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FROM DIRECTIVE ASPIRATION TO STATUTORY ENTITLEMENT: INTERROGATING THE ENFORCEABILITY OF THE RIGHT TO HEALTH IN INDIA'S COMMERCIALISED MEDICAL MATRIX

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Abstract

Over four decades the Supreme Court of India has read a right to health into the guarantee of life in Article 21 of the Constitution, converting what the framers had placed among the non-justiciable Directive Principles of State Policy into an enforceable fundamental right. Yet the institutional reality against which this right operates is one of chronic public underinvestment: government health expenditure has hovered around one and a half per cent of gross domestic product, households still bear roughly two-fifths of health spending out of pocket, and the private sector delivers the bulk of hospital care. This article examines the friction that arises when the State seeks to discharge its constitutional obligation through statutes that compel private providers to deliver care, most visibly in mandates to provide emergency treatment without prepayment. Using doctrinal constitutional analysis of the leading precedents alongside the Clinical Establishments (Registration and Regulation) Act 2010, the Rajasthan Right to Health Care Act 2023 and the Digital Personal Data Protection Act 2023, it argues that a mandate to provide free emergency treatment which is not accompanied by an automatic and time-bound State reimbursement mechanism operates as an unfunded mandate that fails the proportionality analysis governing restrictions on the freedom of trade and profession under Article 19(1)(g). The article further contends that uniform executive rate-fixing risks arbitrariness under Article 14, and that the digitisation of health records has outpaced the development of sector-specific data protection. It concludes that judicial expansion of Article 21 has reached its structural limit and proposes a National Emergency Healthcare Reimbursement Fund and an independent Healthcare Tariff Regulatory Authority.

Keywords: right to health; Article 21; Article 19(1)(g); emergency medical care; unfunded mandate; proportionality; Clinical Establishments Act; Rajasthan Right to Health Care Act; health data protection

I. Introduction

Indian health law sits at the intersection of a constitutional paradox. The Supreme Court has repeatedly expanded the right to life in Article 21 to encompass a right to health and to medical care, and has described the preservation of human life as the paramount obligation of the State.¹ Yet health care in India is delivered overwhelmingly through a privatised, fragmented and commercially driven system. According to the National Health Accounts for 2022–23, government health expenditure stood at about 1.48 per cent of gross domestic product, government spending accounted for roughly 43.7 per cent of total health expenditure, and out-of-pocket expenditure by households still accounted for about 43.4 per cent.² The National Health Policy 2017 had aspired to raise public health spending to 2.5 per cent of gross domestic product by 2025, a target that has not been met.³ The constitutional right to health is therefore declared in a system in which the State is neither the principal financier nor the principal provider of care.

This paradox has its roots in a deliberate drafting choice. The Constituent Assembly placed the improvement of public health among the Directive Principles of State Policy in Article 47, alongside the duty to raise the level of nutrition and the standard of living, rather than among the justiciable fundamental rights in Part III. Article 37 declares that these principles are not enforceable by any court, although they are fundamental in the governance of the country. B R Ambedkar explained to the Assembly that the Directive Principles were in the nature of an instrument of instructions to future governments, whose realisation would depend on the resources available to the State.⁴ The placement of health in Part IV thus reflected a sober assessment of fiscal constraint in a newly independent and impoverished nation.

The Supreme Court did not accept that legislative silence should be the end of the matter. Beginning with the recognition in *Francis Coralie Mullin* that the right to life includes the right to live with human dignity and the bare necessities of life,⁵ the Court in *Bandhua Mukti Morcha* read the Directive Principles in Articles 39, 41 and 42 into Article 21 to protect the health of bonded labourers,⁶ and in *Consumer Education and Research Centre* declared that the right to health and medical care is a fundamental right under Article 21 read with Articles 39(e), 41

¹*Paschim Banga Khet Mazdoor Samity v State of West Bengal* (1996) 4 SCC 37.

²National Health Systems Resource Centre, *National Health Accounts Estimates for India 2022–23* (Ministry of Health and Family Welfare 2025).

³Ministry of Health and Family Welfare, *National Health Policy 2017* (Government of India 2017) para 2.4.1.

⁴Constituent Assembly Debates, vol 7 (19 November 1948) (B R Ambedkar).

⁵*Francis Coralie Mullin v Administrator, Union Territory of Delhi* (1981) 1 SCC 608.

⁶*Bandhua Mukti Morcha v Union of India* (1984) 3 SCC 161.

and 43.⁷ Through this process of judicial re-engineering, the Directive Principle in Article 47 acquired a justiciable counterpart in Part III.

The fault line of contemporary health law, however, lies elsewhere. The early cases sought accountability from the State as a provider of care, in its own hospitals and through its own budgets. The more recent and more difficult question concerns how far the State may regulate, and conscript, a private health care industry that delivers most hospital treatment in the country. That question has surfaced in mandates requiring private hospitals to provide free emergency care, in conditions requiring hospitals built on concessional public land to treat poor patients free of charge, in efforts to standardise the rates charged by clinical establishments, and in the construction of a national digital health infrastructure that depends on private providers to generate and share data.

