



# THE BRIEFCASE



## Here's what has happened in the last month and what's to come!

'The Briefcase' returns with an edition exploring one of the most significant issues shaping contemporary society: public health. Public health refers to the systems, policies, and institutions that work to protect and improve the health of communities. It extends beyond hospitals and medical treatment to encompass government policy, healthcare financing, social welfare, sanitation, nutrition, and access to essential services.

As India navigates evolving healthcare needs, questions of accessibility, affordability, accountability, and equity have become increasingly important. This edition examines the evolving landscape of public health in India through a range of contemporary legal and policy issues. From the challenges faced by public hospitals and frontline health workers to debates surrounding private healthcare regulation and the constitutional dimensions of health rights, our contributors explore the factors that shape healthcare outcomes across the country.

By approaching public health as a matter of governance, rights, and social justice, this issue invites readers to consider whether existing frameworks are equipped to meet the needs of a rapidly changing society. Through analyses of legislation, judicial developments, and policy debates, these pieces highlight a fundamental principle: a healthcare system is ultimately measured by its ability to serve people with dignity, fairness, and care.

We invite you to explore this edition with curiosity and reflection.



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# THE BINDER



Your essential collection of the latest legal updates, neatly organised for a quick reference.

## The Case for Legislative Reform in India's Public Health Emergency Framework

As COVID-19 arrived in India, it uncovered much more than an under-funded healthcare system and exposed the fatal loopholes in public health legislation. In the wake of globalisation and an increase in interdependency, movement between nations is so common that disease has no physical barrier. The focus, therefore, shifts from merely remedial measures to the regulatory preparedness of countries.

Outmoded legal grounding India battled 2020 using only laws enacted in the colonial era. The public health legislations had been largely outdated-dating back to the plague-related 'Epidemic Diseases Act of 1897', later coupled with the 'Disaster Management Act 2005' which increased administrative capability but not effective management of the medical challenge. Despite enabling authorities to respond quickly, these laws did not include provisions for facilitating medical coordination between healthcare institutions nor did it envisage community-level health surveillance.

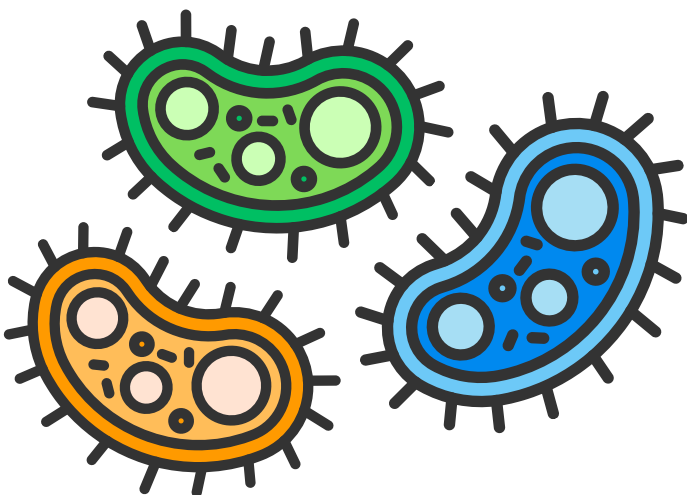
Even the subsequent 'Epidemic Diseases (Amendment) Act, 2020' primarily addresses the violence against medical practitioners. Despite numerous attempts, the gap in legislative framework has not yet been addressed, with one notable attempt being the

broad-ranging public health bill introduced to deal with epidemic and bioterrorist threat, as well as natural disasters, which was tabled in Rajya Sabha in 2020, and could not pass. In 2024, the Law Commission highlighted the gaps once again. In September 2024, a panel constituted by NITI Aayog released a paper titled, 'Future Pandemic Preparedness and Emergency Response: A Framework for Action'. The paper suggested the need for a 'Public Health Emergency Management Act', to have strong centralised authorities to guide the system as well as an improved monitoring of disease trends across states

The new legislation could also accelerate drug approval during the emergency due to their immediacy and impact, coupled with the possibility of a dedicated fund solely for pandemic response that could prevent outbreaks from getting out of hand.



Credits: The New York Times





# THE BINDER

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In the process, a critical observation can be made, i.e. the importance of early interventions immediately after the disease appears; which is evident from the recent global pandemic crisis. Years of underfunding and a fractured system have undermined India's public health framework, inadequate facilities, fewer beds for critical care, the rural-urban gap for treatments and diagnostics, fragmented and largely manual surveillance that does not present real time data of infectious diseases at a national level. The failure of collaboration between the centre and the state, on matters such as public holidays or travel restrictions during a lockdown, is due to their inherent constitutional division where State controls matters relating to health, as provided under the Seventh Schedule to the Constitution of India.

## A SAARC Perspective

Across South Asia varying degrees of success and failure is visible. Bangladesh has formulated a comprehensive 6-part preparedness plan, on the lines of WHO recommendations, whereas Bhutan and Maldives focused on containment of spread, alongside economic continuity. Nepal managed to strengthen health infrastructure immediately after the outbreak.

