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Original Article

From Constitutional Promise to Practical Access: A Comparative Socio-Legal Analysis of the Right to Health in SAARC Countries

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Abstract

Background

The right to health has developed into a key constitutional and legal and policy matter that impacts all countries in the SAARC region because they have established different methods to safeguard public health and allow people to access medical services. Some countries recognize health more directly through constitutional or policy commitments while others utilize indirect health protection through their legal frameworks which include right to life and welfare principles and administrative measures.

Research Question

The study investigates the impact of constitutional and legal recognition of the right to health on actual healthcare access for citizens across SAARC countries. The study investigates whether legal entitlement matches the existing healthcare system which includes infrastructure and financing and institutional capacity and equitable implementation.

Method

The research uses doctrinal and comparative socio-legal methods to gather information from both primary and secondary sources. The study evaluates health rights in India and Bhutan and Nepal and Sri Lanka and Bangladesh and Pakistan and Maldives and Afghanistan through an analysis of constitutional provisions and judicial rulings and national policies and various legal and policy documents.

Finding

Discovery The research findings show that SAARC member countries recognize health rights through different means but their implementation of these rights fails to meet their constitutional and policy obligations. Service access is constrained by the absence of government funding and geographic impediments, and by limited institutional capacity and the demand for private healthcare services and continuing social inequalities. India provides an important reference point because of its development of jurisprudence under Article 21 and the unequal access to constitutional medical services by citizens.

Keywords: *Right to health, SAARC countries, Constitutional recognition, Healthcare access, Socio-legal analysis etc.*

1.2 SAARC Relevance and Comparative Need

The SAARC region offers a valuable research location The member states of SAARC display common structural elements which include their economic condition of poverty and their rural areas which face disadvantages and their uneven distribution of infrastructure and their population density and their ongoing struggle with both infectious and non-infectious diseases[1]. The countries display constitutional differences which extend to their policy frameworks and their ability to execute policies and their level of legal acknowledgment about health matters. A comparative study is therefore necessary to understand how similar social conditions produce different legal and policy responses across the region.

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[1] Constitution of India, art. 21. https://www.india.gov.in/sites/upload_files/npi/files/coi_part_full.pdf

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1.3 Central Argument

The article argues that constitutional promises do not translate into real access. In SAARC countries, the right to health may be expressly recognized, indirectly protected, or policy-driven, yet actual enjoyment of healthcare still depends on implementation, public financing, institutional strength, geography, and social inclusion[2]. The research investigates how people experience legal rights which exist in law but cannot be accessed by them.

2. Conceptual framework

2.1 Meaning of the Right to Health

The legal and policy definition of the right to health extends beyond medical treatment access to establish every individual right to essential conditions which enable them to achieve their maximum physical and mental health potential. The proposal reflects this understanding by drawing on the World Health Organization's definition of health as complete physical, mental, and social well-being and by linking health with nutrition, sanitation, working conditions, maternity relief, and environmental protection. The right to health encompasses both medical treatment and all factors which determine health outcomes.

2.2 Welfare Approach and Rights-Based Approach

The welfare approach considers health to be a social good which the government must protect through its various policies and programs and administrative systems. A rights-based approach establishes health as an enforceable entitlement which exists because of human dignity and equal rights and the fundamental right to life. The proposal shows this change in Indian society because Directive Principles provided the basis for welfare programs and judicial rulings through Article 21 established health as a constitutional right. The distinction between welfare and rights establishes different degrees of political power because welfare depends on political discretion while rights create mandatory responsibilities and obligations.

2.3 Socio-Legal Analysis

A socio-legal analysis examines the right to health not only as a matter of legal doctrine but also as a lived institutional reality. The research investigates actual functioning of constitutional provisions and judicial decisions and state policies and administrative structures and public programmes. The SAARC context requires this method because legal recognition does not ensure actual access to rights. The socio-legal approach establishes a link between legal promises and actual health access in the community.

3. Constitutional promise in SAARC

The constitutional guarantee of health rights in SAARC countries exists because different countries have different levels of recognition and enforcement abilities. The Indian Constitution does not provide an explicit fundamental right to health but establishes a strong indirect right through both the Directive Principles and the Supreme Court's interpretation of Article 21. The Supreme Court has extended the right to life definition through its decisions which establish health rights and medical services as essential components of this right. Indian constitutional law shows that judicial activism enables courts to fill gaps in constitutional provisions through their decisions.