This article addresses two principal research questions. First, does a legislative mandate compelling private hospitals to provide emergency treatment free of charge violate Article 19(1)(g) in the absence of a statutory guarantee of compensation? Secondly, can the right to health be genuinely secured without a binding but rational national framework for standardising the prices of health care? It argues that the answer to the first question is in the affirmative, because placing the primary financial liability for emergency stabilisation on private capital without an automatic reimbursement mechanism fails the necessity and balancing stages of the proportionality test. As to the second, it argues that price regulation is constitutionally permissible but that a uniform executive rate schedule imposed across radically different clinical settings is vulnerable to challenge under Article 14, and that an independent, technically competent tariff regulator offers a better route. Part II traces the jurisprudential evolution of the duty to provide emergency care. Part III examines the Rajasthan Right to Health Care Act 2023 and develops the argument concerning unfunded mandates. Part IV considers the regulation of prices under the Clinical Establishments Act 2010. Part V turns to the digital health infrastructure and the protection of patient data, and Part VI concludes with recommendations.

II. The Jurisprudential Evolution of Emergency Care

A. The Foundation of the Emergency Duty

The modern law on emergency care begins with *Parmanand Katara v Union of India*. The petition arose from a newspaper report that an injured scooterist had been turned away by

⁷*Consumer Education and Research Centre v Union of India* (1995) 3 SCC 42.

a hospital and directed to another that was authorised to handle medico-legal cases, dying before he could be treated. The Supreme Court held that every doctor, whether at a government hospital or otherwise, has a professional obligation to extend medical aid with due expertise to protect life, and that no law or procedural requirement can intervene to delay the discharge of that paramount obligation.⁸ The Court emphasised that the procedural formalities of criminal law, such as waiting for the police in medico-legal cases, could not justify a delay in treating an injured person, and that the preservation of life was of paramount importance.

Two features of *Parmanand Katara* deserve emphasis. First, the duty it articulated was framed principally as a professional and ethical obligation of the individual doctor, grounded in the code of medical ethics as much as in Article 21. Secondly, the judgment said nothing about who should bear the cost of treatment. Its concern was with the timing of care, not its financing. The decision was a powerful statement against procedural obstruction, but it did not purport to transfer to private providers the fiscal responsibility for emergency treatment.

That question of financing came to the fore in *Paschim Banga Khet Mazdoor Samity v State of West Bengal*. Hakim Sheikh, an agricultural labourer who suffered serious head injuries after falling from a train, was turned away by a succession of government hospitals in Calcutta on the ground that beds or facilities were unavailable, and eventually obtained treatment at a private hospital at his own expense. The Supreme Court held that the failure of government hospitals to provide timely medical treatment to a person in need of it violated his right to life under Article 21, awarded compensation, and declared that the State could not avoid its constitutional obligation on account of financial constraints.⁹ Drawing on the recommendations of an expert committee, it directed the State to ensure that primary health centres were equipped to provide immediate stabilisation, to upgrade facilities at district and sub-divisional hospitals, to establish a centralised system for communicating the availability of beds, and to ensure proper arrangements for transporting patients.

Paschim Banga is the high-water mark of the judicially created right to emergency care, but its addressee was the State. The judgment recognised that the provision of adequate medical facilities involves financial resources, and that the Court could not ignore that aspect, but held that whatever is necessary for this purpose has to be done.¹⁰ The duty it enforced was a duty on the State to organise and finance a public system capable of responding to emergencies. It did not hold that the State could discharge that obligation by directing private hospitals to treat

⁸*Pt Parmanand Katara v Union of India* (1989) 4 SCC 286.

⁹*Paschim Banga* (n 1).

¹⁰*Ibid.*

patients free of charge.

The Court's later jurisprudence confirmed that the State's duty is real but bounded by its resources. In *State of Punjab v Mohinder Singh Chawla* the Court held that the right to health is integral to the right to life and that the government has a constitutional obligation to provide health facilities, including reimbursement of the cost of treatment to its employees.¹¹ Yet in *State of Punjab v Ram Lubhaya Bagga* it upheld a revised reimbursement policy that limited the rates payable for treatment in private hospitals, holding that no State has unlimited resources and that the State may legitimately balance its finances when framing health policy.¹² The juxtaposition of these decisions is significant. If the Court accepts that the State's own obligation is qualified by fiscal capacity, it is difficult to see on what principle the State may impose an unqualified and uncompensated obligation on private providers.