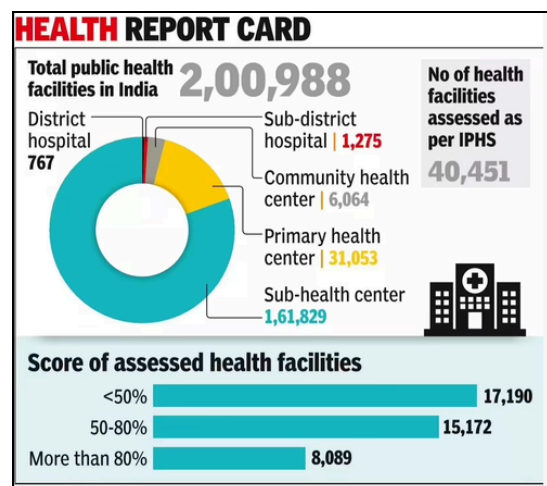
What is notable is SAARC's establishment of the pandemic emergency fund in 2020 that reached over US\$ 18 million, with India taking the lead and contributing \$10 million and taking a lead role in the distribution of COVID-19 vaccine to the region.

The lack of common enforceable policies on cross-border health surveillance have, however, hampered collective preparedness. The way forward India possesses a robust base - the world's largest vaccination campaign, significant manufacturing capacity, and large-scale implementation skills. However, authority without the enabling legal backing fails to



Credits: Sanatan Characters

deliver in crisis situations. Not only will the PHEMA needs to be approved, but the act of 1897 must be repealed or at least reformed, and the One Health approach to monitoring of zoonotic threats, as well as collaborative efforts between the central and state governments must be streamlined and institutionalised, not merely be a well-intentioned idea.



Credits: The Economic Times

Effective response to the pandemic threat should largely deal with legislation, governance, and not just healthcare delivery systems and their funding.

Delays in passage of new legislation may compel India to respond to the emerging public health threat using the colonial-era legal framework of the 1897 law, much like it did in 2020.

**Ms. Rucha Kankal**  
Student, 4<sup>th</sup> Year

# THE BINDER



Your essential collection of the latest legal updates, neatly organised for a quick reference.

## The Delayed Healthcare Crisis in India

The public healthcare system in India is currently in a crisis. This crisis is not due to a sudden collapse, but rather decades of systematic underfunding that has caused policy gaps to widen in infrastructure, workforce, and access to healthcare. The world health organisation (WHO) has recommended 5% of GDP expenditure towards public health but the public health expenditure in India has stayed around 1.2-1.5% of GDP for a long time. The consequences of this are being faced by the most vulnerable and marginalised sections of the society. Patients in need have to wait for months to even be able to get a basic check-up to diagnose the illness.

The constitution promises the right to life under Article 21. The Supreme Court has also interpreted the right to health as a part of the right to life under Article 21. In Paschim Banga Khet Mazdoor Samity v. State of West Bengal (1996) 4 SCC 37, the Hon'ble Supreme Court held that the State is obligated to provide adequate medical facilities to its citizens. This very gap between the interpretation of right to life and the ground reality still remains persistent. Public hospitals across India operate with chronic shortages of doctors, diagnostic equipment, and beds. India has only about 0.6 hospital beds per 1000 population, India's shortfall of roughly 2.4 million hospital beds.

The delay in healthcare caused by such underfunded facilities, long wait times and/or financial barriers come at a cost of human life. According to The National Health Policy, 2017 recommendation, by 2020, states should have allocated at least 8% of their budget towards health care. As of 2025-26, only three states have allocated 8% or more of their budget towards health care. These are Delhi, Odisha, and



Credits: Canva



Credits: Ayushman Bharat

Rajasthan. Though India is emerging as one of the world's fastest growing economies, deaths from treatable conditions such as tuberculosis, sepsis, and maternal complications remain a reminder of persistent gaps in the healthcare system. A case study of Nanded Hospital by ORF highlighted how underfunding, staff shortages, inadequate infrastructure, and overcrowding in public hospital resulted in the deaths of 31 patients. This is not an isolated incident but a reflection of a pattern across public healthcare sector in India.

The National Health Mission which was introduced to bridge the disparities in the urban-rural healthcare, has made a positive impact on maternal and child mortality indicators. However, it is persistently underfunded. The Ayushman Bharat scheme which was introduced as an health insurance scheme up to 5 lakhs to the eligible households, represents a policy with commitment toward reducing disastrous health expenditure. However, such insurance space models cannot replace primary care infrastructure. Insurance coverage becomes ineffective without investment in healthcare and a well-distributed medical workforce in regions where the nearest public hospital is hours away.

The question of whether India can afford delayed healthcare is a question of political will. The money is available; what is needed is a change in budget priorities and an understanding that spending on healthcare is not an expense to cut, but a key investment for fair and inclusive development. A citizen denied timely medical care is not merely a public health failure, it is a constitutional one.

