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Right to Emergency Care in India: Legal Obligations and Recent Judicial Interpretations

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ABSTRACT :

The right to emergency care in India, based on Article 21 of the Constitution, is getting defined progressively by judicial interpretations and reinforced by statutory frameworks. Since emergency care is recognized as an extension of the right to life, landmark decisions in Parmanand Katara v. Union of India and Paschim Banga Khet Mazdoor Samity v. State of West Bengal have made it obligatory on both public and private medical professionals to provide emergency services. The Supreme Court has extended the ambit of Article 21 to include timely medical intervention, with refusal or denial of emergency medical care by the state amounting to a violation of this constitutional right. At the statutory level, the Clinical Establishments Act, Indian Medical Council Regulations, Consumer Protection Act, and Mental Healthcare Act, among others, together impose ethical and professional standards in the provision of emergency care. Yet, the severe problems of implementation remain, including infrastructural issues, workforce shortages, socio-economic inequalities, and the lack of legal recourse, especially in rural and poorer areas. Recent changes in judicial trends during 2020-2025, especially throughout the COVID period, advocating greater cost regulation and accountability in private healthcare, reinforce an even stronger endorsement for the establishment of standardized emergency protocols. Policy-related proposals recommend passing an Emergency Medical Services Act; putting in place monitoring arrangements; along with capacity-building and public awareness programs. For the right to emergency care to be realized, India would have to bridge the gap between legal guarantees and healthcare realities, under an umbrella of integrated rights-based health governance.

Keywords: Right to emergency care, Art.21, Infrastructure for health care, Clinical Establishments Act, Medical negligence

Introduction

Emergency medical care contributes massively to the protection of the right to health, a fundamental right underlying human dignity. In India, where accidents are very common, medical emergencies abound, and public health crises often take a central stage, timely access to such care assumes immediate importance. The judiciary has recognized the same in its pronouncement in *Parmanand Katara v. Union of India*[1], holding that no hospital shall refuse treatment to any patient in an emergency. The same has been imposed in order to ensure right to life by the State, hence there is a call for concrete legal frameworks that will address the large gaps that exist in healthcare delivery, particularly in underserved regions.

India's vast population and uneven-set healthcare infrastructure amplify the challenges of emergency care provision in the country. While urban hospitals face overcrowding, rural areas remain below hospitals for treatment, thus raising the mortality rates. Socio-economic disparities limit access, hence private hospitals resorting to outright refusal for care on grounds of inability to pay. The Supreme Court gave force majeure to the emergency aspects in the Public Health Calamity by ordering States to provide emergency facilities in *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*[2]. This state of things emphasizes the urgent need to implement the legal provisions to reduce lopsidedness and ensure equal access to pressing health interventions across varied populations.[3]

Constitutional Framework for the Right to Emergency Care

Article 21 guarantees life and personal liberty, and therefore, the right of emergency care is intertwined within it. The judiciary applies a broader interpretation and includes fixation for the emergency medical treatment time in *Pt. Parmanand Katara v. Union of India*[4]. This imposes a positive obligation upon the state to enact an adequate healthcare infrastructure. The evolution of this jurisprudence has been aimed at the realization of human

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[1] AIR 1989 SC 2039.

[2] (1996) 4 SCC 37.

[3] Edward Premdas Pinto, "The Jurisprudence of Emergency Medical Care in India", 14 *Indian J. Med. Ethics* 53 (2017).

[4] AIR 1989 SC 2039.

rights, making the emphasis of emergency care a kaizen for whichever body, be it public or private, thus strengthening the constitutional obligation for the protection of life-the very constitutionally guaranted right of every citizen.