B. The Shift to the Private Sphere

The extension of constitutional duties to private hospitals proceeded cautiously and, until recently, through a particular doctrinal route: the conditions attached to public largesse. In the 1990s and 2000s many private hospitals in Delhi were allotted land by public authorities at concessional rates on the condition that they would provide a proportion of free treatment to poor patients. When it became apparent that these conditions were widely ignored, the Delhi High Court in *Social Jurist v Government of NCT of Delhi* directed such hospitals to reserve 10 per cent of their in-patient beds and 25 per cent of their out-patient services for free treatment of patients from economically weaker sections.¹³ In *Union of India v Moolchand Khairati Ram Trust* the Supreme Court upheld the condition, reasoning that hospitals that had obtained land at a fraction of its market value could not repudiate the charitable and public purpose on which the allotment had been made.¹⁴ Compliance has nonetheless remained poor: in May 2026 the Court recorded that only four of the fifty-one hospitals to which contempt notices had been issued were complying, and directed the Delhi government to frame a standard operating procedure for enforcement.¹⁵

The logic of *Moolchand* is contractual and quid pro quo. The obligation of free treatment is the price of a public subsidy voluntarily accepted. That logic offers a constitutionally secure

¹¹*State of Punjab v Mohinder Singh Chawla* (1997) 2 SCC 83.

¹²*State of Punjab v Ram Lubhaya Bagga* (1998) 4 SCC 117.

¹³*Social Jurist v Government of NCT of Delhi* 140 (2007) DLT 698 (DB).

¹⁴*Union of India v Moolchand Khairati Ram Trust* (2018) 8 SCC 321.

¹⁵'Supreme Court Directs Delhi Govt to Frame SOP to Enforce Free EWS Treatment in Delhi Private Hospitals' (*LiveLaw*, 20 May 2026).

basis for imposing free treatment obligations on some private hospitals, but it is not a general warrant for conscripting every private establishment. Legislatures have nevertheless begun to move beyond the subsidy rationale. Section 397 of the Bharatiya Nagarik Suraksha Sanhita 2023, re-enacting section 357C of the Code of Criminal Procedure 1973, requires all hospitals, public or private, to provide first aid or medical treatment free of cost to victims of acid attacks and sexual offences.¹⁶ Section 134 of the Motor Vehicles Act 1988 imposes a duty on those in charge of a vehicle involved in an accident to secure medical attention for the injured, and the 2019 amendment added a scheme for cashless treatment during the golden hour.¹⁷ It is against this background that the Rajasthan legislature enacted the first State statute that expressly codifies a general right to health, including a right to emergency treatment in private establishments.

III. The Statutory Battleground: The Rajasthan Right to Health Care Act 2023 and Unfunded Mandates

A. A Legislative First

The Rajasthan Right to Health Care Act 2023 was passed by the State Legislative Assembly on 21 March 2023 and received the Governor's assent on 12 April 2023.¹⁸ It is the first Indian statute to confer on every resident of a State a set of enforceable rights in relation to health care. These include the right to free out-patient and in-patient services at public health institutions, the right to information about one's diagnosis and the expected cost of treatment, the right to confidentiality and informed consent, the right to choose the source of medicines and diagnostic tests, and the right to emergency treatment. The Act imposes corresponding obligations on the State, including the obligation to make budgetary provision for the fulfilment of these rights, and establishes State and District Health Authorities to formulate protocols, monitor implementation and redress grievances.

From the perspective of constitutional theory, the Act represents a welcome shift from judicial to legislative articulation of the right to health. Much of the criticism of judicially created social rights in India has centred on the inability of courts to make polycentric budgetary choices and to supervise implementation over time.¹⁹ A statute enacted by an elected legislature, which defines the content of the right, allocates responsibilities and creates

¹⁶Bharatiya Nagarik Suraksha Sanhita 2023, s 397; Code of Criminal Procedure 1973, s 357C.

¹⁷Motor Vehicles Act 1988, ss 2(12A), 134, 162 (as amended by the Motor Vehicles (Amendment) Act 2019).

¹⁸Rajasthan Right to Health Care Act 2023 (Rajasthan Act 8 of 2023).

¹⁹Varun Gauri and Daniel M Brinks (eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (CUP 2008).

institutions for grievance redressal, answers many of these objections. The difficulty lies not in the decision to legislate but in the design of one particular obligation.

B. The Emergency Clause Controversy

The most contentious provision is the guarantee in section 3 that every resident is entitled to emergency treatment and care, without prepayment of fees or charges, at public health institutions and at designated private health care establishments, in cases including accidental emergencies, snake or animal bites, and obstetric emergencies. The provision requires such establishments to provide emergency stabilisation and, where necessary, to transfer the patient. The enacted text contemplates that where the patient does not pay after receiving emergency care, the provider will be entitled to receive the requisite fee or appropriate reimbursement from the State Government, but leaves the manner of reimbursement to be prescribed by rules.²⁰

The private medical profession responded with a sustained strike in March and April 2023. Its objections were that emergency was inadequately defined, that the obligation extended to establishments that were not equipped to manage the relevant emergencies, and above all that there was no assurance of when, at what rate and through what procedure reimbursement would be made.²¹ The strike ended with an agreement under which the State undertook to confine the obligations to private medical college hospitals, hospitals established under public-private partnerships, and hospitals that had received land or buildings from the government at concessional rates, while excluding hospitals with fewer than fifty beds and private hospitals established without public assistance.²² In substance, the political settlement retreated to the subsidy rationale of *Moolchand*. Rights that remain dependent on unframed rules, and an emergency guarantee that now excludes the great majority of private establishments, illustrate how a declaration of entitlement can stall when the financing question is left unanswered.