**Ms. Arya Temgire**  
Student, 4<sup>th</sup> Year

# THE GAVEL



*The strike of the mallet, in recent judgements, summarised for easy reading.*

## Dr. Jaya Thakur v. Union of India & Ors 2026 INSC 97

### Introduction

According to the [Global Menstrual Health Report 2024](#), India has ranked in the bottom third of countries for menstrual equity. Menstrual Hygiene Management also known as (MHM) in India has remained more of an administrative objective than a welfare project having genuine concern for women's rights and wellbeing. Despite various schemes by both State and Central authorities, only 12% of menstruating women in India have access to affordable sanitary products. These structural gaps, including the alarming levels of dropout and absenteeism from schools, have drawn attention to "period poverty" in India. The institutionalized exclusion either by silence or avoidance was challenged openly when a PIL was filed before the Supreme Court of India under Article 32 of the Constitution of India.

### Procedural History

The Supreme Court of India, in the landmark judgment of [Dr. Jaya Thakur v. Union of India & Ors \(2026\)](#), responded to a writ of mandamus, to compel the government to provide free sanitary napkins, separate female toilets, and dedicated cleaning staff across schools. The judgment was delivered on January 30, 2026, by a bench comprising Justices R. Mahadevan and J.B. Pardiwala, wherein both judges have gone on record to state that "a period should end a sentence, not a girl's education." The Court also recognized and acknowledged menstrual health as an integral part of the fundamental rights guaranteed under Articles 14, 21, and 21A of the Constitution.



*Credits: Healthcare Radius*



*Credits: The Medium Organic*

### Issues

- Whether unavailability of gender-segregated toilets and non-access to menstrual absorbents could be said to be in violation of the right to equality for adolescent girl students under Article 14 of the Constitution?
- Whether the right to dignified menstrual health could be said to be part of Article 21 of the Constitution?
- Whether unavailability of gender-segregated toilets and non-access to menstrual absorbents could be said to be in violation of the right to education under Article 21A, and the right to free and compulsory education under the Right of Children to Free and Compulsory Education Act, 2009?

### Reasoning

The Supreme Court in this case highlighted the impact of failure to afford menstruation products, which acts as a resistance in the ability to live a life with dignity. Extending the scope of interpretation of Article 14, the Bench followed a principle of substantive equality, which suggests that merely affording equal treatment without addressing the systemic inequalities resulting in

# THE GAVEL



*The strike of the mallet, in recent judgements, summarised for easy reading.*

exclusion of women would be insufficient. Interpreting the mandate of the Right of Children to Free and Compulsory Education Act, 2009, the Court ruled that education must be barrier-free; forcing a student to miss classes due to a lack of MHM facilities imposes an unconstitutional "additional cost" on girls' education. The foundation of the Court's argument lay in the premise that failure to provide basic hygiene in the schools constituted a violation of human rights. As per the court under Article 21, denying basic sanitary conditions constitutes an attack on reproductive health, bodily autonomy, and constitutional dignity. Additionally, according to Article 21A, the right to education is to be guaranteed and that the denial of basic sanitation in schools constitutes a violation of the right of girls to receive proper education. It was found to be a structural barrier, leading to absenteeism and drop-outs.

## Conclusion

This case highlights enforcing laws where state actions have been incompetent to bridge such gender gaps through their policies. The significance of this judgment lies in its ability to end the old social stigmas by moving menstruation issues from an executive program to the domain of rights guaranteed by the constitution.



*Credits: Bustle*



*Credits: Forbes*

**Mr. Akhilesh Nanoti**  
Student, 4th Year



**MENSTRUAL  
HYGIENE IS  
FUNDAMENTAL TO  
WOMEN'S DIGNITY  
AND WELL-BEING**

# THE GAVEL



*The strike of the mallet, in recent judgements, summarised for easy reading.*

## Article 21 and Hospital Pharmacy Pricing: Analysing Siddharth Dalmia & Anr. v. Union of India & Ors.

### Background

The petitioners, Siddharth Dalmia (a law student) and Vijay Pal Dalmia, filed a writ petition under Article 32 of the Constitution of India. It was during the petitioner's experience of his mother's extensive cancer treatment when they found hospital-affiliated pharmacies selling medicines and consumables at marked-up rates far beyond the Maximum Retail Price (MRP).

Several private hospitals in India maintain their own pharmacies where medicines, medical equipment, implants, and surgical consumables are sold at much higher prices than prevailing in the open market. There is no other choice available to the patients getting treated other than buying these things from there, a process which exerts tremendous pressure on the pockets of the poor and middle-class patients. There is no comprehensive law enacted by the Indian government regulating the price structure of the pharmaceuticals of the private hospital pharmacies, while the Drug Price Control Order, 2013 regulates only those pharmaceuticals which are listed in the open market. It was in this context that the petitioners went to the Supreme Court of India arguing that the pricing policy in private hospital pharmacies violated the right to health guaranteed under Article 21 of the Constitution.

### Issues Before the Court

Is the practice followed by private hospitals whereby they insist on patients purchasing medicines and consumables only through hospital pharmacies at purportedly higher prices infringing Article 21?

- Can the fixation of prices of medicines, devices

and consumables supplied by hospital pharmacies be regulated by law?

