
HEALTHCARE OR HOSTAGE-TAKING? WHAT THE KERALA HC'S VERDICT ON CLINICAL ESTABLISHMENTS MEANS FOR INDIA

Mathew Dayi, LLB, Jindal Global Law School, Sonipat

ABSTRACT

The corporatisation of healthcare in India has created an ecosystem where private hospitals often operate without sufficient accountability, leading to inflated pricing, non-transparent procedures, and patient exploitation. In Kerala, public hospitals continue to suffer from underfunding and lack of personnel, making private institutions the default option for quality care. However, this dependence has allowed many five-star hospitals to impose arbitrary costs, sell unnecessary treatments, and commodify even organ donation campaigns¹. The Kerala Clinical Establishments (Registration and Regulation) Act, 2018 was introduced to standardise healthcare infrastructure, enforce transparency in billing, and establish clear patient rights. Following challenges by hospital owners, the Indian Medical Association (IMA), and dental associations, the Kerala High Court upheld the Act in June 2025, affirming its constitutional validity. This article critically analyses the judgment, explores its legal and policy implications, and discusses the evolving power dynamic between private healthcare providers and regulatory authorities. It further addresses ethical concerns, systemic inefficiencies, and the tension between professional autonomy and public interest. Drawing on comparative state responses and past case studies, the article concludes with recommendations to improve enforcement — including tiered compliance models, co-regulation, and patient-inclusive governance — with the ultimate goal of making healthcare in India both ethical and equitable.

¹ Scroll Staff, *Why India's Organ Donation System Is Still Prone to Abuse*, Scroll.in (July 13, 2017),

Introduction

In Kerala, hospitals are not just buildings—they are the first line of defense whenever a health emergency strikes. Yet, the disparity between government-run facilities and luxury private hospitals is growing stark. Most taluk and district hospitals suffer from underfunding, shortage of doctors, outdated equipment, and politically influenced appointments that leave the system gasping for breath. This systemic void has fueled the rise of sleek five-star hospitals that promise quality care but often operate like corporate enterprises.

The state's growing dependence on private healthcare, bolstered by foreign investment and unchecked commercial incentives, has led to an ecosystem where patients are treated as consumers, doctors as salespeople, and human bodies as economic units. The Kerala High Court's judgment on June 24, 2025, upholding the Kerala Clinical Establishments (Registration and Regulation) Act, 2018, marks a pivotal moment in challenging this exploitative model.

The Exploitative Nature of Private Healthcare

Kerala's weakened public healthcare infrastructure has made the private sector indispensable.

However, this reliance has created space for unethical practices:

- Five-star hospitals charge exorbitant fees without clearly informing patients of their condition.
- Unnecessary diagnostic tests and medications are prescribed to inflate bills.
- Prices vary based on the perceived financial capacity of the patient.
- Hospitals operate like businesses—some even turn organ donation into a revenue model. Doctors are handed revenue targets and risk losing their jobs if they don't push high-cost treatments. Many ethical practitioners feel helpless. Though trained and capable, they are reduced to sales agents under administrative pressure.

The Legal Framework and Kerala's Challenge

The Clinical Establishments (Registration and Regulation) Act, 2010,² enacted under Article 252³ of the Constitution, seeks to regulate healthcare services across India by ensuring that all

² The Clinical Establishments (Registration and Regulation) Act, No. 23 of 2010, Acts of Parliament, 2010 (India).

³ INDIA CONST. art. 252.

clinical establishments meet minimum treatment and infrastructure standards. However, since health is a State subject (Entry 6, List II), it applies only to states that adopt it.

Kerala adopted a state-specific version of the Act in 2018⁴, and on its day of implementation in January 2019, petitions challenging its provisions were filed by the Kerala Private Hospitals' Association, the Indian Medical Association (IMA) Kerala, and the Dentists' Association. This delayed enforcement for over six years.

M.K. Salim and the Demand for Regulation

The push for this law stemmed from a petition by public activist M.K. Salim in 2016. Alarmed by rising complaints against exploitative practices by private hospitals, he filed a case before the Kerala High Court urging legislative regulation. The Court directed the government to enact a law to monitor healthcare institutions, resulting in the Kerala Clinical Establishments Act, 2018.

