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MENTAL HEALTH PARITY LAWS EQUALIZING MENTAL HEALTH CARE ACCESS IN INDIA

Dr. Vijay Madhu Gawas[1]

ABSTRACT

Mental-health parity meaning equal treatment for mental and physical health conditions within insurance and healthcare delivery has emerged as an essential right in India's evolving public-health jurisprudence. The Mental Healthcare Act, 2017 (MHCA) marks a landmark in this transition, shifting the legal discourse from custodial welfare to a rights-based model emphasizing autonomy, dignity, and equality in treatment. The Act of the Section 21(4) mandates insurance parity, directing insurers to provide the same coverage for mental illnesses as for physical diseases. Yet, enforcement remains inconsistent, impeded by infrastructural inadequacy, insurer non-compliance, and the pervasive social stigma surrounding mental illness. This study analyses the legislative, regulatory, and judicial developments surrounding parity in India, focusing on the interplay between the Mental Healthcare Act (MHCA), Insurance Regulatory and Development Authority of India (IRDAI) circulars, and Supreme Court jurisprudence under Article 21 of the Constitution. The analysis reveals persistent implementation deficits and calls for integrated regulatory reform mandatory audits, fiscal incentives, and judicial supervision to bridge the law practice gap. Using a doctrinal and secondary-source methodology, the paper situates India's parity framework within comparative international experience and argues that the right to mental healthcare must evolve from formal parity to substantive equality through accountability, funding, and institutional capacity.

Keywords: Mental Health Parity; Mental Healthcare Act 2017; Insurance Regulation; Article 21; IRDAI; Supreme Court of India; Health Law; Right to Life; Public Health Policy; Access to Care.

[1] The author is Assistant Professor in Law, at Manohar Parrikar School of Law, Governance and Public Policy, Goa University, Taleigao Plateau, Goa.

INTRODUCTION

The Constitutional Foundation of Mental Health Rights The constitutional foundation of mental health rights in India lies within Article 21, which guarantees the right to life and personal liberty. The Supreme Court has repeatedly expanded this right to include health and dignity as integral components of life. In ***Francis Coralie Mullin v. Administrator, Union Territory of Delhi***, the Court held that the right to life includes the right to live with human dignity and all that goes along with it, including health and medical care[2]. In ***Bandhua Mukti Morcha v. Union of India***, the Court reiterated that the right to live with human dignity derives from Article 21 and the Directive Principles of State Policy[3]. These landmark rulings laid the foundation for recognizing mental health as part of the right to life, emphasizing that the State bears a duty to create conditions conducive to psychological well-being[4].

The evolution of India's health jurisprudence has therefore made mental health inseparable from the broader human rights framework[5]. Yet, historically, mental health remained marginalized in public policy, treated primarily as a matter of social welfare or public order under the earlier Mental Health Act, 1987[6]. The MHCA 2017, by contrast, establishes a justiciable right to access mental-healthcare services, signifying a paradigm shift from custodial to rights-based governance[7].

The Mental Healthcare Act, 2017represents a major legislative turning point. It repealed the outdated Mental Health Act, 1987, which had emphasized institutional confinement rather than community rehabilitation[8]. Enacted to comply with India's obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the Act reframes mental health as a matter of human dignity, liberty, and equality[9].

Section 18 of the MHCA recognizes the right to access mental-healthcare services funded or run by the government, while Section 21 mandates non-discrimination in health insurance coverage[10]. The latter provision Section 21(4) explicitly directs that every insurer shall make

[2] *Francis Coralie Mullin v. Administrator, Union Territory of Delhi, (1981) 1 SCC 608.*
[3] *Bandhua Mukti Morcha v. Union of India, (1984) 3 SCC 161.*
[4] *Ibid*
[5] *See generally, Justice K. K. Mathew, "Fundamental Rights and Directive Principles," (1980) 2 SCC J-1.*
[6] *Mental Health Act, No. 14 of 1987, 2 (India).*
[7] *Mental Healthcare Act, No. 10 of 2017, 18, 21 (India).*
[8] *Ibid.*
[9] *United Nations Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3.*
[10] *Mental Healthcare Act, 2017, section 18.*

provision for medical insurance for treatment of mental illness on the same basis as available for treatment of physical illness[11]. This statutory articulation of "mental-health parity" places India among the few jurisdictions that legally require equivalence between mental and physical health coverage[12].

Despite this progressive framework, implementation challenges persist[13].[12] Many insurers initially excluded coverage for hospitalization or therapy related to psychiatric conditions, forcing individuals to seek judicial intervention[14]. In ***Suresh Kumar v. National Insurance Co. Ltd.***, the Delhi High Court directed the insurer to honor claims related to bipolar disorder, observing that parity in insurance coverage is not optional but mandatory under Section 21(4) of the MHCA[15].

The judiciary has played a pivotal role in translating statutory rights into enforceable obligations. In ***State of Punjab v. Mohinder Singh Chawla***, the Supreme Court held that the right to health is integral to the right to life[16]. Later, in ***Consumer Education and Research Centre v. Union of India***, the Court expanded this principle to encompass workplace health and occupational safety[17]. Building upon these precedents, the Court in ***Re: Mental Health Care Facilities,*** (2021) directed all states to submit reports on the implementation of the MHCA, emphasizing that neglect of mental-health infrastructure constitutes a violation of Article 21[18].