- If yes, then what would be the proper scope and contents of such regulations?
- Whose responsibility will it be (the Union Government, State Governments or any regulator like the NPPA) to regulate this issue?
- Should the Court make specific orders or leave the matter to the States?

### Reasoning

The Supreme Court recognized the negative effect of high medical expenses on the health of citizens and noted that these concerns fall within the ambit of Article 21. But the court refused to directly regulate the price of medicine, instruments, and consumable items supplied by private hospitals through their pharmacy department. It was opined by the Supreme Court that the question of regulation of prices in the private medical sector is a policy-related one that needs deliberations in the legislature and machinery which cannot be substituted by the judicial process. In line with the principle of separation of powers, the Supreme Court directed the state governments to consider framing appropriate regulations. Though the Supreme Court gave a direction, it is a clear indication of the constitutional perspective that in future any inaction by states will be very difficult from a constitutional angle.

### Conclusion

This judgment in the case of Siddharth Dalmia is a balanced yet substantial addition to the growing body of health law jurisprudence in India. While recognizing the dimensions of Article 21 rights of private hospitals in terms of drug pricing, the Court has confirmed that constitutional rights have to be meaningful and not just declaratory. On the other hand, while leaving such decisions to the discretion of policymaking bodies, the judgment shows the cautious approach of the Court to directly supervise economic regulation. Whether this judgment will make a mark will depend on the action taken by the States. This is because there is now an evident expectation placed upon the States to regulate the pricing policies of the hospitals' pharmacies.

**Ms. Pari Shah**  
Student, 4<sup>th</sup> Year

# THE COMMENTARY



*Straight from the commentary box of our editorial board, curated reads to expand your legal mind.*

## Outsourcing Embryos - HBO VICE Season 3, Episode 4 (2016) on Commercial Surrogacy in India

*Outsourcing Embryos*, chronicles the tale of yet another form of cheap labour (pun intended) for which the West turned to India. This compelling watch captures the “business” of surrogacy and the regulatory lacunae in public health and reproductive autonomy spheres, which once led to the rise of commercial surrogacy in India. Shocking scenes of recruiters travelling to slums and inducing women to become surrogates by playing on their financial necessities, abandoned babies (resulting from multiple successful embryo implantations) being sold over dinner in restaurants, clinics undercutting prices to compete with one another and concluding transactions in back-alley offices, showcased the reality of the fertility industry and the gross subordination of the surrogates’ welfare. Footage from Dr. Nayana Patel’s surrogacy clinic in Anand, Gujarat (the surrogacy capital of India) showed how the babies were being “churned out”, with multiple back-to-back deliveries being scheduled on a daily basis, almost in an assembly-line fashion, tempting the “baby-factories” nickname.



*Credits: FTen Productions*

*Outsourcing Embryos* does an excellent job in exposing just how easily the lines between well-intended empowerment and exploitation can be blurred. Dr. Patel paints commercial surrogacy a rosy tale of *voluntary* empowerment, a noble act of one woman helping another, enabling the surrogate women to earn the kind of money

traditional labour could never provide. However, interviews with the surrogate women revealed how often they were left at the mercy of the clinics and their own socio-economic realities, prompting viewers to wonder if the surrogates did really have a choice.

Today, after the enactment of the Surrogacy (Regulation) Act, 2021, commercial surrogacy has been banned in India for both foreign and Indian couples. However, as this [article](#) poignantly points out, the practice has not stopped, only travelled underground. In portraying the heart-breaking plight of surrogate women in India, *Outsourcing Embryos* helps one understand the rationale behind banning commercial surrogacy. This is why even after a decade after its release, it remains a gripping portrayal of the reproductive autonomy of Indian women.

Link to the episode 14:30 onwards:

[https://youtu.be/GED9rYPkAIQ?si=rQcHTV\\_c9OnbM7gU](https://youtu.be/GED9rYPkAIQ?si=rQcHTV_c9OnbM7gU)

Readers might also be interested in seeing the following Ted Talks and documentaries to better understand both sides of the debate:

[https://youtu.be/tv9KnJIV\\_dUsi=Yo7STWt6Z12jAQ9b](https://youtu.be/tv9KnJIV_dUsi=Yo7STWt6Z12jAQ9b)

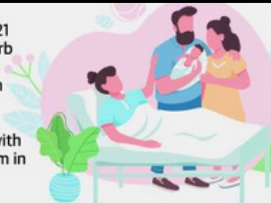
<https://youtu.be/p7kIWc7S8lQsi=ovqL6Sxpy6z3B6UI>

<https://youtu.be/IIVRHwZICr0si=iKtsy9mYYfoHoG4H>

Google Baby (not publicly available)

Made in India (not publicly available)

The Surrogacy (Regulation) Act, 2021 was introduced to curb unethical practices related to issues such as sex selection and exploitation of surrogate mothers, with provisions for jail term in case of violations