Judicial Expansion of Article 21

The courts have broadly interpreted Article 21 so as to consider emergency medical care to be an extremity of the right to life. In *Parmanand Katara v. Union of India*[5], the Apex Court held that hospitals cannot refuse emergency treatment, public or private, underscoring a duty on the State to safeguard lives. Thus, the Constitution stands as a precedent of saving life at any cost, even if it means overlooking procedural formalities. Following the precedent, the subsequent judgments have cemented the notion that the courts ensure the efficacy of this right by broadening the purview of Article 21 to include modern-day problems relating to health.[6]

Directive Principles and Emergency Care Obligations

In the Directive Principles of State Policy, Article 47 mandates the improvement of public health, directly concerning emergency care infrastructure. In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*[7], the Supreme Court ruled that Article 21, devoid of merely hypothetical object, is violated by inadequate medical facilities and that the states are therefore directed to improve emergency services. Article 47, being non-justiciable, acts as a guideline for policy formation. Governments are therefore bound to ensure resource allocation for life-saving care. The fusion of fundamental rights and directive principles underlines the state's obligation toward guaranteeing access to emergency medical facilities on an equal footing for all.

Right to Health as a Fundamental Right

Judicial activism elevated the right to health to a fundamental right under Article 21, thus linking it with the right to life. In the case of *Common Cause v. Union of India*[8], the Supreme Court of India reiterated accountability of the state to facilitate access to healthcare, including emergency care. This evolution indicates an integrated interpretation, placing health as essential to dignity and liberty. The courts have consistently pushed for systemic reforms so that duties relating to public health are not merely aspirational but enforceable, leading to a fortified constitutional framework for emergency care in India.

Statutory Framework Governing Emergency Care

The Clinical Establishments (Registration and Regulation) Act provides a regulation for health-care establishments, under which facilities maintain standard quality emergency care. Section 11 is an imperative provision requiring registration and violating the minimum standards, including the provision of emergency treatment to a patient immediately without any delay, in public or private hospitals. This provision was contemplated taking into consideration how irregular the delivery of services would be with the private hospitals denying care sometimes for a bankruptcy consideration. In case of default, penal sanctions are imposed, which supplement the provision being made accountable. Implementation of the Act in rural India faces obstacles as very few establishments are registered there, demanding stricter enforcement of emergency care on a pan-India basis across the diversified health care milieu.[9]

An Act enacted on cl. 5 of the constitution in force since 15.3.2011 recognises the registration of establishments and the regulation of establishments through the Clinical Establishments (Registration and Regulation) Act, 2010. This Act establishes a regulatory framework for healthcare establishments to ensure standardised emergency care. Section 11, thus, requires registration and adherence to minimum standards to be met, compelling emergency treatment to be rendered by all hospitals, both public and private, without any loss of time. Therefore, this section went to the disparity in service delivery, particularly in private hospitals where their denial of treatment due to monetary reasons was prevalent. This also becomes a deterrent through penalties for non-compliance. Implementation of the Act remains problematic in rural areas where very few facilities are registered, thus demanding stricter enforcement to guarantee emergency care access throughout India's variegated health care system.[10]

Both the National Health Mission and the Ayushman Bharat Scheme collaborate at the helm, especially in providing emergency healthcare under public health programs. NHM covers the inculcation of health infrastructure, including emergency services, whereas Ayushman Bharat takes care of promulgating the paying-off of emergency treatment charges at empanelled hospitals. But despite the steps taken, problems in implementing are rampant, with hospital procurement being inadequate in the rural heartland, while claim reimbursement procedures are cumbersome. If these gaps are not addressed, they will further limit the reach of the schemes, especially to the poor. Weighing their effectiveness and enhancing their funding in relation to enabling the schemes to stand on their own feet for the rendering of emergency care would, thus, greatly pay off, even though this is more of a state obligation on the health side.

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[5] AIR 1989 SC 2039.

[6] Right to Emergency Medical Care: Legal Protections in India, available at: https://nyaaya.org/legal-explainer/right-to-emergency-medical-care/ (Visited on March 15, 2025)..

[7] (1996) 4 SCC 37.

[8] (2018) 5 SCC 1.