C. The Unfunded Mandate Doctrine

1. The Article 19(1)(g) challenge

Article 19(1)(g) guarantees to all citizens the right to practise any profession or to carry on any occupation, trade or business, subject under Article 19(6) to reasonable restrictions imposed by law in the interests of the general public. The practice of medicine and the running

²⁰Rajasthan Right to Health Care Act 2023 (n 18) s 3.

²¹'Rajasthan's Right to Health Care Act: Promises and Pitfalls' (*The Leaflet*, 2023) <<https://theleaflet.in/rajasthans-right-to-health-care-act-promises-and-pitfalls/>> accessed 7 October 2026.

²²*Ibid*.

of a hospital are plainly within the protected sphere. In *TMA Pai Foundation*, the Supreme Court held that the establishment and administration of educational institutions is an occupation protected by Article 19(1)(g), and that while such institutions may not engage in profiteering, they are entitled to a reasonable surplus and may not be compelled to subsidise the State's welfare objectives at their own cost.²³ In *PA Inamdar*, the Court held that the State could not appropriate seats in unaided institutions or impose its reservation policy on them, since doing so amounted to nationalisation of seats without compensation.²⁴ Although these cases concerned education, their reasoning, that the State may regulate a private service in the public interest but may not shift its own welfare obligations onto private actors without compensation, applies with equal force to health care, which the Court has recognised as a service rendered for consideration and subject to consumer law.²⁵

The most instructive analogy is *Society for Unaided Private Schools of Rajasthan v Union of India*, in which the Court upheld section 12(1)(c) of the Right of Children to Free and Compulsory Education Act 2009, requiring unaided private schools to admit children from disadvantaged groups to a quarter of their entry-level seats.²⁶ A decisive feature of the scheme was section 12(2), under which the State is obliged to reimburse the school at the lower of its per-child expenditure in its own schools and the fee actually charged.²⁷ The obligation was therefore not a confiscation of private resources but a regulated public procurement of school places. The contrast with an emergency treatment mandate whose financing is left to future rules is striking.

It is true that a court will ordinarily be slow to invalidate a welfare measure merely because its financial machinery is incomplete. The standard response would be that the statute contemplates reimbursement and that its absence is a matter of implementation, not validity. But the constitutional question is not whether the statute uses the word reimbursement; it is whether the restriction it imposes on the Article 19(1)(g) right is proportionate. Where the legislature imposes an immediate, enforceable and penalised obligation to treat while leaving the corresponding obligation to pay to the discretion of the executive, the effect on the provider is the same as if there were no reimbursement at all.

A further and more radical argument might draw on Article 23, which prohibits forced labour. In *People's Union for Democratic Rights v Union of India*, the Court held that labour

²³*TMA Pai Foundation v State of Karnataka* (2002) 8 SCC 481.

²⁴*PA Inamdar v State of Maharashtra* (2005) 6 SCC 537.

²⁵*Indian Medical Association v VP Shantha* (1995) 6 SCC 651.

²⁶*Society for Unaided Private Schools of Rajasthan v Union of India* (2012) 6 SCC 1.

²⁷Right of Children to Free and Compulsory Education Act 2009, s 12(1)(c), (2).

or service provided for less than the minimum wage is forced labour within the meaning of Article 23.²⁸ Since emergency mandates fall on establishments rather than individual practitioners, who remain salaried, this argument is weaker than the Article 19 challenge, but it underlines the constitutional discomfort of compelling uncompensated service.

2. Applying the proportionality test

Since *Modern Dental College* and the nine-judge Bench in *Puttaswamy*, restrictions on fundamental rights in India have been assessed through a structured proportionality analysis.^{29,30} The measure must pursue a legitimate aim, be rationally connected to that aim, be necessary in the sense that no less restrictive but equally effective alternative is available, and strike a proper balance between the importance of the aim and the extent of the intrusion into the right. In *Anuradha Bhasin* the Court reaffirmed that the necessity stage requires the State to consider less restrictive measures.³¹

An emergency treatment mandate easily satisfies the first two stages. Ensuring that no person dies or suffers permanent harm because of an inability to pay at the point of emergency is a pressing public interest, closely tied to Article 21, and requiring the nearest equipped hospital to stabilise the patient is rationally connected to it. The difficulty arises at the necessity stage. There is an obvious, less restrictive alternative that is equally effective in securing the aim: an obligation to treat accompanied by an automatic, rule-based and time-bound reimbursement from public funds. Such an alternative achieves the same protection for the patient while removing the confiscatory element of the mandate. Its feasibility is demonstrated by the State's own practice. Rajasthan already reimburses empanelled private hospitals under its publicly funded insurance scheme, and in May 2025 the Union notified a national scheme under section 162 of the Motor Vehicles Act 1988 entitling road accident victims to cashless treatment of up to one and a half lakh rupees for seven days at designated hospitals, with stabilisation at other hospitals and payment to hospitals through the National Health Authority.³² Where a funded alternative of this kind exists and is administratively workable, a mandate that omits it cannot be regarded as the least restrictive means.