<ul style="list-style-type: none"> <li>■ Under the Act, a couple can opt for surrogacy only on medical grounds and should produce certificates of eligibility</li> <li>■ The couple should have been married for five years and not have a living child</li> <li>■ The surrogate mother</li> </ul>	<ul style="list-style-type: none"> <li>has to be a close relative of the couple, a married woman with a child of her own and aged between 25 and 35</li> <li>■ Though the law allows a single woman to resort to surrogacy, she has to be a widow or a divorcee between the age of 35 and 45</li> <li>■ Single men are not eligible</li> </ul>
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*Credits: Civildaily*

**Adv. Tanisha Choudhary**  
Alumnus, SVKM's PGCL

# THE COMMENTARY



*Straight from the commentary box of our editorial board, curated reads to expand your legal mind.*

## Conceptualization of Public Health in India: An Evolutionary Perspective

Rohit Barach's insightful paper, Conceptualization of Public Health in India: An Evolutionary Perspective, offers a timely and comprehensive account of how public health jurisprudence has evolved in India since independence. The study identifies five distinct phases—nation-building (1947–1983), pragmatic private sector accommodation (1983–1990), market-dominated liberalization (1990–2005), rights-based re-conceptualization (2005–2020), and emergency governance with digital surveillance during COVID-19 (2020–present). Each phase, rather than replacing the previous, layered new principles onto existing frameworks, creating a complex and sometimes contradictory landscape.

The paper highlights how early nation-building efforts, rooted in the Bhore Committee's vision of a publicly funded health system, were undermined by resource constraints and centralized governance. Later, liberalization entrenched market dominance, leading to household impoverishment through rising healthcare costs. The rights-based phase attempted to reconcile these contradictions by reframing health as a constitutional entitlement under Article 21, with initiatives like the National Health Mission and Ayushman Bharat.



Credits: The Economic Times



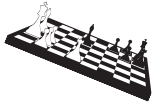
Most compelling is the analysis of the COVID-19 era, where India relied on colonial-era laws like the Epidemic Diseases Act of 1897 and the Disaster Management Act of 2005. These frameworks proved inadequate, exposing gaps in legal preparedness and raising constitutional questions about federalism, privacy, and individual rights. The introduction of digital surveillance tools such as the Aarogya Setu app marked a paradigm shift, embedding technology into public health governance while simultaneously sparking debates on privacy and accountability.

Barach's work underscores that public health in India is not merely a technical or medical issue but a deeply legal and political one. It reveals the ongoing tension between collective welfare and individual freedoms, and calls for coherent legislation that balances crisis adaptability with constitutional safeguards.

Link: [International Journal of Research in Social Science and Humanities \(IJRSS\)](#) - Vol. 6 (8), August 2025, DOI: 10.47505/IJRSS.2025.8.6

**Adv. Rajlaxmi Pawar**  
Associate at MDP Legal, Alumni  
PGCL

# THE BLACK & THE WHITE



*A legal chessboard of diverse opinions, which shade of justice are you going to checkmate?*

## Anganwadi Workers as Frontline Public Health Providers in India

In the architecture of India's public health system, the Anganwadi Workers (AWW) are integral but yet unfairly undervalued. These workers have been deployed under the Integrated Child Development Services (ICDS) scheme since 1975. For decades, these women have served as the first point of contact for millions of children under six, pregnant women, and lactating mothers across rural and urban India. As of 2024, ICDS' network operates through more than 13.9 lakh Anganwadi Centres, making it one of the world's largest community-based early childhood development and nutrition programmes. They facilitate immunisation, counsel, weigh, refer, and maintain records. They are, therefore, by every functional measure, frontline public health providers. Yet the law does not recognise them as such, and the state compensates them as simply volunteers.

### **Analysing the Gap Between Function and Status**

The duties assigned to an AWW look like a detailed public health mandate, including growth monitoring of children, supplementary nutrition, pre-school education, health and nutrition education, referral services, and immunisation support under the National Health Mission. She maintains birth and death registers, tracks at-risk pregnancies, and coordinates with Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives. The overlap and interdependence between these cadres is well documented. Yet ASHAs, AWWs, and other frontline health functionaries continue to occupy an uncertain position between volunteerism and formal public employment.

The Supreme Court of India has, in a series of pronouncements such as Ameerbi v. State of Karnataka (AIR ONLINE 2006 SC 648 2007), acknowledged the indispensability of Anganwadi functionaries while stopping short of conferring formal civil status. Courts have repeatedly acknowledged the importance of Anganwadi workers and have intervened regarding honoraria and service conditions, but these directions have been inconsistently implemented across states. The result is an uneven patchwork system where the same essential health function is compensated differently depending on geography, political will, and available budgetary allocation.



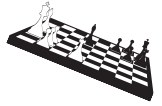
Credits: Newsclick

### **The Honorarium Dilemma**

The state's central justification for classifying AWWs as honorary workers rests on the premise that their role is community-based and participatory, not purely professional. However, this justification strains under further scrutiny. A worker who clocks mandatory hours, maintains prescribed registers, attends regular training, reports to supervisory staff, and faces disciplinary consequences for dereliction should not be described as a volunteer rendering honorary service. It is worth noting that Article 21 of the Constitution, as expansively interpreted by the judiciary, encompasses the right to livelihood and dignified working conditions. Where the state is both the employer in substance and the authority responsible for public health delivery, it carries a constitutional obligation that cannot be discharged.