The textual models of Nepal and Bhutan present a greater degree of strength. Under the Constitution of Bhutan, the government is obligated to ensure that its citizens have access to free basic health care services[3]. These services include contemporary medical services and traditional healing practices. The Interim Constitution of 2007 grants all Nepalese citizens the right to receive free basic health services from the government which has helped establish free healthcare programs in the country[4]. Citizens of these two nations now enjoy a stronger legal right to access health services which their governments must provide.

Sri Lanka holds an intermediate status between two different points. The Constitution of Sri Lanka does not specifically acknowledge health as a fundamental right yet the legal framework protects citizens through equality rights and welfare provisions and judges use the right to life as their legal reference[5]. Pakistan lacks constitutional strength because it does not recognize health as a basic right whereas its legal system relies on policy guidelines and rare judicial extensions of the right to life[6]. Bangladesh Maldives and Afghanistan show a stronger focus on government policies than protection of individual rights because their health obligations exist primarily through administrative channels and governmental duties and national programs instead of strong constitutional protections[7]. The region

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[2] World Health Organization, *Constitution of the World Health Organization* (WHO, 1948). https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf

[3] Constitution of the Kingdom of Bhutan, 2008. https://www.nationalcouncil.bt/assets/uploads/docs/laws/2017/Constitution_of_Bhutan_2008.pdf

[4] Interim Constitution of Nepal, 2007. https://www.constituteproject.org/constitution/Nepal_2007.pdf

[5] Constitution of the Democratic Socialist Republic of Sri Lanka, 1978. https://www.parliament.lk/files/pdf/constitution.pdf

[6] Constitution of the Islamic Republic of Pakistan, 1973. https://na.gov.pk/uploads/documents/1333523681_951.pdf

[7] Constitution of the People's Republic of Bangladesh, 1972. http://bdlaws.minlaw.gov.bd/constitution.html

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shows a range of constitutional commitment that exists between two extremes which include direct textual proof and judicial interpretation and governmental duty based on policies.

4. From promise to access

The movement from constitutional promise to practical access is where the comparative differences among SAARC countries become most visible. The legal recognition of healthcare rights does not lead to equal healthcare access because actual healthcare access depends on multiple factors which include infrastructure and public financing and administrative capacity and geographical factors and social inequality. India demonstrates this gap because the Article 21 judicially established right to health shows strong protection yet public health expenditure only reached 1.1 percent of GDP in 2009 while 78 percent of outpatients and 60 percent of inpatients received treatment from private medical facilities. The state implemented mission-mode reforms which included the National Rural Health Mission to address the dual problems of rural geography and insufficient health insurance and poverty and malnutrition[8].

The situation in Nepal shows different results. The constitution established basic health services as mandatory public services which the government needed to provide without charging users at primary health facilities. The proposal demonstrates better healthcare access which leads to lower personal expenses and people satisfied with free medical services. The distribution of wealth and the division between rural and urban spaces and different ecological zones all show ongoing existence of structural inequality because formal rights do not eliminate existing disparities. Bhutan demonstrates better public health commitment because it provides free essential health services which the government supports through its funding system and universal health coverage that follows both constitutional regulations and public health policies. Sri Lanka maintains its welfare system through effective public service delivery which operates alongside provincial administration. This shows that a complete constitutional right to health is not necessary for a welfare system to operate successfully.

Bangladesh operates its healthcare system through centralized control which supports a vast network of primary-care facilities yet the proposal reveals multiple operational shortcomings through its demonstration of two main issues which include an incomplete referral network and operational deficiencies of community health centers that were constructed in large numbers. Maldives has improved service provision through hospitals, health centres, and island-level expansion, but its dispersed island geography raises delivery costs while it maintains ongoing transportation challenges and needs for pharmaceutical access. Afghanistan demonstrates progress toward better health access through its increased number of healthcare facilities yet its health system development continues to be determined by three main factors which include reconstruction efforts and institutional weaknesses and the extensive support from WHO and other UN agencies[9]. The main challenge for the region does not involve health recognition but rather tests whether the government can transform its legal and policy obligations into permanent and affordable healthcare systems that include all citizens.

