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JUSTICE AND WELL-BEING: THE LEGAL ANATOMY OF HEALTH RIGHTS IN INDIA

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Abstract

Health remains a fundamental concern for all individuals, regardless of caste, colour, gender, or ethnicity, and is regarded as one of the most vital aspects of human life. A life of dignity, as envisaged by the Indian Constitution, can only be realised when people enjoy good health, feel secure, and have access to quality healthcare services that are affordable and accessible to all. This article presents a concise exploration of the recognition of health as a human right, while also examining relevant constitutional provisions and important decisions delivered by the Supreme Court and various High Courts. In addition, the article highlights several government programmes and policies aimed at enhancing the health and well-being of the population, including specific measures adopted during the COVID-19 pandemic.

Introduction

The Indian Constitution, particularly through Part III, provides for fundamental rights that are central to upholding the dignity and welfare of individuals. These rights are not merely guarantees of survival but are designed to facilitate a dignified and meaningful life, reflecting the vision of the framers of the Constitution. One of the most vital among these rights is Article 21, which ensures every individual's right to life and personal liberty.

In the Maneka Gandhi case[2], Justice P.N. Bhagwati significantly broadened the interpretation of Article 21. He asserted that the right to life is not limited to mere physical survival but extends to a life lived with dignity. His interpretation paved the way for a more expansive understanding of constitutional rights, allowing the judiciary to embed

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[2]AIR 1978 SC 597.

within Article 21 various essential facets of life necessary for human dignity. Following this landmark judgment, the Supreme Court of India adopted a liberal and progressive approach in construing Article 21. This broader interpretation has brought several subsidiary rights under its umbrella, including the right to health. The judiciary has emphasized that good health is an essential condition for enjoying personal liberty and living with dignity. Consequently, healthcare is not just a service or a policy concern—it is a constitutional entitlement derived from the right to life.

India's alignment with international human rights instruments has further fortified this judicial interpretation. Global declarations and covenants, such as the Universal Declaration of Human Rights (1948) and the International Covenant on Economic, Social and Cultural Rights (1966), recognize the right to the highest attainable standard of health as a universal human right. By referring to these instruments, Indian courts have consistently reaffirmed that the State is duty-bound to ensure access to health services for its citizens.

Judicial activism in this area has manifested in a series of landmark judgments where the Court has held the State accountable for failing to provide adequate healthcare. These rulings have reinforced the government's obligation to protect public health and to ensure that access to essential medical services is not denied, especially to marginalized and vulnerable groups. The Court has addressed issues ranging from healthcare infrastructure and essential medicine shortages to the quality of public health facilities, urging the State to adopt a rights-based approach to healthcare delivery. In response to such judicial directions and the growing healthcare needs of the population, the Government of India has implemented several policies and schemes aimed at enhancing the health system. Major initiatives like the National Health Mission, along with the formulation of a comprehensive National Health Policy, have been rolled out to strengthen health infrastructure, reduce regional disparities in healthcare access, and improve service delivery across both urban and rural areas. These measures reflect an acknowledgment of health as a public good and a constitutional priority.

The recognition of the right to health as a fundamental right under Article 21 has not only emerged from legal interpretations but has also gained traction through practical policy implementation. The combined efforts of the judiciary and the executive have helped build a more inclusive public health framework. However, challenges remain, including

disparities in healthcare access, underfunding, and infrastructural deficiencies, which must be addressed with sustained commitment and policy reform. The development of the right to health within the Indian legal landscape illustrates how constitutional principles can evolve through dynamic interpretation and responsive governance. It underscores the urgent need for continued attention to public health as a core component of human dignity and as a foundational right guaranteed by the Constitution.

Right to Health regarded as a Human Right

Numerous bilateral and multilateral treaties have been entered into by various nations to ensure the protection and promotion of different rights for their citizens. Following the conclusion of the Second World War, the global health scenario had significantly deteriorated, marked by food shortages and widespread outbreaks of diseases. To address these concerns, the Constitution of the World Health Organization (WHO), adopted in 1946, became the first international legal instrument focusing on the improvement of global health. Article 2 of the WHO Constitution outlines its core objectives, which include the promotion of mental health.[3] As per the WHO, health is defined as a state of complete physical, mental, and social well-being, and not merely the absence of illness or infirmity.