[9] Manish Tewari, "India's Fight Against Health Emergencies: In Search of a Legal Architecture", available at: https://www.orfonline.org/research/indias-fight-against-health-emergencies-in-search-of-a-legal-architecture-63884 (Visited on March 22, 2025).

[10] Uttam Dubey, "Right to Emergency Medical Services In India", available at: https://ssrn.com/abstract/3639124 (Visited on March 10, 2025)..

The Motor Vehicles (Amendment) Act, 2019, is an act giving legal protection to Good Samaritans under Section 134A who render help to road accident victims in possession of timely administration of emergency care at the site of the accident. The Good Samaritans, by virtue of this provision, cannot be subjected to any civil or criminal liability or even face harassment in the course of any pending legal action, exacting a major impediment to intervention by a bystander. This, in a way, promotes an enabling milieu, whereby immediate aid can be rendered; reducing fatalities under road accidents which constitute a major share of emergencies in India. The positive effect of this law is being witnessed now to an extent as the public are more willing to help accident victims, but the Government should run awareness campaigns to give this provision a wider reach.[11]

Persons undergoing mental crises require urgent care and immediate attention, wherever possible. Section 21 of the Mental Healthcare Act, 2017, provides for such emergency treatment by recognizing mental health as an integral part of the overall well-being of an individual. It emphasizes a right to access immediate medical treatment in a psychiatric emergency-specific right to health under Article 21. The Supreme Court in India's *Gaurav Kumar Bansal v. Union of India* stated the argued need for adequate implementation of services for mental health emergencies, given the neglect at a system's level in this regard. Very few specialized centers coupled with the inadequately trained personnel are the diverging impediments to such service delivery. Therefore, there is a need for more improvement in both infrastructure and awareness programs to ensure the equitable access of mental health emergency services to all sections of Indian society.

Judicial Interpretations and Landmark Cases

The Mental Health Act of 2017, especially Section 21, contains provisions in regard to cases of emergency treatment of individuals undergoing mental health crises, giving due recognition to mental health as an aspect of general well-being. Hence, whenever circumstances amount to psychiatric emergencies, care should be immediately granted to the affected individuals. The Supreme Court observed in the matter of *Gaurav Kumar Bansal v. Union of India*[12] after noting the systemic neglect of urgent mental healthcare treatments that emergency mental healthcare must be afforded in a much more robust manner, considering the right to health under Article 21 of the Constitution of India. However, there are still very few private institutions with emergency mental health services, and training for personnel in mental health emergencies is also quite inadequate-the very contrasting factors preventing implementation of emergency mental health services standards. Thus, there still appears a long way to go in terms of further strengthening very many empty spaces in the mental healthcare infrastructure and very low mental health awareness for providing emergency care evenly across India.

Recent Judicial Trends (2020–2025)

Public Interest Litigation (PIL) has shaped the right to emergency care, allowing the courts to intervene against systemic healthcare inadequacies. Through PILs, courts have forced states to uphold their responsibilities, ensuring the provision of life-saving treatment. In *Pt. Parmanand Katara v. Union of India*[13], the Supreme Court directed hospitals to give immediate care to a patient regardless of delay due to procedures, hence emphasizing the patient's life above all. Likewise, *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*[14] placed further emphasis on the state's obligation to ensure the availability of infrastructure for emergency care, thereby demonstrating the transformational power of PILs.

Challenges Highlighted by Courts

The recent trend in judicial decisions exhibits a proactive approach to fix emergency care protocols. In *Sanjay Gupta v. Union of India*[15], the Supreme Court had issued directives to enforce uniform emergency care guidelines in the backdrop of the COVID-19 crisis, which had almost brought the medical infrastructure to a standstill, emphasizing a coordinated response. In *People's Union for Civil Liberties v. Union of India*[16], the Court ordered free emergency care to those that belonged to the economically weaker sections and would intoxicate any financially induced barrier for emergency treatment.4 These decisions depict how private hospitals are under greater scrutiny, becoming accountable, and better enforcement is placed on ensuring equal access to treatment during public health emergencies, thus articulating evolved judicial concerns.[17]