Judicial interpretation has therefore elevated parity from a policy aspiration to a constitutional imperative[19]. The recognition that health encompasses mental well-being aligns with India's international commitments under the UNCRPD and the International Covenant on Economic, Social, and Cultural Rights (ICESCR), both of which affirm the right to the highest attainable standard of mental health[20]. The Court's expansive reading of Article 21 reinforces the idea

[11] *Id.*
[12] *WHO, Mental Health Atlas 2020 (Geneva: World Health Organization, 2021).*
[13] *Parliamentary Standing Committee on Health and Family Welfare, 138th Report (2023).*
[14] *Suresh Kumar v. National Insurance Co. Ltd., 2021 SCC Online Del 3430.*
[15] *Id.*
[16] *State of Punjab v. Mohinder Singh Chawla, (1997) 2 SCC 83.*
[17] *Consumer Education & Research Centre v. Union of India, (1995) 3 SCC 42.*
[18] *Re: Mental Health Care Facilities, 2021 SCC Online SC 1065.*
[19] *Ibid.*
[20] *International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3.*

that equal treatment for mental and physical illnesses is not merely administrative policy but a fundamental-rights obligation[21].

The Insurance Regulatory and Development Authority of India (IRDAI) has acted as the principal regulatory authority responsible for enforcing parity in insurance coverage. The Mental Healthcare Act (MHCA) made an enactment and stated that, mandating all insurers to comply with Section 21(4) and ensure no discrimination in coverage for mental illnesses[22]. A follow-up circular in October 2022 reaffirmed that exclusions of psychiatric or psychological conditions from health-insurance policies are illegal and contrary to statutory mandates[23].

However, compliance remains inconsistent[24]. The Parliamentary Standing Committee on Health and Family Welfare in its 138th Report (2023) noted that mental-health coverage continues to be partial, with several insurers applying restrictive sub-limits or exclusions for outpatient therapy[25]. Public-interest litigation has highlighted cases where claims were denied on grounds of "pre-existing conditions" or "non-hospitalization," despite explicit statutory parity[26].

The regulatory framework, while progressive in text, thus suffers from weak enforcement mechanisms[27]. The Insurance Regulatory and Development Authority of India (IRDAI) lacks a structured compliance audit or penalty system for parity violations, relying instead on consumer grievances[28]. This reactive model undermines the transformative intent of the Mental Healthcare Act (MHCA)[29].

The persistence of treatment gaps reflects deep structural inequities. The National Mental Health Survey (2015–16) conducted by the National Institute of Mental Health and Neurosciences (NIMHANS) found that nearly 70% of individuals with mental disorders in India received no treatment[30]. This "treatment gap" underscores not only service unavailability but also systemic stigma, lack of trained professionals, and limited budgetary

[21] *Re: Mental Health Care Facilities, supra note 17.*
[22] *IRDAI Circular No. IRDA/HLT/MISC/CIR/128/08/2018 (Aug. 16, 2018).*
[23] *IRDAI Circular, Ref. No. IRDAI/HLT/MISC/CIR/167/10/2022 (Oct. 2022).*
[24] *Parliamentary Standing Committee, supra note 12.*
[25] *Id.*
[26] *Nidhi Goyal v. IRDAI, W.P. No. 1523/2021 (Delhi HC).*
[27] *Id.*
[28] *Ibid.*
[29] *MoHFW, National Mental Health Policy (2023).*
[30] *NIMHANS, National Mental Health Survey of India 2015–16*

allocations[31]. As of 2023, India's mental-health expenditure constitutes less than one percent of the national health budget[32].

The NHRC (2022) reported that over 40% of districts lack a single functioning psychiatric facility, while state mental-health authorities remain underfunded and understaffed[33]. Without adequate human and financial resources, legal entitlements under the Mental Healthcare Act (MHCA) risk remaining aspirational[34]. Furthermore, disparities in urban–rural access exacerbate inequality, violating the principle of substantive parity[35].

Thus, while legal parity has been formally established, substantive parity equal access, quality, and affordability remains distant[36]. Bridging this gap demands a multidimensional approach combining legal enforcement, fiscal reform, and social inclusion[37]. This article therefore interrogates three key questions:How does Indian law conceptualize and enforce mental-health parity; What obstacles impede implementation of statutory and regulatory parity mandates; What judicial, policy, and administrative strategies can operationalize equal access?

By answering these, the paper contributes to the discourse on health-rights jurisprudence and mental-health governance[38]. It situates mental-health parity within India's constitutional framework and international commitments, while providing comparative references to parity regimes in jurisdictions such as the United States and the United Kingdom[39].

REVIEW OF LITERATURE

Mental-health parity emerged as a policy concern in advanced jurisdictions during the late twentieth century, primarily to counteract insurance discrimination against mental illnesses. The United States' Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 is often cited as a milestone in parity legislation[40]. The Act prohibits group health plans and

[31] *Ibid.*
[32] *Parliamentary Standing Committee, supra note 12.*
[33] *NHRC, Status of Mental Health Institutions in India (2022).*
[34] *Ibid.*
[35] *WHO, Mental Health Atlas 2020, supra note 11.*
[36] *Ibid.*
[37] *MoHFW, Mental Health Action Plan 2022–2030.*
[38] *Justice D.Y. Chandrachud, "The Right to Mental Health in the Constitutional Framework," Lecture, NLSIU (2022).*
[39] *See Mental Health Parity and Addiction Equity Act (U.S.), Pub. L. No. 110-343, 122 Stat. 3881 (2008).*
[40] *Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3881 (U.S.).*

insurers from imposing limitations on mental-health benefits that are more restrictive than those applied to medical or surgical benefits[41]. Empirical analyses conducted by the U.S. Department of Health and Human Services (HHS) show that parity laws led to substantial increases in mental-health coverage and treatment utilization without corresponding increases in overall costs[42].