The balancing stage reinforces this conclusion. The burden of an unfunded emergency mandate does not fall evenly. Large corporate hospitals can absorb or cross-subsidise the cost,

²⁸*People's Union for Democratic Rights v Union of India* (1982) 3 SCC 235.

²⁹*Modern Dental College and Research Centre v State of Madhya Pradesh* (2016) 7 SCC 353.

³⁰*Justice KS Puttaswamy (Retd) v Union of India* (2017) 10 SCC 1.

³¹*Anuradha Bhasin v Union of India* (2020) 3 SCC 637.

³²Cashless Treatment of Road Accident Victims Scheme 2025, notified by the Ministry of Road Transport and Highways under the Motor Vehicles Act 1988, s 162 (5 May 2025); 'Govt Notifies Cashless Treatment Scheme for Road Accident Victims Nationwide' *The Week* (New Delhi, 6 May 2025).

while smaller nursing homes, which are often the only facilities in rural and semi-urban areas, may be pushed towards insolvency or towards declining to hold themselves out as equipped for emergencies. The likely consequence is a contraction of emergency capacity in precisely the places where it is most needed, which undermines the very aim the statute pursues. The disproportionate burden is aggravated by the absence of a definition of emergency, the lack of rate schedules, and the exposure of providers to penalties and grievance proceedings for failure to treat.

Comparative experience supports this analysis. The United States Emergency Medical Treatment and Active Labor Act requires hospitals participating in Medicare to screen and stabilise any person who presents with an emergency medical condition, regardless of ability to pay.³³ It is widely regarded as the paradigm unfunded mandate in health care, and the resulting burden of uncompensated care has been documented as a significant cause of the closure of emergency departments.³⁴ Yet even EMTALA operates as a condition of participation in a federally funded insurance programme, so that its burden is offset, at least in part, by public revenue. An Indian mandate that is detached from any public payment system is more vulnerable still.

The conclusion is not that the State may never require private hospitals to treat emergencies, nor that private providers have a right to profit from every patient. The *Parmanand Katara* duty to provide immediate life-saving care remains, and the State may legitimately insist that no hospital turn away a patient in extremis. The argument is narrower: when the legislature converts that professional duty into a general statutory obligation to bear the cost of emergency stabilisation, it must provide, in the statute itself or in rules that are a condition precedent to the enforcement of the obligation, an automatic reimbursement mechanism at defined rates within a defined time. Absent such a mechanism, the mandate fails the necessity and balancing stages of the proportionality test and is liable to be read down or struck down under Article 19(1)(g).

IV. Price Regulation and Economic Liberty: The Clinical Establishments Dilemma

A. The Implementation Deficit

The Clinical Establishments (Registration and Regulation) Act 2010 was enacted by

³³Emergency Medical Treatment and Active Labor Act 1986, 42 USC § 1395dd.

³⁴Institute of Medicine, *Hospital-Based Emergency Care: At the Breaking Point* (National Academies Press 2007).

Parliament under Article 252, which permits Parliament to legislate on a State subject for States whose legislatures pass resolutions consenting to such legislation, and which other States may later adopt.³⁵ The Act requires the registration of all clinical establishments, prescribes minimum standards of facilities and services, and imposes on establishments an obligation to provide medical examination and treatment necessary to stabilise any individual brought in an emergency condition.³⁶ It is, in principle, the most comprehensive framework for regulating private health care in India.

Its implementation, however, has been strikingly limited. Health is a State subject, and adoption of the Act depends on State resolutions. As of the Union's most recent submissions to the Supreme Court, nineteen States and Union Territories had adopted the Act, while seventeen others operate under their own legislation, and even among adopting States enforcement of the Act's substantive standards has been uneven.³⁷ Several of the larger States with significant private hospital sectors declined to adopt the Act, in large part because of resistance from private providers to its regulatory and pricing provisions.

B. Rule 9 and Standardised Rates

The most contentious element of the framework is rule 9 of the Clinical Establishments (Central Government) Rules 2012. Rule 9(i) requires every clinical establishment to display the rates charged for each type of service and facility in a conspicuous place in the local and English languages. Rule 9(ii) requires establishments to charge rates for each procedure and service within the range of rates determined and issued by the Central Government from time to time, in consultation with the State Governments.³⁸ For more than a decade after the Rules were made, no such range was determined.

That failure became the subject of public interest proceedings in *Veterans Forum for Transparency in Public Life v Union of India*. In February 2024 a Bench of the Supreme Court expressed strong dissatisfaction with the Union's inaction, noted the wide disparity in the cost of the same procedure in public and private hospitals, and warned that if the Union did not produce a concrete proposal within six weeks, the Court would consider applying the rates fixed under the Central Government Health Scheme as an interim measure.³⁹ The Union

³⁵Clinical Establishments (Registration and Regulation) Act 2010; Constitution of India 1950, art 252, sch 7, list II, entry 6.