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# THE BLACK & THE WHITE



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The ICDS scheme documents describe the Anganwadi Worker as a "lady selected from the local community" acting as an "agent of social change" which is language that anchors the role in voluntarism and pre-empts the vocabulary of employment. The tension between functional reality and legal classification is most visible in the judiciary's treatment of Anganwadi workers. The Supreme Court's eventual ruling in Ameerbi held that Anganwadi workers were scheme-based functionaries rather than holders of civil posts, a classification that has subsequently been used to limit claims to labour protections ordinarily available to employees. The implications of this classification extend beyond service law. By denying employee status, the state also avoids obligations associated with minimum wage protections. The Supreme Court in People's Union of Democratic Rights had already established that sub-minimum wage labour constitutes forced labour and a violation of Article 23, irrespective of whether a worker qualifies as an industrial workman. However, Ameerbi did not engage with such broader constitutional reasoning.

## Consequences of Formal Recognition


Formal recognition as public health workers, rather than scheme beneficiaries or honorary volunteers, would carry three essential consequences. First, it would bring AWWs within the protective ambit of labour legislation, ensuring minimum wage compliance, occupational safety protections, and social security coverage. Second, it would create enforceable accountability mechanisms in both directions: clearer performance standards for workers and defined obligations for the state as employer. Third, it would strengthen the institutional standing of AWWs within the public health system, enabling more effective coordination with health facilities and reducing bureaucratic barriers in referral processes

A critique would be that regularisation would impose unsustainable fiscal burdens on state governments and potentially bureaucratise a

system whose strength lies in community embeddedness. However, they do not justify the perpetuation of precarious working conditions. A tiered framework; acknowledging varied cadres, responsibilities, and tenures; could balance fiscal prudence with statutory protection. The goal need not be uniformity but it must be dignity.

**DEMANDING THEIR RIGHTS** File photo

- Anganwadi workers and helpers are essential in implementing govt schemes for women and children in villages
- They feel their pleas for better pay were being ignored
- Despite numerous protests, workers still earned only ₹10,500 per month and helpers earned ₹5,500
- They were demanding an increase in wages in line with the current times, as well as pension and gratuity benefits



- In response to their unmet demands, they plan to boycott submitting their monthly reports and other govt meetings
- **The workers have decided to hold an agitation in Mumbai's Azad Maidan on July 29**

*Credits: Times of India*

## Conclusion

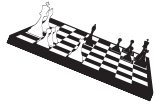
India's Anganwadi Workers are not peripheral actors in the public health ecosystem - they are its foundation. The Poshan Abhiyaan, the National Nutrition Mission, and successive National Health Policies have all affirmed this centrality in principle. What remains is the political and legal will to affirm it in practice. Reclassifying AWWs as frontline public health workers, conferring upon them the employment protections they are constitutionally owed, and investing in their training and professional advancement is not an act of charity. It is the minimum obligation of a state that has, for five decades, relied on their labour to sustain the health of its most vulnerable citizens.

**Ms. Tisha Manek**  
Student, 4<sup>th</sup> year

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# THE BLACK & THE WHITE



*A legal chessboard of diverse opinions, which shade of justice are you going to checkmate?*

## Should Healthcare Remain A Market When Health Is A Right?

Healthcare is often suffixed with the word "industry/sector" but rarely with the word "right", which is unfortunate because industries are profit-driven, whereas rights exist to preserve human life. Healthcare is every aspect, service, process, product, and device that offers care. Therefore, the definition of healthcare not only includes hospitals and doctors but also diagnostics, insurance, and sanitation. The main aim of healthcare is to protect human life by providing quality of care and reducing the cost of medical care.

In the 2026-27 budget, the Government of India allocated a record Rs.1,06,530.42 crore (\$12.05 billion) to the Ministry of Health and Family Welfare (MoHFW), marking a ~10% increase over the previous year. Yet studies indicate that 122 Indians per 100,000 die due to poor quality of care each year, while nearly 70% of the healthcare services are being provided by private hospitals, which remain inaccessible to a large section of the population who cannot afford private healthcare.

Supporters of private healthcare argue that private hospitals offer advanced technology and specialised treatment and shorter waiting times than many state-run facilities. However, the average cost of a private hospital in Tier 1 and Tier 2 cities is 220,000 and 95,000, respectively. With 90% of poor households not having health insurance, healthcare expenses are largely paid out of pocket, often consuming up to 80% of a household's income or savings.



*Credits: Common Dreams*

### **Health As Fundamental Right**

The Constitution of India does not expressly mention the right to health. However, within the ambit of Article 21, the right to life and personal liberty, the right to health was declared a fundamental right by the Supreme Court in the Bandhua Mukti Morcha v Union of India & Ors (1983) judgement. The Apex Court in State of Punjab & Ors v Mohinder Singh Chawla (1996), also reaffirmed that the right to health is inseparable from the right to life.