Challenges in Implementation

The courts have always considered systemic barriers to accessing emergency medical care. Many private hospitals refuse treatment because patients are not able to pay, thereby violating constitutional guarantees. In *Ramakant Rai v. Union of India*[18], the Supreme Court condemned the bureaucratic expansionism that creates impediments to timely care and urged for a speedy process. This result is again worsened by a non-coordination between the

[11] Edward Premdas Pinto, "The Jurisprudence of Emergency Medical Care in India", 14 *Indian J. Med. Ethics* 1 (2017).
[12] Writ Petition (C) No. 539 of 2021.
[13] AIR 1989 SC 2039.
[14] (1996) 4 SCC 37.
[15] 2022/DHC/005856.
[16] AIR 1997 SC 568.
[17] Emergency Medical Care to Victims of Accidents and Women under Labour, available at: https://www.advocatekhoj.com/library/lawreports/emergencymedicalcare/1.php (Visited on March 20, 2025)..
[18] W.P (C) No 209 of 2003.

two systems, especially in rural areas. There have been a few judicial interventions pressing for policy changes to address these issues, which highlights the need for integrated healthcare frameworks to address crisis care obligations that are met uniformly by all parties in both sectors.[19]

Shortage of Trained Personnel and Equipment

India's emergency care system faces many structural challenges that abet underdevelopment of its rural and semiurban healthcare infrastructure. The National Health Profile 2024 had stressed a critical shortage of emergency care facilities, so much so that many zones have no working trauma center or ambulance. Left to themselves, such gaps only increase pending interventions and consequently, mortality rates. Healthcare development is very urban-centric, thus leaving the vulnerable remote populations even more unassisted. The absence of standards concerning operating procedures for emergency services worsens the situation. This calls for investment in infrastructure to include mobile medical units and telemedicine, distinguishably across geographies so that all may avail life-saving care.

Socio-Economic Barriers

Socio-economic barriers: a significant factor impeding access to emergency care-though treatment is refused in private hospitals on grounds of affordability. In *Laxmi Mandal v. Deen Dayal Harinagar Hospital*[20], the High Court of Delhi condemned discrimination in denial of care to economically disadvantaged patients and reiterated that equal access must be afforded to all.3 Besides this lack of awareness concerning their legal rights under Article 21 are the commonalities preventing these individuals from seeking redress. Worse still, such a problem is most pronounced among marginalized populations who are rendered self-excluded. This very aspect demands robust public awareness initiatives and stringent regulation of private hospital matters to ensure equal access and constitutionally guaranteed emergency healthcare.[21]

Legal and Policy Gaps

Lack of emergency care legislation truly interferes with consistent implementation of emergency care across India. Existing laws such as the Clinical Establishments Act are ineffective in terms of enforcement, enabling hospitals to escape penalties. Service delivery has become fragmented, especially in neglected areas, owing to the absence of a national policy on emergency care. The courts have identified such lacunae and called for harsher penalties. In order to counteract the deficiencies and guarantee emergency care are addressed under law across the country, an Emergency Medical Services Act needs to be passed alongside a national policy with stipulated nationally standardized protocols and mechanisms for accountability.[22]

Conclusion

The "Right to Emergency Care" has become a domain for progressive interpretation by the courts and legislations. The Supreme Court, in these landmark judgments, *Parmanand Katara v. Union of India*, and *Paschim Banga Khet Mazoor Samity v. State of West Bengal*[23], were some of the earliest occasions where emergency care was declared to be part of the right to life, whereby anybody requesting emergency treatment could not be refused treatment either in a public hospital or private hospital. Hence, these rulings bear testimony to the judiciary taking an active role in interpreting constitutional rights into concrete mandates for healthcare. Supporting legislations, namely, the Clinical Establishments Act, Indian Medical Council Regulations, and Consumer Protection Act, also contribute to enforcing this duty by setting ethical, legal, and professional standards concerning emergency care. Other types of initiatives contemplated for the extension of this right are the Ayushman Bharat Scheme alongside the Mental Healthcare Act; but implementation remains a matter of discussing, mostly lacking in rural pockets and marginalized sections.[24]

Laws have sought to set things right in the system over time, but some systemic impediments persist in India's emergency care setting: infrastructural gaps affecting physical setups and/or facilities, an uneven distribution of medical personnel, and social and economic discriminations. Recent judicial trends, more and more so during the post-COVID era, have made it highly desirable to have standardized emergency care and to augment accountabilities, perhaps more at the level of private hospitals. In the absence of a uniform emergency care policy, courts have described the deficiency in the approach while emphasizing the drafting of unified standards to put an end to disjointed regulatory and enforcement execution gaps. Going into the foreseeable future, reforms will have to be better integrated through policy decisions and investment in infrastructure, training, and knowledgeable communities to ensure that emergency care, since it is legally a right, becomes a daily reality for every citizen, anywhere, irrespective of their economic status.

Suggestions

The following measures can be suggested to strengthen implementation of, and the right to emergency care service in India and to allow for accessibility to emergency care services on an equitable basis considering legal and judicial developments in respect of right to emergency care in

[19] "Emergency Provisions in India: A Critical Analysis", available at: https://blog.ipleaders.in/emergency-provisions-india-critical-analysis-2/ (Visited on March 20, 2025)..

[20] Writ Petition (C) No. 8853 of 2008.

[21] Manish Tewari, "India's Fight Against Health Emergencies: In Search of a Legal Architecture", available at: https://www.orfonline.org/research/indias-fight-against-health-emergencies-in-search-of-a-legal-architecture-63884 (Visited on March 22, 2025)..

[22] Prachi Salve, "Absence of Emergency Care Law Is Costing Lives in India", *IndiaSpend*, December 10, 2023.

[23] (1996) 4 SCC 37

[24] Soumitra Kumar Chatterjee, "Right to Health, Constitutional Safeguards and Role of Judiciary", Odisha Review 85 (2016).

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1. Enact a dedicated Emergency Medical Services Act that clearly defines roles, responsibilities, and penalties for non-compliance. This would streamline emergency care delivery across all states and healthcare providers.
2. Mandate regular audits and compliance checks under the Clinical Establishments Act, particularly for rural and semi-urban establishments. There is a need for stronger enforcement mechanisms so that hospitals do comply with minimum standards of emergency care.
3. Institutions should provide training across the country for upgrading the existing knowledge among medical personnel and paramedics about emergency response protocols. Working and collaborating with medical institutions will further mitigate the problem of shortage of skilled professionals in high-need areas.
4. Emergency care triage, treatment, and referral procedures should be standardized by a national emergency care protocol. Such uniform guidelines will go a long way in lessening disparities, especially during public health crises.
5. Expand empanelment of hospitals under Ayushman Bharat to more rural and tribal areas. Making reimbursements faster and creating awareness among beneficiaries about the scheme will increase its utility during emergencies.
6. Economic incentivization should be provided to private hospitals for the delivery of emergency treatments to the economically weaker sections of society. This will help dissuade refusals of treatment on the pretext of lack of financial means and further aid in ensuring that such treatment is duly provided as a matter of constitutional obligation.
7. Conduct a public awareness campaign on Article 21 rights for emergency care. There should be a special focus on marginalized populations so these legal rights translate into actionable information.
8. Promoting telemedicine with mobile health units as interim measures for remote areas that still lack an emergency infrastructure. Digital investments can fill these gaps in service accessibility.
9. Attempt to reinforce and raise awareness about Good Samaritan Laws through community outreach and law enforcement agency training. This will eliminate reluctance bystanders might have in assisting for fear of being harassed.
10. Instituting a central mechanism for transacting complaints related to emergency care and ensuring their resolution in a transparent and timely manner will go a long way in holding health authorities accountable and building trust in the healthcare system.