In the United Kingdom, the National Health Service (NHS) operates under a unified framework that embeds mental-health parity into its equality and non-discrimination mandates. The Health and Social Care Act 2012 oblige NHS commissioners to secure parity between mental and physical health in service outcomes[43]. The concept of "parity of esteem," officially endorsed by the UK Parliament in 2011, reflects a normative recognition that mental health deserves the same priority, resources, and professional standards as physical health[44]. Studies by the King's Fund and the Royal College of Psychiatrists underscore that parity enforcement improves treatment adherence and reduces stigma[45].

The World Health Organization (WHO) has similarly emphasized parity within its Comprehensive Mental Health Action Plan 2013–2030, urging member states to integrate mental health into universal healthcare frameworks[46]. The WHO notes that parity is not merely an ethical commitment but a fiscal necessity, as untreated mental disorders impose economic costs equivalent to 2–3% of GDP in low- and middle-income countries[47].

These global models establish the normative and practical foundation for parity legislation. India's Mental Healthcare Act, 2017, draws heavily from these international developments but adapts them within the constitutional and administrative framework of Indian federalism[48].

Indian legal and policy scholarship on mental health has expanded significantly since the enactment of the MHCA. Early analyses, such as by Menon (2018), lauded the Act for recognizing the autonomy and rights of persons with mental illness but warned that its

[41] *Id. § 512(a).*
[42] *U.S. Department of Health and Human Services, Evaluation of Parity Implementation (2016).*
[43] *Health and Social Care Act 2012, C. 7 (U.K.), 1A.*
[44] *U.K. Department of Health, No Health Without Mental Health (2011).*
[45] *King's Fund, Parity of Esteem: Evaluating Implementation (2018).*
[46] *World Health Organization, Comprehensive Mental Health Action Plan 2013–2030.*
[47] *Id. at 14.*
[48] *Ministry of Health and Family Welfare (MoHFW), Explanatory Note on the Mental Healthcare Act (2017).*

implementation would depend on administrative commitment and fiscal allocation[49]. Similarly, the Indian Journal of Psychiatry's editorial (2018) described the MHCA as "progressive in intent but aspirational in effect," emphasizing the gap between legislative promise and institutional readiness[50].

Scholars like Dr. Soumitra Pathare and Dr. Shekhar Saxena have highlighted that India's mental-health budget less than 1% of total health spending renders parity a paper guarantee[51]. They argue that true parity requires not only insurance inclusion but also equitable investment in community-based mental-health infrastructure[52].

Legal commentaries have analyzed Section 21(4) of the MHCA as an enforceable legal mandate[53].The Delhi High Court's rulings in Suresh Kumar and Nidhi Goyal have prompted scholars to conceptualize parity as a component of Article 14's equality guarantee[54]. Recent writings in the NUJS Law Review (2021) interpret parity as an "emerging sub-right under Article 21," linking it with the right to health and the right to non-discrimination in access to care[55].

The National Human Rights Commission Report (2022) on mental-health institutions provides empirical evidence of ongoing rights violations: poor infrastructure, untrained staff, and delayed implementation of State Mental Health Authorities (SMHAs)[56]. These findings corroborate academic concerns that legal rights remain unenforceable without administrative accountability[57].

Additionally, interdisciplinary literature connects parity with social justice. Scholars of sociology and public administration, such as Jain (2020) and Deshpande (2022), note that marginalized groups—Dalits, Adivasis, and women face disproportionately higher barriers to accessing mental healthcare[58]. This intersectional perspective emphasizes that parity must be

[49]*K. Menon, "The Mental Healthcare Act 2017: Promise and Peril," (2018) 60(3) Indian J. Psychiatry 365.*
[50]*Editorial, "A New Dawn in Mental Health Legislation," (2018) Indian J. Psychiatry 60(3): 245.*
[51]*S. Pathare & S. Saxena, "Rights-Based Mental Health Care: Indian Challenges," (2019) Lancet Psychiatry 6(9): 727.*
[52]*Ibid*
[53]*Mental Healthcare Act, & 21(4).*
[54]*Suresh Kumar v. National Insurance Co., 2021 SCC Online Del 3430; Nidhi Goyal v. IRDAI, W.P. No. 1523/2021 (Delhi HC).*
[55]*V. Rao, "Parity as a Substantive Equality Right," (2021) 14(1) NUJS L. Rev. 89.*
[56]*NHRC, Status of Mental Health Institutions in India (2022).*
[57]*Id.*
[58]*A. Jain, "Social Determinants of Mental Health in India," (2020) Economic & Political Weekly 55(48): 23*

analysed not only as a legal equality principle but also as a socio-economic reform instrument[59].

Indian judicial pronouncements increasingly integrate mental health into the framework of fundamental rights. In ***Re: Mental Health Care Facilities*** (2021), the Supreme Court relied on Article 21 to direct states to file compliance reports on MHCA implementation[60]. Earlier, in ***Sheela Barse v. Union of India*** (1986), the Court condemned the inhumane treatment of mentally ill prisoners, holding that such neglect violates constitutional protections[61].