In Mohinder Singh Chawla's judgement, Justice K. Ramaswamy stated "Government has constitutional obligation to provide the health facilities." The importance of health as a fundamental right has also been recognised by policy experts. The High-Level Group constituted under the 15th Finance Commission also recommended shifting health from the State List to the Concurrent List and declaring the right to health as a fundamental right. Health is an essential component of life, and access to quality healthcare cannot be based on individuals' capacity to pay because rights are universal and belong to every person, unlike industry goods. A right ceases to perform the function of a right the moment it is only available to those who can afford it.

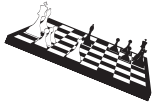
### **Private Healthcare**

According to the WHO, the private health sector are individuals and organisations that are neither owned nor directly controlled by governments. Private healthcare can be classified into subcategories such as profit, non-profit, formal, informal, domestic, and international. There are approximately 69,000 hospitals in India, out of which 26,000 are government hospitals and 43,486 are private hospitals. After COVID, there has been a rise in the commercialisation of healthcare. In 2023, the healthcare market in India was valued at about \$180 billion and is projected to reach roughly \$320 billion by FY 2028. Healthcare becomes a profit-generating module the moment it becomes commercialised. Some private hospitals focus less on the patient's well-being and more on the profit. They often advise patients to undergo unnecessary treatment and diagnostics.

#### **DISCLAIMER:**

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# THE BLACK & THE WHITE



**A legal chessboard of diverse opinions, which shade of justice are you going to checkmate?**

As a result, 23% of Indians relied on informal loans or borrowing to take care of hospital expenses. These hospitals are often located in metro cities and their suburbs, making quality private healthcare inaccessible to rural areas. Thus, only 25% of the semi-rural and rural population in India has access to modern healthcare within their localities. The out-of-pocket medical expenses in India account for 43.4% of the total health expenditure, often attributed to an increase in the commercialisation of healthcare. Thus, private care is not only inaccessible and unaffordable to the poor but also the reason why countless Indian families are in debt.

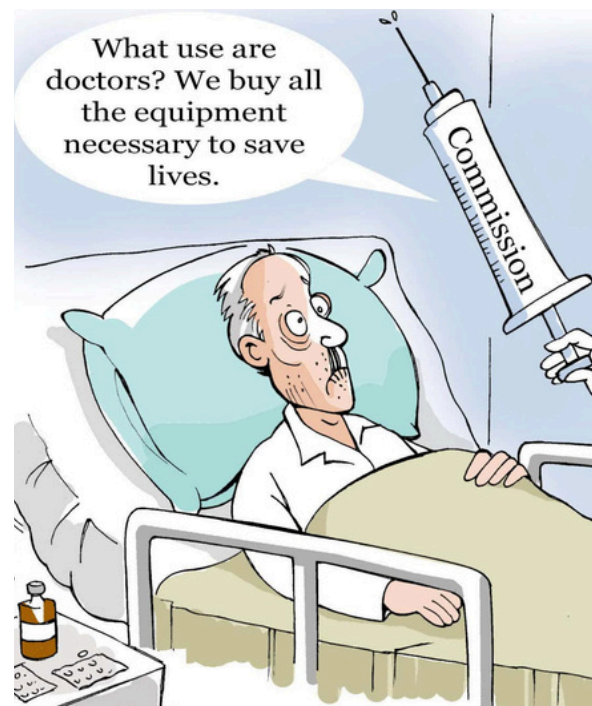
## India Needs To Learn

According to the 2025 CEOWORLD Health Care Index, Taiwan ranks first as the country with the best healthcare in the world among 110 countries. In the Legatum Prosperity Index 2023, which ranks 167 countries based on the accessibility to healthcare tools and services along with the overall health of their societies, Japan ranks second, followed by South Korea. Japan also has the highest life expectancy, the lowest rate of obesity, at 4.6% of the population, (lower than the global average), and a high number of hospital beds, i.e., 12.6 per person. In countries such as Japan and Taiwan, medical bankruptcy is extremely rare because of social health insurance, which guarantees universal medical coverage to all citizens and long-time residents, reducing the out-of-pocket expenses of patients. The cost of an MRI at a small clinic will be similar to the MRI cost at a multispecialty hospital because these countries have a standardised fee schedule that sets a uniform price for all medical procedures, pharmaceuticals, and diagnostics to keep costs predictable. Thus, India can also improve its healthcare system by adopting a standardised fee structure for medical procedures and treatments across all state-run and private hospitals, along with establishing universal health insurance for all its citizens and residents.

## Conclusion

The line between healthcare as a right and not an industry is blurrier now than ever. When private healthcare treats medical care as a profit-generating commodity, citizens' fundamental rights are violated. Healthcare differs from ordinary goods and services. A customer purchasing a phone can compare prices, search for other options available in the market, and pick one that caters best to their requirements and needs, whereas a patient suffering from a heart attack cannot do the same while choosing a hospital to receive medical care for saving their life. The need for healthcare arises in situations of urgency and vulnerability, leaving patients and their families with very little ability to understand the cost of treatment. This lack of bargaining power during times of crisis is exploited when healthcare becomes a market. Therefore, though commercialised healthcare offers better services than state-run facilities and imposes charges for these services, when it's a matter of life and death, profit should be secondary. In a country where health is a fundamental right, healthcare cannot become a privilege.