Country	Legal/policy promise	Main access reality
India	Judicially expanded right to health under Article 21	Low public spending, heavy private dependence, rural and poverty barriers
Nepal	Free basic health services and constitutional recognition	Improved access, but persistent social and regional disparity
Bhutan	Free basic public healthcare and universal coverage orientation	Stronger public support, though sustainability remains important
Sri Lanka	Welfare-oriented public system with indirect constitutional support	Comparatively stable public delivery structure
Bangladesh	Centralized ministry-led health system and community network	Operational gaps, weak referral system, incomplete clinic functionality
Maldives	Ministry-led service expansion across islands	Geography, transport costs, and import dependence raise access barriers
Afghanistan	National policy and expanding facility network	Access improving, but reconstruction and donor support remain central

5. India as special reference

5.1 Why India Is Central to the Comparison

The complexity of India's health rights regime due to judicial innovations, its demographic size and policy frameworks, makes it the first point of reference for comparison of the right to health in SAARC countries. The proposal itself places special emphasis on India by examining how health has been read into the Constitution and how courts have interpreted it as part of Article 21. India holds this central position because its massive population and

[8] Constitution of the Republic of Maldives, 2008. https://www.maldivesinfo.gov.mv/home/files/library/constitution/The%20Constitution.pdf

[9] Constitution of the Islamic Republic of Afghanistan, 2004. https://www.afghan-web.com/republic-afghanistan-constitution-2004/

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extensive rural areas and severe poverty and malnutrition issues and its healthcare system challenges from both infectious and chronic diseases. The extensive size of India establishes it as an essential experimental site to evaluate whether constitutional advancements result in better public health services[10]. The research site provides a unique socio-legal environment where various elements of constitutional obligations and judicial activism and government programs and market needs interact in multiple ways.

5.2 Article 21 and Right-to-Health Jurisprudence

The right-to-health development in India received its best achievement through the Constitution's Article 21 extension. The Supreme Court has developed a broad interpretation of the right to life which includes health rights despite the Constitution not recognizing health as an independent fundamental right. The proposal highlights several important cases in this regard. The Court established in Bandhua Mukti Morcha v. Union of India that human dignity rights include health protection rights. Public health was regarded the highest priority for the community in Vincent Panikulangara v. Union of India[11]. The Court established in Consumer Education and Resource Centre v. Union of India that Article 21 protects health rights and medical care as fundamental rights[12]. The Court in Paschim Banga Khet Mazdoor Samity v. State of West Bengal reaffirmed that government hospitals must provide emergency medical care which constitutes a basic duty[13]. The judicial decisions established health rights as essential to human dignity and life according to constitutional law.

5.3 NRHM, NHM, and Access Reforms

The judicial expansion process failed to solve health care access problems which required policy reforms as their second solution. The proposal notes that India launched the National Rural Health Mission in 2005 to improve the health system, especially in rural areas, and to provide universal access to equitable, affordable, and quality healthcare[14]. The mission-based framework of this approach obtained its importance through its ability to transform constitutional and policy goals into visible government activities. The National Health Mission implemented its mission-based changes through a framework that combined service delivery operations with their planning and assessment processes. The state acknowledges health rights require both judicial confirmation and program execution to achieve their complete implementation.

5.4 The Continuing Contradiction

India demonstrates a fundamental conflict between its legal obligations and actual public access to its rights. The proposal records that public spending on health was only 1.1 percent of GDP in 2009, while heavy dependence on private providers and high out-of-pocket expenditure made healthcare financially difficult for many citizens. The constitutional advancements were practically ineffective because rural distance and underdeveloped insurance and poverty and weak public capacity restricted their implementation[15]. The most informative SAARC example exists in India which possesses strong judicial health rights recognition yet demonstrates how legal rights lead to unequal access for people.

6. Comparative findings

The legal frameworks between Bhutan and Nepal show the strongest agreement across all SAARC countries since both nations link their health obligations to their commitment of providing free basic health services. Bhutan provides free basic healthcare services to its citizens while establishing public financing as the foundation for its universal health coverage system. The constitution of Nepal provides health rights while establishing free health services and abolishing user fees at primary healthcare facilities and creating specific social assistance programs. Nepalian society shows ongoing social and regional disparities but both systems in the country demonstrate stronger links between legal commitments and actual policy implementation than other SAARC member states.

India and Sri Lanka operate as welfare systems which provide indirect rights to their citizens. Both nations utilize constitutional provisions to protect health rights, but neither constitution presents the health right as an independent legal right. Sri Lanka operates through its welfare system and statutory protections and its right-to-life framework while India built its essential right-to-health legal system through Article 21 and judicial decisions. India

[10] *Bandhua Mukti Morcha* v. *Union of India*, AIR 1984 SC 802. https://indiankanoon.org/doc/8563/
[11] *Vincent Panikulangara* v. *Union of India*, AIR 1987 SC 990. https://indiankanoon.org/doc/1743152/
[12] *onsumer Education and Resource Centre* v. *Union of India*, AIR 1995 SC 922. https://indiankanoon.org/doc/1359644/
[13] *Paschim Banga Khet Mazdoor Samity* v. *State of West Bengal*, AIR 1996 SC 2426. https://indiankanoon.org/doc/145453/
[14] Ministry of Health and Family Welfare, *National Rural Health Mission: Framework for Implementation 2005–2012* (Government of India, 2005). https://nhm.gov.in/images/pdf/about-nhm/nrhm-framework-implementation/nrhm-mission-document.pdf
[15] World Bank, *Public Expenditure on Health in South Asia* (World Bank Group, 2009). https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS

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demonstrates that strong constitutional development exists together with substantial implementation challenges because its system depends on private health services while rural communities possess insufficient public funding for their health needs.