Subsequently, the Universal Declaration of Human Rights (UDHR), adopted on December 10, 1948, in Paris, emerged as one of the most influential human rights documents. Article 25 of the UDHR affirms that every individual has the right to an adequate standard of living that ensures the health and well-being of themselves and their family, covering essential needs such as food, clothing, housing, medical services, and necessary social support. It also guarantees security during times of unemployment, illness, disability, widowhood, old age, or any other condition that affects one's livelihood beyond their control.[4]

In addition, Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) imposes an obligation on State parties to acknowledge and work towards securing for everyone the highest attainable level of physical and mental health.[5]

Right to Health under the Indian Constitution

[3]Constitution of The World Health Organisation, art. 2 (m).
[4]Universal Declaration of Human Rights, art. 25.
[5]Sonia Jain, "Right to Health: With Special Reference to Women's Right to Reproductive Health in India – A Human Rights Perspective", (2012) PL July 76.

As discussed above also, Article 21 of the Indian Constitution has undergone extensive judicial interpretation over the years, with courts emphasizing its role in upholding the dignity of both citizens and non-citizens. Among the many rights emanating from this provision, the right to health has been firmly established through various judgments. In *Bandhua Mukti Morcha v. Union of India*[6], the Supreme Court recognised health as an essential element of the right to life. Similarly, in *Vincent Panikurlangara v. Union of India*[7], the Court observed that a healthy body is a prerequisite for all meaningful human pursuits. It went on to underscore that improving public health must be a top priority for the State, as it is fundamental to the very existence of a civilized society and essential for realizing the aspirations enshrined in the Constitution.

While the Directive Principles of State Policy (DPSPs) under Part IV are not legally enforceable, the judiciary has consistently read them in conjunction with the Fundamental Rights. Courts have effectively made these principles binding on the State by integrating them with enforceable rights. A striking example is the right to education, initially a DPSP under Article 41, which was later recognized as a Fundamental Right through judicial interpretation under Article 21. In the landmark *Kesavananda Bharati v. State of Kerala* case[8], Justices Hegde and Mukherjea observed that the Fundamental Rights and Directive Principles represent the moral soul of the Constitution. Far from conflicting with one another, they were seen as mutually reinforcing. Justices Shelat and Grover similarly asserted that harmony between Parts III and IV is necessary to realize the constitutional vision of human dignity and well-being. This harmonization was reaffirmed in *State of Kerala v. N.M. Thomas*[9], where the Court held that any apparent contradiction between Fundamental Rights and DPSPs should be reconciled in a manner that advances constitutional goals.

In line with this judicial stance, Article 38 mandates the State to promote social welfare by ensuring justice and security. Without adequate health services, this goal is unattainable. Articles 39(e) and 42 further obligate the State to ensure the physical well-being of workers and provide maternity relief and humane working conditions. When interpreted alongside Article 21, these provisions reinforce the State's duty to secure comprehensive

[6]AIR 1984 SC 802.
[7]AIR 1987 SC 952.
[8]AIR 1973 SC 1461
[9]AIR 1976 SC 490.

healthcare for all. Additionally, Article 243G empowers State legislatures to assign responsibilities to Panchayats, including those concerning public health as outlined in Schedule XI, reinforcing decentralized healthcare governance.

Government initiatives to promote public health

The Government of India has launched various initiatives aimed at enhancing the quality of public healthcare services across the country. While several of these programmes were introduced prior to the outbreak of the COVID-19 pandemic, additional measures were specifically implemented during the pandemic to curb the transmission of the virus and strengthen the healthcare system. Below are some of the key schemes and programmes introduced by the government in this regard –

Ujjwala Scheme[10] – In many Indian villages, women still cook using coal, exposing themselves and their families to harmful gases like carbon monoxide. To address this, the Government launched the Pradhan Mantri Ujjwala Yojana on May 1, 2016, aiming to provide free or subsidized LPG connections to BPL families, especially women. The scheme promotes women empowerment, healthier cooking alternatives, and reduced health risks from traditional fuels. With an allocation of ₹8000 crore over three years and savings from the LPG subsidy 'Give It Up' campaign, it targeted five crore households. Notably, during the COVID-19 lockdown (April–June 2020), 10 crore free LPG cylinders were distributed.

