximately 550 million poor and vulnerable people; and (b) Health and Wellness Centres upgrading primary care infrastructure. According to the WHO, PMJAY is the world's largest government-funded health assurance scheme. It has expanded over time, including in 2024 to cover additional elderly populations. While these programs significantly extend benefits, they function as welfare schemes rather than constitutional rights.

At the state level, some legislative efforts are noteworthy. Assam's Public Health Act (2010) takes a broad view: Section 3(2) requires the health ministry to coordinate with other departments to ensure access to nutrition, safe water, sanitation, and housing, recognizing that social determinants are vital to public health. In 2023, Rajasthan enacted India's first 'Right to Health Act' after extensive advocacy. The Act explicitly lists patient rights (dignity, informed consent, non-discrimination) and mandates emergency care without upfront payment. It provides for grievance redressal and accountability bodies. However, even this state law has faced implementation delays and political controversy.

Other statutes address fragments of health rights. The Clinical Establishments Act (2010) mandates registration and standardization of hospitals, and state-specific laws include provisions like reserving beds for poor patients. The Mental Healthcare Act (2017) explicitly articulates a 'right to access mental healthcare,' requiring affordable, quality, geographically accessible, non-discriminatory services. It adopts the WHO's AAAQ framework (Availability, Accessibility, Acceptability, Quality) and protects patients' rights. These laws demonstrate legislative recognition of health entitlements, but enforcement often hinges on policy and budgetary support.

In summary, India's policy framework is replete with declarations and programs aimed at universal health. Yet, none of these confer a constitutional fundamental right. Rather, they create conditional or policy commitments. Scholars argue that without transforming these into enforceable law — as was done for education via Article 21A and the RTE Act 2009 — the promise of health rights remains aspirational.

VII. Contemporary Challenges and Gaps

Despite constitutional assurances and policy efforts, significant challenges persist. Healthcare delivery in India is fragmented and under-resourced. Public health expenditure is low (hovering at approximately 1–1.5% of GDP against a 2.5% target), and infrastructure gaps are stark: rural areas often lack basic facilities, resulting in long travel for treatment or reliance on underqualified providers. Meanwhile, private out-of-pocket expenditure remains high: a systematic review finds OOP was about 47% of total health spending in

2019–20. This means many Indian households face catastrophic medical costs, undermining health equity and the ideal of healthcare as a right.

The COVID-19 pandemic exposed and exacerbated these fault lines. Prior to COVID, tragedies like the 2017 Gorakhpur encephalitis outbreak (60+ children died due to oxygen shortage) and the Muzaffarpur incident (2019) showed deadly system failures. During the pandemic, public hospitals were overwhelmed, and vaccine rollouts revealed inequalities. The High Courts in multiple states took suo-motu cognizance of pandemic mismanagement, ordering the government to ensure oxygen and beds. These judicial interventions reaffirm health's centrality under Article 21 but also highlight how courts fill policy gaps by mandamus.

Social determinants further complicate health rights: malnutrition, unsafe drinking water, poor sanitation, and housing (especially for the urban poor) lead to preventable diseases, yet systematic redress is limited. Health disparities by caste, region, and gender persist. Implementation of rights is also procedural. Even where the Supreme Court has recognized a health right (e.g. emergency care), citizens face hurdles in invoking them. There is no dedicated 'right to health' act at the national level; thus remedies must be sought via PILs under Articles 32/226. Without legislative backing or budget, even progressive judgments can remain largely aspirational.

Mental health, though recently recognized by the Court as part of life-right, exemplifies the gap between law and reality. India's Mental Healthcare Act (2017) promises comprehensive care, but in practice there are only an estimated 0.75 psychiatrists per 100,000 population (far below WHO's recommendation of 3 per 100,000) and mental health spending is under 1% of the total health budget. Rural and poor populations have virtually no access to counselors or treatments. In summary, the contemporary challenge is a classic rights vs. resources dilemma. Unless the State not only 'recognizes' but also finances and structures health services, constitutional proclamations alone will not guarantee health outcomes.

VIII. Conclusion

The legal landscape in India today acknowledges health as integral to life and dignity. Through expansive interpretations of Article 21, the Supreme Court of India has consistently held that adequate medical care, a clean environment, and safe working conditions fall within the scope of the right to life. Policy initiatives such as the National Health Policy, 2017 and flagship programs like Ayushman Bharat reflect a political commitment toward achieving universal health coverage. Legislative measures including the Mental Healthcare Act, 2017 and the Rajasthan Right to Health Act further demonstrate that rights-based health frameworks are institutionally feasible within India's constitutional structure.

Despite these advancements, the recognition of health as a fundamental right remains predominantly judge-made and normative in character. There is no explicit constitutional amendment or comprehensive central legislation guaranteeing a justiciable right to health across the country. Structural deficiencies, financial constraints, and administrative gaps continue to hinder effective realization. As scholarly critiques observe, without corresponding legislative backing and adequate budgetary allocation, the broad judicial interpretation of Article 21 risks remaining aspirational rather than transformative.

Thus, while India possesses a strong constitutional and jurisprudential foundation for the right to health, the central challenge lies in translating doctrinal recognition into universal, enforceable, and accessible healthcare delivery. The promise of health as a human right is constitutionally visible and normatively affirmed, but its material realization requires sustained structural reform.

IX. Suggestions

To bridge the gap between constitutional recognition and practical implementation, several reforms are necessary.

1. Enact a Comprehensive National Right to Health Act

India should consider enacting a comprehensive national Right to Health Act, drawing inspiration from the Rajasthan model, or alternatively, introducing a constitutional amendment explicitly incorporating health within the catalogue of fundamental rights. Such legislation must clearly define enforceable entitlements, including emergency medical care, preventive healthcare, maternal and child health services,

and non-discriminatory access. It should also establish institutional enforcement mechanisms such as independent health commissions, grievance redressal authorities, and clearly defined judicial remedies. The evolution of the Right to Education Act, 2009 from judicial pronouncements to a codified right under Article 21A offers a valuable legislative precedent.

2. Substantially Increase Public Health Expenditure

Public health expenditure must be substantially increased. Achieving the National Health Policy target of allocating 2.5% of GDP to healthcare is imperative. Enhanced funding should prioritize strengthening primary healthcare infrastructure, expanding rural health services, improving hospital capacity, ensuring availability of essential medicines, and addressing workforce shortages through structured training and recruitment of healthcare professionals.

3. Institutionalize Accountability Mechanisms

Accountability mechanisms must be institutionalized. Judicially recognized health rights — particularly in emergency care jurisprudence — require administrative compliance within fixed timelines. State-level health authorities, similar to those envisaged under the Rajasthan framework, could be empowered to audit institutions, adjudicate grievances, and impose sanctions for non-compliance. Civil society participation and oversight by human rights bodies would further reinforce transparency and rights enforcement.

4. Adopt a Multisectoral Approach

A multisectoral approach must be adopted. The right to health extends beyond clinical services to determinants such as nutrition, sanitation, potable water, housing, and occupational safety. Legislative models such as the Assam Public Health Act demonstrate the necessity of integrating environmental and social determinants into public health governance. A holistic national framework must therefore address structural conditions that directly impact population health.

5. Ensure Continuous Reform and Adaptive Governance

Ultimately, the transformation of the right to health from a judicial doctrine into a lived constitutional reality requires coordinated legislative action, administrative commitment, financial investment, and societal awareness. If effectively implemented, such reforms would not only strengthen constitutional governance but also advance substantive equality and dignity for all citizens, thereby actualizing the vision of health justice in India. Regulatory frameworks must remain flexible and adaptive, with periodic statutory review and international harmonization efforts essential to prevent gaps in health rights protection.

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