The legal policies of Bhutan and Nepal exist as the most compatible legal frameworks which operate within the SAARC region because both nations establish health recognition through their dedicated public service commitments which provide free health services. The Bhutanese system delivers basic healthcare services at no cost to all citizens through its system that receives public funding support, while the Nepali system brings together constitutional rights with free healthcare services and primary healthcare facilities that charge no fees and its social assistance programs. The legal commitments and actual policy implementation in both systems show stronger connections than most other countries in the SAARC region because Nepal still experiences unequal treatment between different geographic areas and social groups. The institutional capacity of Bangladesh and Pakistan and Maldives and Afghanistan exists below their operational boundaries which restrict their institutional power. Bangladesh operates a centralized system with extensive policy goals yet its operational effectiveness suffers because of referral system deficiencies and non-operational community health facilities. Pakistan lacks explicit constitutional recognition of the right to health, Maldives struggles with island geography, transport costs, and dependence on imported medicines, and Afghanistan's progress remains closely tied to reconstruction conditions and external institutional support. The general comparative discovery indicates that legal recognition provides essential guidance through its creation of legitimate authority which establishes accountability frameworks yet institutional capacity together with funding resources and administrative capabilities and community participation all play vital roles in determining the actual implementation of health rights.

7. Conclusion

The rights to health in SAARC countries have shifted from a welfare-based approach to a rights-based approach according to the comparative study which found that health rights now exist as constitutional rights and public policies and judicial decisions recognize health as essential for human dignity and life existence. The region faces healthcare accessibility problems because financing systems and healthcare facilities and geographical factors and administrative abilities and social disparities lead to different healthcare access levels across various parts of the area. The main value of this document comes from its social-legal research which demonstrates how constitutional language and policy commitments fail to provide actual access to healthcare services in SAARC countries.

Reference

1. Constitution of India, art. 21. https://www.india.gov.in/sites/upload_files/npi/files/coi_part_full.pdf
2. World Health Organization, *Constitution of the World Health Organization* (WHO, 1948). https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf
3. *Bandhua Mukti Morcha* v. *Union of India*, AIR 1984 SC 802. https://indiankanoon.org/doc/8563/
4. *Vincent Panikulangara* v. *Union of India*, AIR 1987 SC 990. https://indiankanoon.org/doc/1743152/
5. *Consumer Education and Resource Centre* v. *Union of India*, AIR 1995 SC 922. https://indiankanoon.org/doc/1359644/
6. *Paschim Banga Khet Mazdoor Samity* v. *State of West Bengal*, AIR 1996 SC 2426. https://indiankanoon.org/doc/145453/
7. Constitution of the Kingdom of Bhutan, 2008. https://www.nationalcouncil.bt/assets/uploads/docs/laws/2017/Constitution_of_Bhutan_2008.pdf
8. Interim Constitution of Nepal, 2007. https://www.constituteproject.org/constitution/Nepal_2007.pdf
9. Constitution of the Democratic Socialist Republic of Sri Lanka, 1978. https://www.parliament.lk/files/pdf/constitution.pdf
10. Constitution of the Islamic Republic of Pakistan, 1973. https://na.gov.pk/uploads/documents/1333523681_951.pdf
11. Constitution of the People's Republic of Bangladesh, 1972. http://bdlaws.minlaw.gov.bd/constitution.html
12. Constitution of the Republic of Maldives, 2008. https://www.maldivesinfo.gov.mv/home/files/library/constitution/The%20Constitution.pdf
13. Constitution of the Islamic Republic of Afghanistan, 2004. https://www.afghan-web.com/republic-afghanistan-constitution-2004/
14. Ministry of Health and Family Welfare, *National Rural Health Mission: Framework for Implementation 2005–2012* (Government of India, 2005). https://nhm.gov.in/images/pdf/about-nhm/nrhm-framework-implementation/nrhm-mission-document.pdf
15. World Bank, *Public Expenditure on Health in South Asia* (World Bank Group, 2009). https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS