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The jurisprudential evolution of health law in India: Interfacing constitutional mandates, regulatory frameworks, and ethical imperatives

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Abstract
The legal landscape governing public health in India has undergone a profound transformation, evolving from colonial-era administrative management to a sophisticated, rights-based constitutional discourse. While the Indian Constitution does not explicitly enumerate the right to health as a fundamental right, the judiciary has, through an expansive and purposive interpretation of Article 21, elevated it to a cornerstone of a dignified life. This doctrinal research article explores the intricate intersection of constitutional mandates, statutory regulations, and medical ethics in India. It provides an exhaustive analysis of the transition from the Medical Council of India (MCI) to the National Medical Commission (NMC), the rights-based shift in mental healthcare evidenced by the 2025 Sukdeb Saha guidelines, and the emergent challenges of data privacy in the digital health era. By scrutinizing landmark judicial pronouncements, including Paschim Banga Khet Mazdoor Samity, Jacob Mathew, Puttaswamy, Common Cause, and Parmanand Katara, the article delineates the positive obligations of the state and the professional duties of medical practitioners. Furthermore, it addresses persistent gaps between normative constitutional promises and structural inequalities, such as the 2025 CBI investigations into regulatory corruption. The article concludes by proposing a centralized Public Health Emergency Management Act (PHEMA) to reconcile commercial interests with the sanctity of human life.

Keywords: Health Law, Article 21, Medical Ethics, Passive Euthanasia, Informational Privacy, National Medical Commission, Judicial Activism, Public Health Regulation, Sukdeb Saha v State of Andhra Pradesh, Jacob Mathew

Introduction

The Genesis of Health Rights in Independent India

The evolution of health law in India is intrinsically linked to the nation's identity as a welfare state, a vision articulated by the Constituent Assembly following the harrowing experiences of colonialism and partition. In the early years of the Republic, Independent India approached the public as the right holder and the state as the duty-bound primary provider of health for all [1]. This ethos was not merely a policy choice but a moral imperative rooted in the Preamble's promise of social justice and a socialistic pattern of society [1]. However, the initial constitutional design reflected a cautious approach toward economic and social rights. The framers, cognizant of the fledgling nation's limited resources, placed health-related obligations primarily within the Directive Principles of State Policy (DPSP) in Part IV of the Constitution [1]. These directives, while fundamental to the governance of the country, were explicitly made non-justiciable under Article 37, meaning they could not be enforced by the courts [1].

This bifurcated structure created a paradox: while the state was constitutionally urged to improve public health and raise the standard of living, citizens lacked a direct legal mechanism to demand these services as a matter of right. Over the subsequent seven decades, the Indian judiciary has bridged this divide through what legal scholars describe as "judicial creativity" or "transformative constitutionalism." By reading the non-justiciable Directive Principles into the enforceable Fundamental Rights, particularly the right to life and personal liberty under Article 21, the Supreme Court of India has fundamentally altered the legal character of healthcare [2]. Today, health is viewed not merely as the absence of disease, as defined by the World Health Organization, but as a state of complete physical, mental, and social well-being that is essential for the exercise of all other human rights [6].

A closer examination of the current health law landscape reveals unprecedented pressures. The shift from a state-led health model to a market-driven, insurance-based medical-industrial complex has introduced complex ethical and regulatory challenges. Catastrophic healthcare costs have become a primary driver of impoverishment in India, with almost 75 percent of health expenditure coming from out-of-pocket household funds. The emergence of digital healthcare and the lessons of the COVID-19 pandemic have further underscored the inadequacy of colonial-era statutes, such as the Epidemic Diseases Act of 1897, necessitating a robust, modern legal framework that can balance public health security with individual privacy and autonomy [8].

Literature Review: From Directive Principles to Justiciable Rights

The scholarly discourse on health law in India is dominated by the tension between constitutional aspiration and structural reality. Academic researchers frequently highlight the shift from a negative rights framework, where the state is merely restricted from interference, to a positive obligations framework, where the state is duty-bound to provide the infrastructure necessary for a dignified life.[4] This transition is anchored in the belief that a life devoid of health and nourishment cannot be aligned with the constitutional vision of human dignity [10].

Scholars emphasize that the right to health is an inclusive right, extending beyond clinical medical care to the underlying determinants of health, such as safe water, sanitation, nutrition, and environmental protection [7]. The International Covenant on Economic, Social and Cultural Rights (ICESCR), specifically Article 12, provides the most

comprehensive international baseline, recognizing the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" [12]. Indian courts have consistently utilized these international instruments to expand domestic jurisprudence, arguing that international law should be read into domestic law in the absence of conflicting statutes [12].