³⁶*Ibid* s 12.

³⁷'Centre Defends Clinical Establishment Rule in Supreme Court, Says It Curbs Excessive Pricing of Medical Services' (*LiveLaw*, 11 August 2026).

³⁸Clinical Establishments (Central Government) Rules 2012, r 9.

³⁹*Veterans Forum for Transparency in Public Life v Union of India* (SC, 27 February 2024) (order).

subsequently convened consultations with the States, but by August 2026, in proceedings arising from a challenge to rule 9(ii) by the All India Ophthalmological Society, the Union informed the Court that no State had submitted concrete rate proposals, while several States had expressed concern that rate fixing could compromise quality, render facilities unviable and impede research.⁴⁰⁴¹

The Article 14 question

Price regulation as such is not unconstitutional. The Supreme Court has long held that price fixing is a legislative function, and that a price-fixing measure will not be struck down merely because it causes hardship or reduces profits, so long as it is not arbitrary, is based on relevant considerations and is not confiscatory.⁴² The courts accord considerable deference to such measures, recognising that they involve complex economic judgments.

The question under rule 9(ii) is different. It is whether the executive may prescribe a single range of rates applicable across clinical settings as diverse as a single-doctor clinic in a district town, a secondary hospital and a quaternary teaching hospital performing transplants and complex oncology. The doctrine of non-arbitrariness under Article 14, articulated in *EP Royappa* and refined into the doctrine of manifest arbitrariness in *Shayara Bano*, requires that State action be informed by reason and not be capricious, irrational or without adequate determining principle.⁴³ Article 14 also prohibits treating unequals as equals. A uniform rate range that disregards differences in case-mix, infrastructure, staffing, accreditation, geographic cost of inputs and quality of outcomes would be open to the charge that it treats unequals equally, and that it is fixed without adequate determining principle.

The Central Government Health Scheme rates, which the Court mentioned as a possible interim benchmark, illustrate the difficulty. They are rates negotiated for a specific beneficiary population and periodically revised, but they are not derived from a transparent costing exercise across all categories of providers, and their wholesale imposition would likely be challenged as confiscatory for high-cost tertiary care. The constitutional vulnerability lies not in the principle of rate regulation but in its method. A tiered, cost-based framework that differentiates between categories of establishment, is periodically reviewed, and is set through a transparent and consultative process would be far more defensible than a single executive schedule.

⁴⁰*All India Ophthalmological Society v Union of India* WP (C) No 214 of 2024 (SC, pending).

⁴¹'Centre Defends Clinical Establishment Rule' (n 37).

⁴²*Prag Ice and Oil Mills v Union of India* (1978) 3 SCC 459; *Shri Sitaram Sugar Co Ltd v Union of India* (1990) 3 SCC 223.

⁴³*EP Royappa v State of Tamil Nadu* (1974) 4 SCC 3; *Shayara Bano v Union of India* (2017) 9 SCC 1.

C. Medical Devices and Essential Drugs

The regulation of drug and device prices offers a useful contrast. Under the Drugs (Prices Control) Order 2013, made under section 3 of the Essential Commodities Act 1955, the National Pharmaceutical Pricing Authority fixes ceiling prices for scheduled formulations based on market data, and may, under paragraph 19, fix the prices of any drug in extraordinary circumstances in the public interest.⁴⁴ Invoking these powers, the Authority capped the prices of coronary stents in February 2017 and of orthopaedic knee implants in August 2017, after finding that trade margins of several hundred per cent were being captured along the supply chain, much of it by hospitals.⁴⁵

These interventions differ from hospital rate regulation in important respects. Drugs and devices are standardised products whose costs of manufacture and distribution can be measured with reasonable accuracy, and their prices can be capped by reference to market data. Hospital services are bundled, heterogeneous and dependent on the skill and infrastructure of the provider, so that a uniform cap is far harder to justify on a rational basis. The experience with stents also demonstrated a predictable regulatory response: hospitals that lost margins on devices sought to recover them through higher procedure, consumable and room charges. Price regulation of components without regulation of the overall package thus shifts rather than eliminates the burden on patients. This reinforces the case for a specialised regulator capable of costing bundled services and monitoring the behaviour of providers across the whole package of care, rather than piecemeal executive intervention.

V. Digital Health Infrastructure and Patient Privacy

A. The Ayushman Bharat Digital Mission

The most significant structural development in Indian health care since the right to health was first recognised is the creation of a national digital health infrastructure. The Ayushman Bharat Digital Mission, launched nationally in September 2021 on the basis of the National Digital Health Blueprint, aims to create an interoperable ecosystem of electronic health records linked through a unique Ayushman Bharat Health Account number, registries of health professionals and facilities, and consent-based exchange of records between providers.⁴⁶ Its governance is set out in the Health Data Management Policy, which sets out principles of

⁴⁴Drugs (Prices Control) Order 2013, paras 4, 19; Essential Commodities Act 1955, s 3.