Ms. Alifiya Boxwala  
Student, 4<sup>th</sup> year



Credits: Centre For Investigative Journalism Nepal

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# THE WIG & THE WIT



Simple and fun puzzles to judge your wit!

## 15-Day Exercise Challenge

**START**

10 Squats

15 Jumping Jacks

20-second Plank

10 Push-ups

15 Lunges

20 High Knees

20 Mountain Climbers

15 Glute Bridges

30-second Wall Sit

15 Sit-ups

15 Squat Jumps

40-second Plank

20 Jumping Jacks

Bodyweight Squats

30 Lunges

**FINISH**

### HOW TO PLAY

- Complete 1 challenge every day in order.
- Tick it off once completed.
- Miss a day? Do 10 Jumping Jacks or complete the missed challenge before continuing.
- No skipping consistency is key!
- Stay hydrated, have fun, and cheer each other on!

### WORD JUMBLE

Unscramble each jumbled word related to healthcare, public health, and human rights.

THLHEA  
 UEQYTI  
 SRHGIT  
 PTASENIT  
 OTRCOD  
 LIPTSAOH  
 NECCAVI  
 MNIYUTIMM  
 AETRMNTTE  
 NROUITITN  
 AYERPTH  
 ESDSIAE  
 ENEICIDM

# THE CAUSELIST



The Newsletter's schedule for all things high and happening around the world.

## IDEACON 2026

A national-level medical conference focused on the latest developments in diabetes, endocrinology, and metabolic healthcare.



## HEALTHCARE RHYTHM 2026

An online international healthcare conference focused on advancements in mental health, digital healthcare, patient safety, public health, and primary care  
Date: 15 July 2026

## GLOBAL SUMMIT ON PUBLIC HEALTH

An online conference bringing together healthcare professionals, and policymakers discussing challenges in global health  
Date: 15–16 July 2026

## INTERNATIONAL CONFERENCE ON MEDICAL AND HEALTH SCIENCE

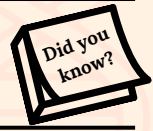
An international academic conference fostering research exchange, scholarly presentations, and industry–academia collaboration in medical and health sciences.  
Date: 15–16th July 2026  
Location: Sheraton New Delhi Hotel, New Delhi, India

## PSG 2026

National conference focused on advancing maternal and infant health outcomes in diabetes care.  
Date: 8–19 July 2026  
Location: Goa Marriott Resort, Panjim, Goa



# THE POST-ITS



Sticky Notes to tack up some fun legal facts.

**INDIA'S UNIVERSAL IMMUNIZATION PROGRAMME (UIP) IS AMONG THE WORLD'S LARGEST PUBLIC VACCINATION PROGRAMS.**

**NON-COMMUNICABLE DISEASES (NCDS) NOW ACCOUNT FOR MOST DEATHS IN INDIA.**

**INDIA'S COVID-19 VACCINATION CAMPAIGN EXCEEDED 2 BILLION DOSES**

**NFHS-5 IS INDIA'S NATIONALLY REPRESENTATIVE BENCHMARK FOR NUTRITION, IMMUNIZATION, ANAEMIA, FERTILITY, AND MATERNAL HEALTH**

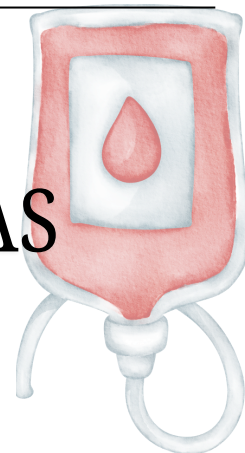
**INDIA RECORDS OVER 25 MILLION BIRTHS ANNUALLY, MAKING IT ONE OF THE LARGEST MATERNAL AND CHILD HEALTH SYSTEMS IN THE WORLD.**

HE WHO HAS HEALTH HAS

*Hope*

AND HE WHO HAS HOPE HAS

*Everything*



Until Next Time...

As we conclude this Public Health in India edition of The Briefcase, we thank you for journeying with us through conversations that explored one of the most pressing issues of our time. This issue invited us to look beyond hospitals and healthcare facilities, and instead examine the laws, policies, and institutions that shape the health and well-being of our communities.

This is not where the conversation ends. It is only the beginning. As healthcare continues to evolve alongside new legal, technological, and societal developments, so too must our understanding of the role law plays in protecting public well-being.

Next month, The Briefcase returns with fresh legal insights, thought-provoking discussions, engaging games, and exciting new features that continue to make the law accessible, relevant, and inspiring.

Until then, stay curious, keep questioning, and continue exploring the law beyond the classroom.

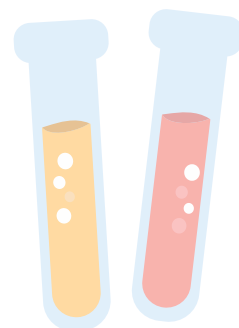
With purpose and commitment,  
The Editorial Board

*Thank you for reading!*

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