Suraksha Store – To ensure the health and safety of citizens during the COVID-19 lockdown, the Government of India launched an initiative to transform local retail outlets (Kirana stores) into 'Suraksha Stores'. These stores were designed to supply essential daily items while adhering to safety protocols such as social distancing, thereby helping to contain the spread of the virus. The key goal of this initiative was to inform and train store owners across the country on pandemic-related guidelines and preventive measures.[11] As part of the programme, around 5 lakh stores were registered, over 7 lakh retailers enrolled for training, and approximately 70,000 employees had successfully completed their

[10]Available at: https://www.india.gov.in/spotlight/pradhan-mantri-ujjwala-yojana#tab=tab-3 (last visited on July 29, 2022).
[11]Available at: https://www.gktoday.in/topic/goi-launches-suraksha-store-initiative/#:~:text=The%20main%20objective%20of%20the,about%20COVID%2D19%20safety%20guidelines (last visited on August 3, 2022).

training.[12] The government had set a target of establishing 20 lakh such stores during the lockdown period.[13]

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM – JAY) –

Launched on 23rd September 2018, this flagship health initiative by the Government of India stands as the world's largest publicly funded health assurance scheme. Its financial structure involves joint contributions from both the central and state governments. The scheme has, so far, been rolled out in 33 states and union territories across the country. Its primary goals include reducing the financial burden of hospitalization on families, addressing unmet healthcare needs, and ensuring improved access to quality inpatient and day-care medical services for selected beneficiaries.[14]

Under the scheme, eligible families receive coverage of up to ₹5,00,000 per year for secondary and tertiary hospitalization through a network of Empanelled Health Care Providers (EHCPs).[15] Beneficiaries are assured of cashless and paperless treatment at both public and private hospitals participating in the programme. The scheme encompasses approximately 1,350 medical procedures, including pre- and post-hospitalization expenses, diagnostics, and prescribed medicines.

In rural areas, the scheme extends its benefits to groups such as –[16]

Scheduled Caste and Scheduled Tribe households,

Families without male members aged 16–59,

Individuals dependent on alms,

Households lacking any member in the 16–59 age group,

Families with at least one person with a disability and no able-bodied member,

Landless families engaged in casual manual labour,

[12]Ibid.
[13]Available at: https://www.business-standard.com/article/current-affairs/coronavirus-lockdown-2-million-suraksha-stores-for-essentials-on-cards-120041300021_1.html (last visited on August 3, 2022).
[14]Available at: https://pib.gov.in/Pressreleaseshare.aspx?PRID=1546948#:~:text=The%20objectives%20of%20the%20Yojana,care%20and%20day%20care%20surgeries. (last visited on August 4, 2022).
[15]Ibid.
[16]Available at: https://www.bajajfinserv.in/insights/ayushman-bharat-yojana-are-you-eligible-for-the-pmjay-scheme (last visited on August 5, 2022).

Members of primitive tribal groups,

Former bonded labourers,

Families residing in one-room dwellings without proper walls or roofing, and

Households engaged in manual scavenging.

In urban settings, the scheme covers individuals involved in occupations such as:

Washers and watchmen,

Ragpickers,

Mechanics, electricians, and repair technicians,

Sanitation workers, gardeners, and sweepers,

Home-based artisans, handicraft makers, and tailors,

Street vendors, hawkers, and cobblers,

Domestic workers,

Construction-related labourers including masons, welders, porters, and painters,

Transport workers like drivers, conductors, and rickshaw pullers, and

Support staff in small businesses such as assistants, peons, delivery personnel, shopkeepers, and waiters.

Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) –Introduced in 2003, this scheme was aimed at addressing regional disparities in access to affordable and dependable tertiary healthcare, while also expanding infrastructure for quality medical education across India.[17] The rollout of the scheme was planned in three distinct phases. In the first phase, the plan involved two key components: establishing six new medical institutions modeled after AIIMS in the states of Bihar (Patna), Chhattisgarh (Raipur), Madhya Pradesh (Bhopal), Odisha (Bhubaneswar), Rajasthan (Jodhpur), and Uttarakhand (Rishikesh), and upgrading 13 existing government medical colleges. Each new institution was projected to cost around ₹840 crore, while the upgradation of existing colleges was estimated at ₹120

[17]Available at: http://pmssy-mohfw.nic.in/index1.php?lang=1&level=1&sublinkid=81&lid=127#:~:text=The%20Pradhan%20Mantri%20Swasthya%20Suraksha,medical%20education%20in%20the%20country. (last visited on August 5, 2022).

crore each—of which ₹100 crore was to be provided by the central government and ₹20 crore by the respective state governments. In the second phase, the scheme proposed the creation of two additional AIIMS-like institutes – one in West Bengal and another in Uttar Pradesh—along with the modernization of six more medical colleges. The cost for each new AIIMS-like institute was projected at ₹823 crore, and the central government was to contribute ₹125 crore for each college being upgraded. The third phase focused solely on upgrading existing medical colleges, with each institution's enhancement budgeted at ₹150 crore. Out of this amount, ₹125 crore was to come from the central government, while ₹25 crore was to be borne by the concerned state governments.

Ministry of Ayush –The Government of India launched a dedicated initiative to support and advance traditional systems of medicine, namely Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homeopathy—collectively referred to as AYUSH. This initiative was officially established on November 9, 2014, with several key objectives[18] -

Enhancing the execution of national and community-level health programmes;

Improving the operational efficiency of various healthcare facilities;

Promoting the global reach and recognition of the Siddha system of medicine;

Encouraging research in different areas related to Siddha medicine;

Delivering quality education at the postgraduate level;

Equipping postgraduate students with a solid foundation in modern science and research skills;

Expanding access to AYUSH medical services through the upgrading of hospitals and dispensaries to offer affordable healthcare; and

Strengthening the educational infrastructure and ensuring quality standards in Ayurveda, Unani, and Siddha systems.

In addition to AYUSH-related reforms, the government also implemented several targeted health initiatives. These include the National Leprosy Eradication Programme, focused on early diagnosis and treatment of leprosy; the Revised National TB Control Programme,

[18]Available at: https://www.collegedekho.com/articles/ministry-of-ayush-function-roles/ (last visited on August 4, 2022).

aimed at eliminating tuberculosis; and the efforts of the National AIDS Control Organisation, which seeks to ensure dignified and accessible treatment for HIV/AIDS patients. During the COVID-19 pandemic, the government also introduced financial relief measures. For instance, the Income Tax Department offered refunds of up to ₹5 lakh to individuals and businesses, and a major economic support package of ₹3 lakh crore in collateral-free automatic loans was announced for Micro, Small, and Medium Enterprises (MSMEs).

National Health Mission (NHM)- Introduced in 2005 by the Indian government, the National Health Mission (NHM) was created to strengthen the healthcare system, with a special emphasis on improving services in underdeveloped and hard-to-reach areas. The mission consists of two major initiatives: the National Rural Health Mission (NRHM), which targets healthcare needs in rural communities, and the National Urban Health Mission (NUHM), which addresses health challenges in urban settings, especially among slum dwellers and economically weaker sections. NHM is aimed at lowering both maternal and child mortality rates by ensuring better access to essential health services. It also focuses on preventing and managing communicable diseases such as malaria, tuberculosis, and other tropical infections. A major component of the mission involves enhancing physical infrastructure by developing and upgrading Sub-Centres, PHCs, and CHCs to make primary healthcare more accessible. Additionally, the mission seeks to expand the healthcare workforce by hiring skilled professionals and improving service quality in government health institutions.