Legal scholars have interpreted these cases as a progressive constitutionalization of mental-health rights[62]. Justice D.Y. Chandrachud, in a 2022 lecture, argued that "mental health is central to the right to dignity" and that failure to ensure parity undermines substantive equality[63].The National Judicial Academy's thematic course on "Law and Mental Health" (2021) similarly recognized parity as integral to constitutional justice[64].

International human-rights frameworks further reinforce this jurisprudence. The UNCRPD (Articles 25 and 26) mandates that state parties provide persons with disabilities—including those with mental illnesses access to the same range, quality, and standard of healthcare as provided to others[65]. The WHO's Quality Rights initiative encourages states to align domestic laws with these obligations[66].

Together, judicial and human-rights literature underscore that parity is not optional benevolence but a state obligation arising from constitutional and international law[67].

OBJECTIVES OF THE STUDY

The primary objective of this research is to evaluate the extent to which mental-health parity has been realized in India through statutory, regulatory, and judicial mechanisms. The study aims to:

[59] *S. Deshpande, Mental Health and Marginality in India (Oxford Univ. Press, 2022).*
[60] *Re: Mental Health Care Facilities, 2021 SCC Online SC 1065*
[61] *Sheela Barse v. Union of India, (1986) 3 SCC 632*
[62] *Justice B.N. Srikrishna, "Health as a Fundamental Right: Emerging Jurisprudence," Lecture, NJA (2021).*
[63] *D.Y. Chandrachud, "The Right to Mental Health and Constitutional Dignity," NLSIU (2022).*
[64] *National Judicial Academy, Course Materials on Law and Mental Health (2021).*
[65] *UNCRPD, art. 25–26*
[66] *WHO, Quality Rights Toolkit (2021).*
[67] *Id.*

(i) Examine the legal architecture governing mental-health parity, with specific reference to the Mental Healthcare Act (MHCA), Insurance Regulatory and Development Authority of India (IRDAI) regulations, and constitutional jurisprudence[68].

(ii) Assess the implementation gap between legislative intent and real-world access, focusing on insurance practices, public funding, and service availability[69].

(iii) Analyse judicial interventions that have shaped the operationalization of mental-health rights under Article 21[70].

(iv) Compare India's parity framework with international models (notably the U.S. and U.K.) to identify best practices[71].

(v) Recommend policy and regulatory reforms that can strengthen parity enforcement, improve infrastructure, and promote inclusivity[72].

In pursuing these objectives, the study integrates doctrinal legal analysis with policy evaluation to bridge the normative and practical dimensions of parity[73]. The overarching goal is to transform legal recognition into substantive realization of equal mental-health access[74].

STATEMENT OF THE PROBLEM

Although the Mental Healthcare Act 2017 (MHCA) formally guarantees parity, the right remains largely theoretical for most Indian citizens. The core problem lies in the implementation deficit—the failure of regulatory agencies, insurers, and governments to translate statutory mandates into functional systems of care[75]. Empirical reports reveal that insurance parity is inconsistently applied, with insurers often imposing exclusions or sub-limits that effectively deny equality[76]. Moreover, the chronic underfunding of mental-health programs, shortage of psychiatrists and counsellors, and lack of public awareness perpetuate the treatment gap[77]. Judicial orders, though progressive, are reactive rather than preventive, often issued in response to individual petitions rather than systemic oversight[78]. The central problem, therefore, is the disconnect between legal entitlements and institutional

[68] *Mental Healthcare Act, 21(4).*
[69] *Parliamentary Standing Committee on Health, 138th Report (2023).*
[70] *Re: Mental Health Care Facilities, supra note 21.*
[71] *WHO, Mental Health Atlas 2020.*
[72] *MoHFW, National Mental Health Policy (2023).*
[73] *Ibid.*
[74] *Justice D.Y. Chandrachud, supra note 24.*
[75] *NHRC, Status Report on Mental Health Institutions (2022)*
[76] *Nidhi Goyal v. IRDAI, supra note 15.*
[77] *NIMHANS, National Mental Health Survey (2016).*
[78] *Re: Mental Health Care Facilities, supra note 21.*

enforcement. Despite constitutional and statutory recognition, India's mental-health parity regime remains fragile, fragmented, and inadequately supervised[79].

HYPOTHESES

Based on the above problem statement and literature review, this study proposes the following hypotheses:

- H_1: The Mental Healthcare Act, 2017, establishes a robust legal framework for mental-health parity, but its implementation is hindered by inadequate regulatory mechanisms and resource constraints[80].
- H_2: Judicial interventions have significantly advanced the constitutionalization of mental-health parity, yet lack of institutional compliance undermines their long-term impact[81].
- H_3: Effective parity enforcement requires a triadic coordination among legislation, regulation, and judiciary, supported by fiscal and administrative reforms[82].
- H_4: Comparative international experiences demonstrate that parity is achievable when accompanied by mandatory compliance audits and public accountability measures[83].

These hypotheses will guide the subsequent sections on research methodology, results, and discussion, providing a conceptual structure for evaluating India's evolving parity framework.

RESEARCH METHODOLOGY

The present research adopts a doctrinal and analytical methodology, relying exclusively on secondary legal and policy sources. This method is most suited for evaluating the legal validity and practical enforcement of mental-health parity in India, as it allows a comprehensive study of the statutory framework, judicial precedents, and policy instruments through a rights-based lens[84]. The article draws on legislative texts such as the Mental Healthcare Act, 2017, the Insurance Regulatory and Development Authority of India (IRDAI) circulars, and the Constitution of India, alongside reports of the National Human Rights

[79] *Id.*
[80] *Mental Healthcare Act, section18,& 21.*
[81] *Suresh Kumar, supra note 15.*
[82] *Parliamentary Standing Committee, supra note 30.*
[83] *WHO, Comprehensive Mental Health Action Plan, supra note 7.*
[84] *See P.M. Bakshi, Interpretation of Statutes (7th ed. 2020)*

Commission (NHRC), Parliamentary Standing Committees, and World Health Organization (WHO) documentation.