⁴⁵National Pharmaceutical Pricing Authority, Notification SO 412(E) (13 February 2017) (coronary stents); National Pharmaceutical Pricing Authority, Notification SO 2668(E) (16 August 2017) (orthopaedic knee implants).

⁴⁶Ministry of Health and Family Welfare, *National Digital Health Blueprint* (Government of India 2019).

consent, purpose limitation and data minimisation for participants in the ecosystem.⁴⁷

The Mission's legal foundations are, however, thin. It operates through executive policy and contractual terms rather than a dedicated statute, and participation in the ecosystem is formally voluntary. The proposed Digital Information Security in Healthcare Act, released in draft in 2018 to create a health-specific data protection framework, was never enacted. The Supreme Court's decision on the Aadhaar scheme is instructive: the Court upheld the scheme largely because it was backed by a statute that defined its purposes and contained safeguards, and struck down provisions that permitted the use of the identity number by private entities without a sufficient legal basis.⁴⁸ A national system for linking the most intimate personal data of the population, operating without a dedicated statute, raises at least a question as to whether it satisfies the legality requirement of the proportionality test.⁴⁹

B. Health Data under the Digital Personal Data Protection Act 2023

The Digital Personal Data Protection Act 2023, together with the Digital Personal Data Protection Rules 2025 notified on 13 November 2025, now provides the general framework for the processing of digital personal data, with the core obligations of data fiduciaries coming into force in May 2027.⁵⁰ The Act is built on a consent architecture: personal data may be processed for a lawful purpose with the consent of the data principal, or for certain legitimate uses specified in section 7.⁵¹ Data fiduciaries must implement reasonable security safeguards, notify breaches to the Data Protection Board and affected individuals, and erase data when the purpose is served, and breaches may attract penalties of up to two hundred and fifty crore rupees.⁵²

The significance of the Act for health data lies as much in what it omits as in what it contains. Unlike the Information Technology (Reasonable Security Practices and Procedures and Sensitive Personal Data or Information) Rules 2011, which recognised medical records and physical, physiological and mental health conditions as sensitive personal data,⁵³ the Act does not create a special category of sensitive data. Health data is therefore governed by the same rules as any other personal data, subject only to the possibility that the Union may notify

⁴⁷National Health Authority, *Health Data Management Policy* (version 2, 2022).

⁴⁸*Justice KS Puttaswamy (Retd) v Union of India* (2019) 1 SCC 1.

⁴⁹*Puttaswamy* (n 30).

⁵⁰Digital Personal Data Protection Act 2023; Digital Personal Data Protection Rules 2025 (notified 13 November 2025).

⁵¹*Ibid* ss 4, 6, 7.

⁵²*Ibid* s 8 and sch.

⁵³Information Technology (Reasonable Security Practices and Procedures and Sensitive Personal Data or Information) Rules 2011, r 3.

particular fiduciaries as significant data fiduciaries on account of the volume and sensitivity of the data they process, triggering obligations such as data protection impact assessments and independent audits.⁵⁴

The statutory carve-outs reflect a pragmatic recognition of the realities of medical care. Section 7 permits processing without consent to respond to a medical emergency involving a threat to the life or immediate threat to the health of the data principal or any other individual, and to take measures to provide medical treatment or health services during an epidemic or other threat to public health.⁵⁵ The Rules exempt clinical establishments and healthcare professionals from the requirement of verifiable parental consent for processing children's data to the extent necessary to provide health services.⁵⁶ These exceptions are justified, since a requirement of prior consent would be unworkable in an emergency. But they are drafted broadly, without the procedural safeguards, such as documentation of the emergency, limits on onward disclosure and subsequent notification of the patient, that a health-specific regime would ordinarily require.

C. The Comparative Deficit

Global benchmarks illustrate the gap. In the United States, the Privacy Rule and Security Rule made under the Health Insurance Portability and Accountability Act of 1996 apply specifically to covered entities such as health plans and providers and their business associates, define protected health information, restrict its use and disclosure to defined purposes such as treatment, payment and health care operations, impose a minimum necessary standard, and give patients rights of access and accounting of disclosures.⁵⁷ In the European Union, the General Data Protection Regulation treats data concerning health as a special category whose processing is prohibited unless a specific condition is met, such as explicit consent, the vital interests of a person who cannot consent, or the provision of health care under the responsibility of a professional bound by secrecy, and requires a data protection impact assessment for large-scale processing of such data.⁵⁸ The European Health Data Space Regulation adds a dedicated framework for primary and secondary use of electronic health data.⁵⁹

⁵⁴DPDP Act 2023 (n 50) s 10.

⁵⁵Ibid s 7(d), (e).

⁵⁶Ibid.

⁵⁷Health Insurance Portability and Accountability Act of 1996, Pub L No 104-191, 110 Stat 1936; 45 CFR pts 160, 164.