However, recent literature has become increasingly critical of symbolic constitutionalism [4]. Critics argue that the Supreme Court's expansion of Article 21 to include rights like mental health, pedestrian safety, and clean air risks collapsing the distinction between enforceable rights and long-term policy commitments [4]. This dual constitutionalism often results in rights that are equal in theory but unequal in practice, where access to life-saving treatment depends more on financial capacity and political networks than on constitutional guarantees [4]. The failure of the state to implement the Clinical Establishments Act of 2010 effectively across all states is often cited as a prime example of the implementation gap that plagues Indian health law [19].

From a doctrinal perspective, the literature also identifies a regulatory ecosystem that remains fragmented. Scholars note that India lacks a unified regulatory architecture comparable to centralized models in the United Kingdom or Australia, leading to bureaucratic inertia and limited digital interoperability [20]. This fragmentation is further complicated by the fact that health is primarily a state subject under the Seventh Schedule of the Constitution, which creates significant disparities in how central laws like the Clinical Establishments Act are adopted and enforced [13].

The Constitutional Framework of Health Rights

The constitutional foundation of health law in India is a triadic structure comprising the Preamble, Fundamental Rights (Part III), and Directive Principles (Part IV). This framework ensures that health is not viewed in isolation but as an integral component of social justice.

1. The Preamble and the Welfare State

The Preamble sets the stage by striving to provide a welfare state with socialistic patterns of society. The commitment to social, economic, and political justice necessitates that the state takes active measures to eliminate health inequities. In a welfare state, the primary duty of the government is to secure the welfare of the people, which includes providing adequate medical facilities. The judiciary has held that this obligation is not an act of charity but a discharge of a sacrosanct constitutional duty [1].

2. Article 21: The Jurisprudence of Life and Dignity

Article 21, which states that "no person shall be deprived of his life or personal liberty except according to procedure established by law," serves as the fountainhead of health rights in India. The Supreme Court has repeatedly observed that "life" in this context is not a mere animal existence but a life consistent with human dignity and decency. Through a series of judicial precedents, the Court has logically extended the interpretation of Article 21 to include specific entitlements such as the right to emergency medical aid, the right to reproductive autonomy, and the protection of sensitive health data.

The Indian judiciary has progressively interpreted Article 21 to encompass a multifaceted right to health that imposes significant positive obligations on the state. Within the realm of emergency care, the preservation of human life is considered paramount, placing every medical professional under an absolute duty to provide immediate aid regardless of administrative or police formalities. This structural accountability extends to the broader provision of medical facilities, where the state is mandated to maintain adequate infrastructure and is strictly prohibited from using a lack of financial resources as a valid defense for the denial of essential treatment. Reproductive health has similarly been established as a facet of personal liberty, ensuring that women possess the right to access medical facilities and the autonomy to make reproductive choices as an integral component of their human dignity. In a transformative recent shift, mental health has been elevated from a mere policy goal to a constitutional guarantee, providing citizens and students with an enforceable entitlement to psychologically safe environments. Furthermore, the constitutional right to privacy now explicitly protects the confidentiality of health records and informational integrity, safeguarding individuals from unauthorized interference by both state and private actors. Finally, the jurisprudence of dignity has been extended to end of life decisions, validating the use of Advance Directives to allow terminally ill patients to refuse life sustaining treatment and ensure a dignified death.

3. Directive Principles: The Source of State Obligations

The Directive Principles provide the substantive content for the right to health. Article 47 explicitly imposes a duty on the state to raise the level of nutrition and the standard of living of its people, identifying the improvement of public health as being among its primary duties [1]. Other relevant directives include Article 38 (promoting social welfare), Article 39(e) (protecting the health and strength of workers), Article 41 (public assistance in sickness and disability), and Article 42 (just and humane conditions of work and maternity relief). The triadic relationship ensures that while Article 21 provides the remedy, the Directive Principles provide the vision [1].

The Regulatory and Legislative Framework

India's health regulatory framework is currently undergoing a structural overhaul intended to address systemic corruption and adapt to the challenges of the 21st century.

1. The National Medical Commission Act, 2019

The National Medical Commission (NMC) Act, 2019, represents the most significant reform in medical education and regulation since independence, repealing the Indian Medical Council Act of 1956 [24]. The defunct Medical Council of India (MCI) had become synonymous with opaque decisions, corruption in college accreditation, and a failure to enforce medical ethics [25].

The NMC was established to improve access to quality medical education and ensure the availability of adequate human resources in healthcare. It consists of 25 members, primarily nominated by the government, which represents a shift away from the self-regulatory, elected model of the MCI [24]. While the NMC aims to enhance transparency through four autonomous boards and a common National

Exit Test (NEXT), the transition has faced significant criticism [28].

From a doctrinal perspective, the shift from an elected to a nominated body raises concerns about the politicization of medical regulation and the erosion of professional autonomy [25]. Furthermore, despite the structural overhaul, systemic corruption remains a persistent threat. In June 2025, the Central Bureau of Investigation (CBI) filed a First Information Report (FIR) implicating officials from the Ministry of Health and Family Welfare and external assessors of the NMC in a network of corruption involving private medical colleges [9]. The investigation revealed unethical practices such as the solicitation of classified information and the arrangement of ghost faculty to secure accreditation, suggesting that the change from MCI to NMC has not yet successfully eradicated the rustic and corrupt structures it aimed to reform [9].

2. The Mental Healthcare Act, 2017

The Mental Healthcare Act (MHCA), 2017, marked a paradigm shift from the custodial approach of the Indian Lunacy Act (1912) and the Mental Health Act (1987) to a rights-based framework. The Act defines mental illness progressively, placing emphasis on care and treatment rather than custody [27].

One of the most revolutionary provisions of the MHCA is the decriminalization of attempted suicide. Section 115 of the Act creates a statutory presumption that any person who attempts to commit suicide is under severe stress and shall not be tried or punished under the Indian Penal Code [29]. Additionally, the Act introduces the concept of Advance Directives, allowing individuals to specify how they wish to be treated for a mental illness and who should be their nominated representative if they lose capacity. The Act also mandates the establishment of Mental Health Review Boards (MHRBs) as independent regulatory bodies to prevent coercion and safeguard patient rights [27].

3. The Clinical Establishments (Registration and Regulation) Act, 2010

The Clinical Establishments Act (CEA) was enacted to provide a national framework for the registration and regulation of all clinical establishments, both public and private, to ensure minimum standards of facilities and services [19]. However, the Act's implementation highlights the challenges of Indian federalism. Because health is a state subject (Entry 6, List II), the Central Act only applies to states that adopt it through a resolution under Article 252 [30].

As of early 2024, only about 11 states and Union Territories have formally adopted the Act, leaving much of India without standardized healthcare regulation [20]. Implementation is further hampered by weak enforcement mechanisms. Over 70 percent of district authorities reported insufficient staff and resources to conduct required inspections [20]. Furthermore, a powerful private medical lobby has successfully stalled key provisions related to price standardization and rate transparency, leading to price variations of up to 1,200 percent for identical procedures across different registered facilities [3].

4. Digital Personal Data Protection Act, 2023 (DPDPA) and the 2025 Rules

The DPDPA, 2023, is India's first comprehensive data protection law, emerging from the constitutional mandate in Puttaswamy [31]. In November 2025, the government notified the Digital Personal Data Protection Rules, 2025, fully operationalizing the Act. In the healthcare sector, doctors and hospitals are classified as data fiduciaries who must obtain informed and verifiable consent from data principals (patients) before processing digital health records. The Act imposes significant penalties for data breaches, reaching up to Rs. 250 crore for failure to implement reasonable security safeguards [31]. While necessary for privacy, the Act creates a clinical quandary: If a patient requests the erasure of their data, a doctor may be left without the records necessary to defend against future malpractice claims or to provide continuity of care [4]. For mental healthcare professionals, the implications are even more profound, as they handle highly intimate and stigmatizing data regarding stressors, sexuality, and treatment history.

Exhaustive Case Law Analysis

The jurisprudential journey of health law in India is best understood through seminal cases that have defined the obligations of the state, the duties of the doctor, and the autonomy of the patient.

1. Parmanand Katara v Union of India (1989): The Absolute Duty to Treat

In Parmanand Katara, the Supreme Court confronted the systemic failure where hospitals refused to treat accident victims until a medico-legal case (MLC) was registered by the police. The petitioner highlighted how this bureaucratic delay often led to the death of victims who could have been saved by timely intervention [6].

The Court held that the preservation of human life is of paramount importance and is a non-delegable duty of the state and the medical profession. It ruled that every doctor, whether in a government or private hospital, is under a professional obligation to extend services with due expertise to protect life [6]. The Court clarified that social laws do not contemplate death by negligence to be tantamount to legal punishment. This judgment effectively prioritized Article 21 over all procedural and statutory laws, ensuring that legal formalities cannot be used as a shield to deny emergency medical care.

2. Paschim Banga Khet Mazdoor Samity v State of West Bengal (1996): Structural Accountability

While Parmanand Katara established the duty to treat, Paschim Banga addressed the infrastructure required to fulfill that duty. The case arose when Hakim Seikh, an agricultural laborer, fell off a train and suffered severe head injuries. He was taken to six different government hospitals, all of which refused admission due to a lack of available beds or specialized facilities.