National Health Protection Scheme (NHPS) - Launched in 2018, the National Health Protection Scheme (NHPS) was designed to safeguard low-income and vulnerable groups from the financial distress caused by high medical expenses. Though it was eventually merged into the broader Pradhan Mantri Jan Arogya Yojana (PM-JAY), several foundational goals of NHPS continue to hold significance. Among these were: providing insurance coverage for secondary and tertiary-level treatments to economically disadvantaged populations; reducing out-of-pocket healthcare expenses that often drive households into debt; and strengthening the overall healthcare system by promoting collaboration between the public and private sectors to ensure wider access to quality medical services. A particular emphasis was placed on extending healthcare benefits to underserved regions, especially rural and backward areas, ensuring that access to essential

medical services did not become a financial burden for already marginalized communities. NHPS thus represented a key step towards building a more inclusive and financially accessible healthcare system in India.

Landmark Judgements regarding Right to Health

People's Union For Civil Liberties (PUCL) v. Union of India[19] - In this case, the Food Corporation of India (FCI) godowns, located roughly 5 kilometers outside Jaipur, were stocked beyond capacity with grains. Due to rainwater seeping in and causing fermentation, a large quantity of these grains was decaying. Ironically, a nearby village was facing such extreme hunger that families had adopted a practice known as 'rotation eating,' where only certain members would eat on one day while others waited for the next. Reports from 2001 indicated that FCI was holding around 40 million tonnes of surplus grain above the required buffer stock, yet starvation deaths continued to occur. In light of this dire situation, the People's Union for Civil Liberties (PUCL) filed a Public Interest Litigation (PIL) before the Supreme Court. Responding to the petition, the Court issued an interim order mandating the public distribution of food grains to individuals and families living below the official poverty line. It further declared that the rights to food, water, a clean environment, education, medical care, and shelter are integral components of the fundamental right to life guaranteed under Article 21 of the Constitution.

Paschim Banga Khet Mazdoor Samity v. State of West Bengal[20] – In this case, petitioner Mr. Hakim Seikh, a member of an agricultural labourers' union, sustained severe head injuries after falling from a train at Mathurapur station. Initially taken to the local Primary Health Centre, he was referred to a higher facility due to the absence of necessary treatment infrastructure. Over the next day, he was denied admission at several government hospitals, including N.R.S. Medical College, Calcutta Medical College, and others, due to lack of beds or inadequate departments. Ultimately, he had to be treated at a private hospital, incurring a cost of around ₹17,000 for 14 days.

A writ petition was filed, highlighting the failure of the public healthcare system in providing timely medical aid. The Supreme Court ruled that the denial of treatment amounted to a violation of Mr. Seikh's right to life under Article 21 of the Constitution.

[19]Civil Writ Petition 196 of 2001.
[20]AIR 1996 SC 2426.

The Court directed the State of West Bengal to pay compensation and develop a strategy for emergency healthcare services. It emphasized that in a welfare state, providing adequate health services is a core responsibility of the government, which must ensure the availability of proper medical infrastructure for all citizens, especially during emergencies.

Bandhua Mukti Morcha v. Union of India[21] – In this case, the petitioner, a non-governmental organization, sent a letter to the Supreme Court highlighting the inhuman working conditions of bonded labourers employed in stone quarries in Faridabad district. These workers, hailing from various states, were allegedly being forced to work under oppressive and exploitative circumstances. The Court treated the letter as a writ petition under Article 32 and appointed two advocates as commissioners to inspect the quarries and interview both the named individuals and a representative group of workers to assess their working conditions and whether their employment was voluntary. Additionally, Dr. Patwardhan from IIT was tasked with conducting a socio-legal study on the matter.

The respondents raised preliminary objections: (a) no violation of any fundamental right was alleged, and therefore Article 32 did not apply; (b) the Court lacked authority under Article 32 to appoint investigative commissions; and (c) a mere letter could not be considered a writ petition. Rejecting these objections, Justice P.N. Bhagwati clarified that the interpretation of Article 32 must align with the Constitution's broader objectives reflected in the Preamble, Part III, and Part IV. He emphasized that Article 32 empowers the Court to take any necessary measures to enforce fundamental rights. The Court concluded that human dignity and humane work conditions are protected under Article 21, and that the use of forced labour violated Article 23. Therefore, Article 32 was rightly invoked.