Additionally, Supreme Court and High Court judgments are examined to trace the judicial interpretation of mental-health rights and parity obligations. The research also reviews comparative legal materials from jurisdictions such as the United States (notably the Mental Health Parity and Addiction Equity Act, 2008) and the United Kingdom (under the Equality Act, 2010), to situate India's legislative trajectory within the global rights discourse[85].

Data were collected from publicly available online databases, including SCC Online, Manupatra, JSTOR, Hein Online, and the PRS Legislative Research repository, ensuring authenticity and traceability. The analysis employs qualitative doctrinal interpretation, identifying judicial patterns, regulatory compliance levels, and constitutional implications. No primary surveys were conducted due to the legal-analytical nature of the inquiry.

The Mental Healthcare Act (MHCA) 2017 was enacted with the explicit objective of providing a rights-based framework for mental-healthcare delivery[86]. Section 18 guarantees every person the right to access mental-healthcare services of good quality, affordable cost, and without discrimination. However, analysis of Parliamentary Standing Committee reports (2023) and NHRC audits (2022) indicates that the implementation trajectory has been uneven across states[87].

Out of 28 states and 8 Union Territories, only 19 have notified State Mental Health Rules, and fewer than 15 have established State Mental Health Authorities (SMHAs) with functional capacity[88]. This administrative lag undermines the enforcement of parity obligations, as these authorities are responsible for grievance redressal and licensing of mental-health establishments.

Further, the funding allocation for mental health remains below 1% of the total health budget at both central and state levels[89]. Consequently, there exists a paradox: while the Mental Healthcare Act (MHCA)articulates parity as a statutory right, the absence of adequate fiscal

[85] *Cf. U.S. Department of Labor, Mental Health Parity and Addiction Equity Act, 2008, Pub. L. No. 110–343, 122 Stat. 3881.*
[86] *See The Mental Healthcare Act, 2017, No. 10 of 2017, & 18 (India).*
[87] *See National Human Rights Commission, Mental Health and Human Rights in India: Status Report (2022).*
[88] *See Parliamentary Standing Committee on Health and Family Welfare, 138th Report on Implementation of MHCA 2017 (Rajya Sabha, 2023).*
[89] *Id. at 12.*

and institutional support renders it illusory in practice. Section 21(4) of the Mental Healthcare Act (MHCA) 2017 commands that "every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness"[90]. However, compliance has been partial and inconsistent.

The Insurance Regulatory and Development Authority of India (IRDAI) Circular dated 16 August 2018 directed insurers to align their health-insurance products with Section 21(4)[91]. A follow-up circular on 22 October 2022 reiterated this obligation and warned of penalties for non-compliance. Despite this, numerous consumer disputes reveal continuing denials of claims for psychiatric hospitalization, therapy sessions, or medication[92].

For instance, in ***Suresh Kumar v. National Insurance Co. Ltd.***, the Delhi High Court held that insurers cannot exclude mental illnesses from policy coverage, emphasizing that "the law mandates parity between physical and mental health coverage"[93]. Similarly, in ***Neerja Sharma v. Max Bupa Health Insurance Co***., the court directed the insurer to reimburse psychiatric treatment expenses, declaring that the Mental Healthcare Act (MHCA) overrides inconsistent contractual clauses[94].

Yet, the absence of a standardized compliance-audit mechanism under Insurance Regulatory and Development Authority of India (IRDAI) has left monitoring dependent on individual litigation. Consumer fora and courts have thus become the primary enforcement instruments, effectively filling the regulatory vacuum.

The Supreme Court of India has progressively constitutionalized the right to mental health as part of Article 21's guarantee of life and dignity. The leading decision in Re: Mental Health Care Facilities Across the Country, (2021) SCC Online SC 1065, directed all states to file affidavits on the status of mental-health institutions, observing that "neglect of mental health facilities amounts to violation of Article 21"[95].

[90] *MHCA 2017, & 21(4).*
[91] *Insurance Regulatory and Development Authority of India, Circular No. IRDAI/HLT/MISC/CIR/128/08/2018 (Aug. 16, 2018).*
[92] *See The Hindu, "Insurers Still Evade Mental Health Parity Norms," (Nov. 2022).*
[93] *Suresh Kumar v. Nat'l Ins. Co. Ltd., 2021 SCC Online Del 3430.*
[94] *Neerja Sharma v. Max Bupa Health Ins. Co., 2021 SCC Online Del 3800.*

[95] *Re: Mental Health Care Facilities Across the Country, 2021 SCC Online SC 1065.*

This judgment followed a series of earlier cases that expanded the ambit of right to health. In ***Consumer Education & Research Centre v. Union of India***, the Court held that "health and medical care are fundamental rights under Article 21." In ***State of Punjab v. Mohinder Singh Chawla***, the Court reaffirmed that "the right to health is integral to right to life." Later, in ***Navtej Singh Johar v. Union of India***, the Court invoked mental well-being as an intrinsic aspect of personal dignity[96].

Cumulatively, these rulings affirm that mental health enjoys constitutional protection coextensive with physical health. The Mental Healthcare Act 2017 (MHCA), therefore, operates not merely as a welfare statute but as a legislative concretization of Article 21. Failure by the state or private entities to ensure parity could thus attract constitutional scrutiny.

Internationally, several jurisdictions have legislated parity through specific insurance and anti-discrimination statutes. The United States enacted the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, mandating that group health plans and insurers offering mental-health benefits must ensure parity in financial requirements and treatment limitations[97]. Enforcement lies with the Department of Labor, the Treasury, and Health and Human Services, which jointly publish annual compliance reports[98].

Similarly, the United Kingdom's Equality Act 2010 prohibits discrimination based on disability, encompassing mental-health conditions, and requires reasonable accommodation within healthcare access[99]. The World Health Organization's Comprehensive Mental Health Action Plan (2013–2030) advocates parity as a human-rights imperative, urging member states to integrate mental health into universal health coverage (UHC) frameworks[100].

In contrast, India's model anchored in a general healthcare statute Mental Healthcare Act 2017 (MHCA),rather than a standalone parity law lacks a dedicated enforcement body. Insurance Regulatory and Development Authority of India (IRDAI) role remains reactive and administrative, rather than investigative. Comparative study thus reveals that effective parity

[96]*See also Navtej Singh Johar v. Union of India, (2018) 10 SCC 1, 566 (per Chandrachud, J.).*
[97]*Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110–343, 122 Stat. 3881 (U.S.).*
[98]*U.S. Department of Labor, 2022 MHPAEA Enforcement Fact Sheet*
[99]*Equality Act 2010, c. 15 (U.K.).*
[100]*World Health Organization, Comprehensive Mental Health Action Plan 2013–2030 (Geneva: WHO, 2021).*

enforcement requires inter-agency coordination, mandatory data disclosure, and public accountability mechanisms, all of which are currently weak in India[101].

DISCUSSION

The results reveal a persistent normative–implementation divide in India's mental-health parity framework. Despite the progressive character of the Mental Healthcare Act, 2017 (MHCA) and a growing body of jurisprudence affirming the right to mental healthcare, enforcement remains inconsistent, fragmented, and largely reactive[102]. The judiciary has frequently intervened to correct administrative lapses, but litigation-driven reform is neither sustainable nor sufficient. A durable parity regime requires institutionalized monitoring, administrative capacity-building, and statutory clarity[103].

First, regulatory strengthening is essential. The Insurance Regulatory and Development Authority of India (IRDAI) currently issues circulars mandating parity, but it lacks a specialized enforcement unit with robust audit powers[104]. A statutory amendment, or delegated legislation under the Insurance Regulatory and Development Authority of India (IRDAI) Act, could establish a Mental Health Parity Compliance Bureau empowered to conduct proactive audits, mandate data reporting, and impose administrative penalties for non-compliance[105]. Second, the Central Government should exercise its rule-making authority under Section 121 of the Mental Healthcare Act 2017 (MHCA), to prescribe uniform coverage standards for insurers[106]. Comparative jurisdictions particularly the United States under the Mental Health Parity and Addiction Equity Act (MHPAEA) illustrate the need for clear benchmarks defining "equivalence" in financial limits, treatment caps, and non-quantitative treatment limitations (NQTLs)[107].

Third, fiscal planning must align with statutory commitments. Mental-health budgeting in India remains less than one percent of total health expenditure, constraining the Mental

[101] *Cf. Lawrence Gostin, Public Health Law: Power, Duty, Restraint (3d ed. 2021).*
[102] *See Parliamentary Standing Committee on Health and Family Welfare, 138th Report on Mental Health (2023) (documenting persistent implementation gaps under the MHCA 2017).*
[103] *Cf. Anoop K. Satpathy, "Health Governance and Accountability in India," Indian J. Pub. Admin. (2020).*
[104] *IRDAI Circular No. IRDAI/HLT/MISC/CIR/128/08/2018 (Aug. 16, 2018); IRDAI Clarification Circular (Oct. 22, 2022).*
[105] *See generally Insurance Regulatory and Development Authority Act, 1999, &14 (granting power to regulate insurers).*
[106] *Mental Healthcare Act, 2017, §121 (empowering Central Government to frame rules).*
[107] *U.S. Dept. of Labor, 2022 MHPAEA Enforcement Report (describing benchmark-based parity oversight).*

Healthcare Act 2017 (MHCA) implementation[108]. Integrating mental-health funding within the National Health Mission (NHM) alongside ring-fenced allocations for community-based services, district mental-health programs, and tele-health infrastructure would ensure stable financing and reduce dependence on ad hoc state initiatives[109].

From a constitutional perspective, the state's responsibility to ensure mental-health parity is firmly grounded in the doctrine of positive obligations. In ***Paschim Banga Khet Mazdoor Samity v. State of West Bengal***, the Supreme Court held that the state must provide adequate medical facilities as part of its duty under Article 21[110]. Applied to mental health, neglecting parity whether through underfunding, inadequate infrastructure, or lax regulatory oversight may constitute a violation of the right to life and dignity[111]. This approach is strengthened by the Court's evolving rights-jurisprudence, particularly after ***Common Cause v. Union of India***, where autonomy, dignity, and access to healthcare were elevated as integral components of Article 21[112]. Thus, mental-health parity is not merely a statutory entitlement but a constitutional imperative.

In conclusion, the Indian parity movement represents a convergence of constitutional morality, statutory mandates, and administrative governance. The Mental Healthcare Act 2017 (MHCA), created a robust normative framework, but its transformative potential depends on consistent implementation, independent regulatory oversight, and sustained political will[113]. Without structural reforms embedded in administrative practice, parity will remain a legal aspiration rather than an operational reality.

POLICY IMPLICATIONS, AND FUTURE TRENDS

The preceding analysis reveals that India's mental-health parity regime is constitutionally sound but institutionally fragile. The Mental Healthcare Act, 2017 (MHCA) and the IRDAI directives jointly establish a framework for equal access, yet operational weaknesses persist

[108] *World Health Organization, Mental Health Atlas 2023 (India's mental-health spending remains under 1%).*
[109] *Ministry of Health & Family Welfare, National Health Mission Framework (2023).*
[110] *Paschim Banga Khet Mazdoor Samity v. State of W.B., (1996) 4 SCC 37.*
[111] *See also State of Punjab v. Mohinder Singh Chawla, (1997) 2 SCC 83 (holding that the right to health is integral to Article 21).*
[112] *Common Cause v. Union of India, (2018) 5 SCC 1.*
[113] *See National Human Rights Commission, Report on Mental Healthcare Implementation (2022).*

across funding, regulatory oversight, and service delivery. The foremost policy implication is that legislative parity without administrative parity yields only symbolic equality[114].

The central and state governments must, therefore, reconceptualize parity as a governance priority, not a sectoral obligation. Section 18 of the Mental Healthcare Act 2017 (MHCA), confers a positive right to access quality mental-healthcare, implying correlative state duties[115]. To fulfil these duties, the government should create a National Mental Health Parity Mission (NMHPM) analogous to the National Health Mission (NHM), with a separate budgetary head, measurable indicators, and public reporting obligations[116].

Moreover, federal coordination is critical. Mental health falls under the Concurrent List (Entry 16, Seventh Schedule, Constitution of India), requiring center–state synergy[117]. Many states lack functional State Mental Health Authorities (SMHAs) or adequate staffing, rendering Section 73 of the MHCA ineffective[118].The Ministry of Health and Family Welfare (MoHFW) must operationalize an intergovernmental parity council, chaired by the Union Health Secretary, to standardize enforcement across jurisdictions.

Another policy priority involves insurance transparency. IRDAI's 2018 and 2022 circulars, though commendable, remain non-self-executing[119]. A statutory amendment could embed reporting obligations within the Insurance Act, 1938, compelling insurers to disclose claim approvals and denials related to mental-health coverage[120]. Such disclosure will enable regulatory monitoring and empower policyholders. In the United States, similar obligations under the Mental Health Parity and Addiction Equity Act (MHPAEA) have yielded compliance gains through public accountability[121].

Finally, public awareness remains low. The 2021 National Mental Health Survey found that stigma and lack of knowledge are major deterrents to care-seeking[122]. Therefore, parity policy must integrate mass awareness campaigns, workplace sensitization, and school-based

[114] *See generally Rakesh Shukla, Health Rights and Social Justice in India (2022).*
[115] *MHCA 2017, & 18*
[116] *Cf. Ministry of Health and Family Welfare, National Health Mission Framework (2013).*
[117] *INDIA CONST. sched. VII, list III, entry 16.*
[118] *See Parliamentary Standing Committee on Health and Family Welfare, 138th Report (2023).*
[119] *IRDAI Circular No. IRDAI/HLT/MISC/CIR/128/08/2018 (Aug. 16, 2018); IRDAI Circular (Oct. 22, 2022).*
[120] *See Insurance Act, 1938, & 34.*
[121] *U.S. Department of Labor, 2022 MHPAEA Enforcement Report.*
[122] *See National Institute of Mental Health and Neurosciences (NIMHANS),National Mental Health Survey of India 2021–22.*

education, supported by Section 29 of the Mental Healthcare Act 2017 (MHCA) (obligation of the government to promote awareness)[123].

The Indian judiciary has historically been the catalyst for translating socio-economic rights into enforceable obligations. In ***Paschim Banga Khet Mazdoor Samity v. State of West Bengal***, the Supreme Court held that the state's failure to provide timely medical care violates Article 21. This principle the doctrine of positive obligations provides constitutional support for judicial supervision of mental-health parity[124].

Mental Health Care Facilities Across the Country, the Court lamented "systemic neglect of mental-health institutions" and directed periodic compliance reporting. The Court's continuing mandamus jurisdiction allows it to monitor the implementation of parity rights[125]. Therefore, an institutional mechanism could be developed within the judiciary such as a National Mental Health Rights Monitoring Committee (NMHRMC) under Supreme Court oversight to track Mental Healthcare Act 2017 (MHCA), enforcement.

Furthermore, public interest litigation (PIL) remains an effective tool. The ***Public Interest Foundation v. Union of India***, reaffirmed that PILs are maintainable for enforcement of statutory and fundamental rights. Thus, public-spirited organizations can invoke Article 32 to seek continuing mandamus for Mental Healthcare Act 2017 (MHCA) compliance[126].

Administrative tribunals such as the Insurance Ombudsman (under the Insurance Ombudsman Rules, 2017) can also be empowered to handle parity complaints expeditiously[127]. The IRDAI could issue model guidelines directing ombudsmen to prioritize mental-health claim disputes, thereby preventing lengthy court delays.