The Supreme Court ruled that the serial refusal to admit a patient in a critical condition violated Article 21. Crucially, the Court rejected the state's defense of financial constraints, holding that the constitutional obligation to provide medical care is total and absolute. The Court mandated systemic reforms, including the upgrading of Primary Health Centres and the creation of a centralized bed-management communication system. It also awarded compensation for the violation of the fundamental right, reinforcing the principle of constitutional tort [21].

3. Jacob Mathew v State of Punjab (2005): The Bolam Test and Criminal Negligence

In Jacob Mathew, the Supreme Court dealt with the sensitive issue of medical negligence and the criminal prosecution of doctors under Section 304A of the Indian Penal Code. The case involved a patient who died due to the non-availability of a functional oxygen cylinder in a hospital [34].

The Court sought to strike a balance between patient protection and the need to shield doctors from frivolous or unjust prosecution which could lead to defensive medicine [35]. Adopting the Bolam Test from English law, the Court held that a professional is not negligent merely because a better alternative treatment was available; they are only negligent if they fail to possess or exercise the skill of an ordinary competent practitioner in that field [34]. The Court established that for criminal liability, the negligence must be gross or reckless [36]. To prevent harassment, the Court mandated that no criminal complaint against a doctor should be entertained without a prima facie opinion from another competent medical professional [35].

4. Justice K.S. Puttaswamy v Union of India (2017): Informational Privacy in Health

The Puttaswamy judgment recognized privacy as a fundamental right under Article 21 [16]. The Court identified several facets of privacy relevant to healthcare, including bodily integrity and informational privacy. The judgment held that individuals have a right to control their personal information, specifically mentioning the privacy of health records. It mandated that any state intrusion into privacy must meet a three-fold test: legality (existence of a law), legitimate state aim, and proportionality. This has significant implications for the ongoing efforts to digitize health data in India through the Ayushman Bharat Digital Mission [14].

5. Common Cause v Union of India (2018): Passive Euthanasia and Living Wills

Building on the foundation of dignity in Puttaswamy, the Common Cause case addressed the right to a dignified death.[39] The Supreme Court held that the right to live with dignity under Article 21 encompasses the right to die with dignity, particularly for terminally ill patients in a persistent vegetative state (PVS).

The Court validated the use of Advance Medical Directives or Living Wills, which allow competent adults to specify that they do not wish to be kept alive by artificial means if they reach an irreversible state of suffering [40]. It distinguished between active euthanasia (illegal) and passive euthanasia (legal), which involves the withdrawal or withholding of life-sustaining treatment to allow a natural death [42]. In 2023, the Court streamlined the procedural framework for these directives, making them easier to execute and more time-sensitive.

6. Sukdeb Saha v State of Andhra Pradesh (2025): The Saha Guidelines for Mental Health

In July 2025, the Supreme Court delivered a historic ruling in Sukdeb Saha v State of Andhra Pradesh, significantly reframing the constitutional parameters of mental health. The case involved the suspicious death of a 17-year-old NEET aspirant who fell from her hostel in Visakhapatnam. The local police had prematurely classified the death as a suicide, but the Supreme Court, noting serious lapses in the investigation and medical handling, transferred the case to the CBI.

The Court elevated the right to mental health to a fundamental right under Article 21, asserting that mental well-being is integral to a dignified life. Recognizing a structural malaise in the education system, the Court issued 15 binding Saha Guidelines under Article 141 to prevent student suicides:

1. **Uniform Mental Health Policy:** All institutions must adopt policies aligned with national programs like UMMEED and MANODARPAN.

2. **Mandatory Counselors:** Institutions with over 100 students must appoint trained mental health professionals.

3. **Anti-Discrimination Measures:** Zero tolerance for ragging, bullying, or harassment based on caste, gender, or orientation.

4. **Infrastructure Safety:** Hostels must install tamper-proof ceiling fans and restrict rooftop access.

5. **Parental Engagement:** Mandatory workshops for parents to reduce academic pressure on students.

The Sukdeb Saha verdict clarifies that students are entitled to psychological safety within educational spaces, shifting the understanding of student suicides from individual tragedies to institutional injustices.

Analytical Discussion: The Intersection of Commercialization and Ethics

The transition of Indian healthcare from a public service to a profit-driven industry has created a medical-industrial complex that challenges the ethical foundations of the profession. In corporate healthcare settings, financial incentives often sway treatment decisions away from medical necessity, transforming patients into revenue sources.

1. The Ethics of Commercial Exploitation

Aggressive commercialization has led to predatory actions by under-regulated private players. Excessive billing, inflated drug prices, and the requirement for patients to buy consumables from specific hospital vendors have become commonplace. This environment erodes the trust essential to the doctor-patient relationship. Furthermore, ethics regulation by the NMC has faced scrutiny. In 2023, the NMC notified regulations mandating the prescription of generic drugs and prohibiting pharma sponsorships for conferences, but these were kept in abeyance following severe backlash from the medical community. In July 2025, the NMC issued new guidelines to regulate live surgery broadcasts, addressing concerns that patients were being used as models for commercial gain during medical conferences.

2. Digital Health and the Privacy Paradox

The rise of telemedicine and digital health, accelerated by the COVID-19 pandemic, offers the potential to increase access to care in a country where the urban-rural doctor ratio is 3.8:1 [28]. However, this virtual nature of care raises

critical questions regarding informed consent and data privacy. In a country without universal healthcare, the lack of adequate data protection could lead to employment discrimination or insurance denials based on shared health data. While the DPDP Rules 2025 establish a digital Data Protection Board, the high cost of compliance may further marginalize small rural clinics, inadvertently widening the health equity gap [31].

3. Symbolic Constitutionalism vs. Structural Inequality

A recurring theme in the analysis of Article 21 is the implementation gap. While the Supreme Court is celebrated for its generosity in expanding rights, governments rarely face consequences for failing to provide the infrastructure these rights presuppose [4]. This produces a form of paper promise constitutionalism: a student has a right to mental health support, yet remains in peril due to a psychiatrist-to-population ratio of less than 1 per 100,000. As long as survival depends on wealth and networks, a universal right to health remains a class-contingent privilege.

Challenges and Structural Gaps

Despite the robust judicial framework, several systemic challenges remain entrenched in the Indian healthcare landscape.

1. **Workforce Crisis:** India faces a severe scarcity of qualified health workers, with over 40 percent of sanctioned male health worker posts remaining vacant in rural areas.

2. **Regulatory Capture:** The powerful private medical lobby has successfully stalled key provisions of the Clinical Establishments Act, particularly those related to price standardization [30].

3. **Fragmented Public Health Laws:** India lacks a unified national public health act, relying instead on a patchwork of state laws and pandemic-specific amendments [42].

4. **Inequality in Access:** Survival remains contingent on financial capacity. During the pandemic, resource-rich individuals secured oxygen while the poor faced collapsing public systems, making Article 21 rhetoric for the poor while protecting the privileged.

Reform Proposals and Policy Recommendations

To reconcile the disparities between doctrine and practice, a series of legislative and structural reforms are essential.

1. The Public Health Emergency Management Act (PHEMA)

An expert group of NITI Aayog has recommended the enactment of PHEMA to replace the colonial Epidemic Diseases Act of 1897.

- **Unified Coordination:** PHEMA would establish an Empowered Group of Secretaries (EGoS) chaired by the Cabinet Secretary to coordinate national health security responses.

- **100-Day Response Plan:** It provides a blueprint for rapid response to outbreaks, focusing on tracking, testing, and managing threats within the first 100 days.

- **Health Cadre:** It proposes the creation of national and state health cadres to empower agencies with specialized personnel.

2. Ethical and Structural Standardization

- **Patients' Bill of Rights**: Enforcing a legally binding Bill of Rights, as proposed in recent 2025 and 2026 Private Members Bills, would empower patients to demand transparency and informed consent.

- **National Medical University**: Establishing a National Medical University to organize all postgraduate institutes could eliminate variable standards of certification and residency training [25].

- **Price Regulation**: Implementing notified ranges of rates under the Clinical Establishments Rules is non-negotiable for protecting citizens from price gouging [30].

Conclusion

The jurisprudential journey of health law in India reveals a persistent paradox: rights expand in doctrine but fracture in practice. While the judiciary has been generous in interpreting Article 21 to cover mental health, emergency care, and the right to a dignified death, these rights remain fragile paper promises without commensurate state investment and regulatory accountability. The transition from the MCI to the NMC and the rights-based approach of the Mental Healthcare Act represent significant milestones, yet systemic corruption and the implementation staircase continue to obstruct progress. The future of Indian health law lies in the integration of technological innovation with ethical accountability, ensuring that the socialistic pattern of society promised in the Preamble is realized through a robust, equitable, and transparent healthcare system that honors the dignity of every individual. Unless the state assumes its constitutional responsibility to make these rights real, the right to life risks remaining a rhetorical flourish rather than a lived reality for the majority of the population.

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