Vincent v. Union of India[22] – In this case, a Public Interest Litigation (PIL) was filed seeking several directives from the court. The petitioner requested the following:

A ban on the import, manufacture, sale, and distribution of drugs that had been recommended for prohibition by the Drugs Consultative Committee;

Revocation of all licenses permitting the import, manufacture, sale, and distribution of such drugs;

[21]AIR 1984 SC 802.
[22]AIR 1987 SC 990.

Formation of a high-level authority to investigate the health hazards caused by the continued circulation of these drugs and to propose remedial actions, including compensation for affected individuals;

The creation of strict regulations to maintain the quality and standards of approved drugs and to eliminate harmful and unsafe medicines from the market.

A major concern raised in the petition was that India's pharmaceutical sector was heavily influenced by multinational corporations from countries such as the USA, UK, Germany, Sweden, France, and Japan. The petitioner alleged that India, being highly vulnerable to disease, was being treated as a testing ground due to the government's limited oversight and control over these foreign companies. The plea also referred to the Hathi Committee's recommendations, which had proposed nationalization of the drug industry—though this suggestion was ultimately not implemented by the Indian government. Furthermore, the petitioner pointed out that several drugs banned in developed countries were still available and even prescribed in India. The Supreme Court, recognizing the gravity of the situation, held that the State was duty-bound to ensure the availability of safe, quality drugs, to remove harmful substances from the pharmaceutical market, and to establish a comprehensive drug policy. The Court directed the government to take appropriate action in this regard and also ordered the Ministry of Health to pay ₹5,000 to the petitioner

Murli S. Deora v. Union of India[23]- In this matter, a writ petition was filed under Article 32 of the Constitution, seeking a prohibition on smoking in public places. While the respondents acknowledged the harmful impact of public smoking, the absence of a specific statutory framework posed a challenge. Nevertheless, the Court exercised its authority and issued an order prohibiting smoking in various public spaces, including auditoriums, hospitals, healthcare facilities, educational institutions, libraries, court premises, government offices, and public transportation (such as trains). At that time, Rajasthan was the only state with a law explicitly addressing this issue, through the *Rajasthan Prohibition of Smoking and Non-Smokers Health Protection Act, 1999*

Statistics in regards to state of healthcare in India

Even though the right to health is declared as one of the fundamental rights by the Supreme Court and it is the duty of States to provide adequate health facilities to the citizens as per

[23](2001) 8 SCC 765.

the Directive Principles of State Policy, the health care system in India has flaws, both at operational and conceptual levels[24] because unfortunately, health is a prime example where good politics and good policy diverge.[25] Here are some of the statistics in regards to state of health[26] –

India's public health spending has historically been low compared to neighbouring countries like Sri Lanka and Nepal. Despite an increase to 1.9% of GDP in 2023, it still falls short of the World Health Organization's recommended 5%. This underfunding has led to a high reliance on out-of-pocket spending, which accounted for 58% of health expenses in 2023. Notably, nearly 70% of household health spending goes toward medicines, pushing many families, particularly in rural areas, into debt and poverty. Access to essential medicines is another significant issue, with around 469 million people lacking consistent access. Public healthcare infrastructure is similarly underdeveloped, with 63% of primary health centres lacking operation theatres and 29% missing labour rooms. Community health centres are critically short of specialists, including surgeons and paediatricians, further hindering maternal and child healthcare.

Rural-urban disparities also exacerbate the situation, with 58% of rural and 68% of urban residents relying on private healthcare due to the poor quality of public services. The high burden of non-communicable diseases like cardiovascular conditions adds to the strain, particularly in rural areas, where medical infrastructure is scarce. Financially, health-related costs push between 32 to 39 million people below the poverty line annually. Many families face catastrophic healthcare expenditures, spending more than 10% of their income on medical care, forcing them to make difficult decisions about other basic needs. In response to these challenges, the government launched initiatives like Ayushman Bharat's PM-JAY to provide health insurance for vulnerable populations. While the scheme has enrolled millions, it faces implementation challenges, especially in underserved areas. Greater investment and more effective policies are needed to achieve universal health coverage.

Conclusion

[24] *Id.* at 54.
[25] Professor K.S. Jacob, For a new and improved NRHM, *The Hindu*, 7/8/2011 available at: http: //www.thehindu.com/opiion/lead/article 2333819.ece (last visited on November 6, 2011).
[26] Available at: https://www.oxfamindia.org/blog/15-healthcare-schemes-india-you-must-know-about (last visited on August 5, 2022).

India has made significant strides in recognizing the right to health as a fundamental human right, notably through Article 21 of the Constitution and various judicial pronouncements. However, the COVID-19 pandemic exposed critical deficiencies in the nation's healthcare infrastructure. Shortages of ambulances, hospital beds, and essential medical supplies highlighted systemic issues that demand urgent attention. One of the primary concerns is the underfunding of the public health sector. India allocates approximately 1.9% of its GDP to healthcare, which is significantly lower than the global average of 6% and the OECD standard of 8.8%. This limited investment results in poorly equipped hospitals, a shortage of medical personnel, and inadequate primary care facilities, especially in rural and underserved regions. Consequently, many citizens rely on private healthcare services, leading to high out-of-pocket expenditures that can push vulnerable families into poverty.

The federal structure of India further complicates healthcare delivery. While health is primarily a state subject, disparities in healthcare quality and access persist across different states. States like Kerala and Tamil Nadu have developed robust public healthcare models, whereas others struggle with basic healthcare indicators. Central government interventions, though beneficial in terms of funding and policy guidance, often lack effective accountability mechanisms to ensure consistent quality of care nationwide. Preventive healthcare remains an area requiring significant improvement. The focus has predominantly been on curative services, with insufficient emphasis on preventive measures such as immunization, sanitation, public health education, and early disease detection. Programs like Mission Indradhanush aim to enhance immunization coverage, yet challenges in implementation and awareness persist.

Technological integration in healthcare, including telemedicine and digital health records, offers promising solutions but faces hurdles in widespread adoption, particularly in rural areas. Initiatives like the Ayushman Bharat Digital Mission seek to create a unified digital health infrastructure, but disparities in digital literacy and access hinder their effectiveness. Legally, while the judiciary has interpreted the right to health expansively under Article 21, there is no comprehensive legislation guaranteeing enforceable health rights. The absence of a robust public health law leads to ambiguities and inconsistent enforcement across states. A statutory framework delineating the roles of state and central governments,

outlining citizens' entitlements, and establishing grievance redressal mechanisms is essential.

Internationally, models from countries like the United Kingdom and Scandinavian nations demonstrate the benefits of strong public investment and universal healthcare frameworks. While direct replication may not be feasible due to India's scale and diversity, adapting features such as centralized financing and regulatory oversight could enhance the Indian healthcare system. Conversely, the American model underscores the risks of excessive privatization, emphasizing the need for a balanced approach.

To address these challenges, the researcher would like to suggest following recommendations:

Elevating healthcare expenditure to at least 5% of GDP is crucial to improve infrastructure, ensure adequate medical supplies, and enhance human resources, particularly in rural areas.

Expanding the number of training institutions, improving working conditions, and offering incentives can attract and retain healthcare professionals in underserved regions.

Engaging private entities in infrastructure development and service delivery can be beneficial, provided there are stringent regulations to maintain affordability and equity.

Involving local communities in healthcare planning and monitoring can lead to more inclusive and effective policies. Establishing local health committees and promoting health education campaigns can enhance service delivery.

Prioritizing immunization programs, sanitation initiatives, and disease surveillance can significantly reduce the disease burden and improve public health outcomes.

Investing in telemedicine and centralized health data systems can bridge access gaps, especially in remote areas. Enhancing digital literacy among health workers is also essential.

Engaging with global organizations and learning from international best practices can strengthen India's healthcare ecosystem. Collaborative efforts in vaccine development and health financing are particularly beneficial.

While India's recognition of health as a fundamental right is commendable, the real challenge lies in effective implementation. Achieving Sustainable Development Goal 3, ensuring health and well-being for all – requires sustained commitment, cross-sectoral cooperation, and a renewed focus on equity and inclusiveness. A paradigm shift is necessary to view healthcare not as a privilege but as a fundamental entitlement.