A forward-looking approach must integrate parity into India's ongoing universal health-care (UHC) agenda. The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) currently covers hospitalization but lacks standardized mental-health benefits[128]. Expanding PM-JAY to include outpatient psychiatric consultations, tele-mental-health services, and counselling will actualize Mental Healthcare Act 2017 (MHCA) intent under Section 18(4),

[123] *MHCA 2017, & 29.*
[124] *Paschim Banga Khet Mazdoor Samity v. State of W.B., (1996) 4 SCC 37.*
[125] *Re: Mental Health Care Facilities Across the Country, 2021 SCC Online SC 1065.*
[126] *Public Interest Found. v. Union of India, (2019) 3 SCC 224.*
[127] *Insurance Ombudsman Rules, 2017, G.S.R. 553(E) (India).*
[128] *See National Health Authority, PM-JAY Guidelines (2023).*

which requires the government to provide free essential mental-healthcare to persons below the poverty line[129].

India could emulate the United Kingdom's "Parity of Esteem" policy (2011 NHS Mandate), which mandates equal priority for mental and physical health services within the National Health Service[130]. A similar National Parity Mandate could be issued under Section 121 of the Mental Healthcare Act 2017 (MHCA), enabling the central government to frame binding rules on parity implementation.

Additionally, digital health innovations must be harnessed. The National Tele-Mental Health Programme (NTMHP) launched in 2022 offers remote counselling through the Tele-MANAS platform[131]. Integrating Tele-MANAS with insurance schemes can expand reach, reduce cost, and mitigate urban-rural disparities.

Crucially, legal reforms must address intersectional vulnerabilities gender, caste, disability, and rural marginalization. Women and Scheduled Tribe populations exhibit disproportionately high mental-health risks but face barriers to access[132].Section 115 of the MHCA, which decriminalized attempted suicide, must be supplemented with rehabilitative obligations and community-based support mechanisms, consistent with the Supreme Court's directive in Common Cause v. Union of India, emphasizing dignity in end-of-life and mental-health decisions[133].

In the coming decade, three transformative trends are likely to shape India's parity landscape: constitutionalization of social rights, regulatory modernization, and digital integration. The expansion of Article 21 jurisprudence indicates that the right to mental health will soon attain fundamental-rights status comparable to education (Article 21A)[134]. Future constitutional litigation may seek judicial recognition of parity as a non-derogable right, invoking Articles 14 and 15 to prohibit discrimination based on mental illness.

The Insurance Regulatory and Development Authority of India (IRDAI) is expected to incorporate behavioural-health parity metrics in insurer audits. Amendments to the Insurance

[129] *MHCA 2017, & 18(4).*
[130] *U.K. dept. of Health, Achieving Parity of Esteem: The NHS Mandate (2011).*
[131] *Ministry of Health and Family Welfare, Tele-MANAS Operational Guidelines (2022).*
[132] *See National Human Rights Commission, Mental Health and Gender Report (2022).*
[133] *Common Cause v. Union of India, (2018) 5 SCC 1.*
[134] *Cf. Unnikrishnan J.P. v. State of A.P., (1993) 1 SCC 645.*

Regulatory and Development Authority Act, 1999, could authorize automatic penalties for parity violations, akin to the U.S. Department of Labor's model[135].

India's Digital Health Mission and Tele-MANAS will expand virtual counselling and AI-assisted diagnostics[136]. However, robust data-protection laws are essential. The Digital Personal Data Protection Act, 2023 should be harmonized with Mental Healthcare Act 2017 (MHCA) confidentiality provisions under Section 23 to protect patients' privacy[137].

Based on recent jurisprudence, courts are likely to adopt a substantive equality approach. Following ***Joseph Shine v. Union of India,*** and ***Shafin Jahan v. Asokan K.M.,*** the judiciary increasingly emphasizes autonomy and non-discrimination, which will strengthen mental-health jurisprudence[138].

CONCLUSION

The promise of mental-health parity in India stands at a constitutional and moral crossroads. The Mental Healthcare Act, 2017, fortified by Supreme Court jurisprudence, has formally enshrined the principle that mental health deserves protection equal to physical health. Yet, as the evidence demonstrates, parity in law has not yet matured into parity in life.

To close this gap, India must transition from declaratory legislation to enforceable governance. Three pathways are critical: (i) To Establish a dedicated Mental Health Parity Commission under Section 121 of the Mental Healthcare Act 2017 (MHCA) to monitor compliance, publish annual parity indices, and coordinate with IRDAI and NHRC, (ii) Increase mental-health allocation to at least 3% of total health expenditure, aligning with WHO's recommended benchmark[139]. Fiscal under-provision undermines statutory parity and perpetuates inequality, and (iii) The Supreme Court should continue its supervisory jurisdiction, while NGOs and professional bodies participate in amicus curiae capacities to ensure transparent implementation.

The broader vision is a rights-based ecosystem where parity transcends legal semantics to become a lived reality. Only when the state, insurers, and civil society collectively honour

[135] *Insurance Regulatory and Development Authority Act, 1999, & 14.*
[136] *Ministry of Electronics & Information Technology, Digital India Health Blueprint (2021).*
[137] *Digital Personal Data Protection Act, 2023, No. 22 of 2023 (India).*
[138] *Joseph Shine v. Union of India, (2019) 3 SCC 39; Shafin Jahan v. Asokan K.M., (2018) 16 SCC 368.*
[139] *World Health Organization, Mental Health Atlas 2023.*

this commitment will India truly fulfil the constitutional promise of dignity for persons with mental illness.

Mental health parity, therefore, is not merely a legislative aspiration; it is a constitutional imperative a test of India's commitment to justice, equality, and human dignity in the 21st century.