⁵⁸Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) [2016] OJ L119/1, arts 9, 35.

⁵⁹Regulation (EU) 2025/327 of the European Parliament and of the Council of 11 February 2025 on the European

Measured against these benchmarks, Indian law lacks three features. First, it does not recognise health data as a special category attracting heightened protection by default. Secondly, it imposes no specific fiduciary duties on hospitals, laboratories, insurers and health technology platforms, such as a duty of confidentiality enforceable by the patient, restrictions on the use of health data for marketing or insurance underwriting, or a minimum necessary standard. Thirdly, it leaves the governance of the national digital health ecosystem to executive policy rather than statute. Since the right to privacy is itself a facet of Article 21,⁶⁰ the right to health and the right to privacy converge in the digital health context: the trust that patients must place in providers is a precondition for seeking care at all, and a digital health system that erodes that trust may undermine access to care.

VI. Conclusion and Policy Recommendations

A. Synthesis

The trajectory traced in this article reveals that the judicial expansion of Article 21 has reached its structural limit. The Supreme Court has transformed a non-justiciable Directive Principle into a justiciable fundamental right, and decisions such as *Parmanand Katara* and *Paschim Banga* remain powerful statements of the State's obligation to preserve life. But judicial rhetoric cannot substitute for budgetary allocation. The Court itself has recognised in *Ram Lubhaya Bagga* that the State's obligation is shaped by its resources,⁶¹ and the long histories of non-compliance in *Moolchand* and of inaction under rule 9 demonstrate the limits of judicial supervision when the underlying financing and regulatory architecture is missing.

When the State has responded legislatively, it has too often sought to discharge its obligation by shifting the cost of care onto private providers rather than by financing it. The Rajasthan experience shows that such an approach provokes resistance, invites constitutional challenge under Article 19(1)(g), and ultimately results in a diluted entitlement. The constitutionally sound path, illustrated by the reimbursement provision in the Right of Children to Free and Compulsory Education Act 2009 that saved the scheme in *Society for Unaided Private Schools*,⁶² and by the cashless treatment scheme for road accident victims, is to combine an obligation to treat with a guarantee of payment. The same lesson applies to price regulation, where rational, tiered and transparent rate setting is more likely to survive scrutiny

Health Data Space [2025] OJ L2025/327.

⁶⁰*Puttaswamy* (n 30).

⁶¹*Ram Lubhaya Bagga* (n 12).

⁶²*Society for Unaided Private Schools* (n 26).

under Article 14 than uniform executive caps, and to digital health, where the absence of a sector-specific legal framework threatens the trust on which health care depends.

B. The Institutional Solution

The first recommendation is the establishment by Parliament of a National Emergency Healthcare Reimbursement Fund. The Fund would guarantee reimbursement to any registered clinical establishment, public or private, that provides emergency stabilisation to a patient who is unable to pay, at rates notified in advance and differentiated by category of establishment. Claims would be submitted electronically through the existing infrastructure of the National Health Authority and settled within thirty days, failing which interest would be payable automatically. The Fund could be financed through a combination of Union and State contributions, a portion of the health and education cess, and integration with the Motor Vehicle Accident Fund and the Pradhan Mantri Jan Arogya Yojana, so that the financing of emergency care is consolidated rather than fragmented. Crucially, the enforcement of any statutory emergency obligation against a private establishment should be conditional on the Fund being operational, so that the obligation to treat and the obligation to pay come into force together.

The second recommendation is the creation of an independent Healthcare Tariff Regulatory Authority, modelled on sectoral regulators such as the Telecom Regulatory Authority of India and the Central Electricity Regulatory Commission. The Authority would be constituted by statute, composed of experts in health economics, clinical practice, public health and consumer protection, and empowered to develop scientifically costed, tiered rate benchmarks for standard procedures and packages, differentiated by category of establishment, region and accreditation. Its determinations would follow a transparent consultative process and be subject to appeal to a specialised tribunal, which would provide the reasoned basis that Article 14 requires and reduce the risk of arbitrary executive caps. The Authority could also provide the rate schedules on which the Reimbursement Fund would rely, ensuring coherence between the regulation of prices and the financing of care.

Two supporting reforms would complete this architecture. Parliament should enact a dedicated health data protection law, or a health-specific chapter within the data protection framework, that recognises health data as a special category, imposes specific fiduciary duties on health data processors, places the Ayushman Bharat Digital Mission on a statutory footing, and constrains the use of health data for commercial and insurance purposes. And the Union and the States should commit, through a binding fiscal framework rather than aspirational policy statements, to raising public health expenditure to at least the 2.5 per cent of gross

domestic product promised in the National Health Policy 2017.⁶³

The right to health in India has travelled a long way from directive aspiration to statutory entitlement. Its final step, from entitlement to reality, cannot be taken by courts alone, nor by conscripting private hospitals into an unfunded public service. It requires the State to accept that a constitutional right to health is, in the end, a promise that must be paid for.

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