Despite its enactment, the law remained stayed due to opposition from hospital owners and professional bodies. Between 2019 and 2025, multiple judges recused themselves from the matter, reportedly due to the influence wielded by the private healthcare sector.

The June 2025 Verdict

On June 24, 2025, Justice Harisankar V. Menon delivered a landmark judgment in *Kerala Private Hospitals Association v. State of Kerala*. The court upheld the validity of Sections 19(11), 25, and 39⁵ of the Act:

- Section 39: Mandating display of package rates was held to be essential for transparency.
- Section 25: Empowering suspension or cancellation of registration was found to be proportionate and procedurally fair.
- Inclusion of dentists and patient representatives in regulatory bodies was upheld.

⁴ Kerala Clinical Establishments (Registration and Regulation) Act, No. 11 of 2018 (India).

⁵ CEA 2010, §§ 19(11), 25, 39.

Referring to *McDowell & Co. Ltd. v. State of Andhra Pradesh* (1996)⁶, the court rejected claims of arbitrariness and affirmed the law's public interest objectives.

Relief for Ethical Doctors

The Act provides these doctors with a shield. By enforcing treatment protocols, mandating disclosure of package costs, and ensuring independent oversight, it gives them the freedom to serve patients ethically. It also holds hospital owners accountable for malpractice, helping doctors distance themselves from exploitative institutional directives.

Ironically, IMA, which was meant to protect doctors' autonomy, opposed the Act—effectively aligning with hospital owners. The court pointed out this contradiction. It reminded the IMA that its duty lies in representing doctors, not business interests.

Case Studies of Corporate Exploitation

- A dengue patient in Gurugram was billed ₹18 lakh by a private hospital⁷, including over 2,700 gloves.
- In Kolkata, a COVID-19 patient was charged ₹10 lakh without clear expense justifications.⁸
- Anonymous testimonies from Kerala doctors revealed internal quotas for tests and procedures.

These incidents reflect a nationwide pattern—where profits dictate care.

Comparative State Responses

States like Rajasthan⁹ and Jharkhand¹⁰ witnessed doctor strikes and public protests when similar Acts were enforced. Tamil Nadu adopted only selective provisions¹¹ under its state laws. This reflects the absence of a coordinated federal approach to healthcare regulation,

⁶ *McDowell & Co. Ltd. v. State of Andhra Pradesh*, (1996) 3 SCC 709.

⁷ Fortis charged Rs 18 lakh for dengue treatment, *Hindustan Times* (Nov. 21, 2017),

⁸ Private hospitals make COVID treatment a costly affair, *The Hindu* (June 20, 2020),

⁹ Rajasthan doctors protest against Clinical Establishments Act, *Business Standard* (Mar. 28, 2017),

¹⁰ Doctors strike against implementation of CEA in Jharkhand, *Times of India* (Apr. 12, 2019),

¹¹ State Health Dept. to implement CEA guidelines, *The Hindu BusinessLine* (July 10, 2021),

resulting in inconsistent enforcement and uneven protections for patients.

Recommendations

To ensure the Clinical Establishments Act is implemented fairly and effectively, a nuanced and inclusive approach is essential. Introducing a **tiered compliance model** would exempt or relax certain norms for small and rural clinics that lack the infrastructure or financial capacity to meet the same standards as large corporate hospitals. This would prevent undue burden on grassroots healthcare providers while maintaining baseline quality.

Simultaneously, establishing a **co-regulatory framework** involving medical associations, such as the IMA, would enhance legitimacy and ground-level practicality. These associations can play a critical role in shaping guidelines that are both ethically sound and administratively feasible. Furthermore, inspections should be carried out by **independent third-party auditors** under a transparent, criteria-based system to avoid harassment or misuse of regulatory power.

To keep the law dynamic and responsive to changing needs, governments must conduct **regular public consultations** with stakeholders — including patient groups, doctors, and healthcare workers. Finally, empowering states to create **context-specific rules** under the broader national framework can strike the right balance between uniformity and flexibility. This adaptive model would ensure that the law serves both the regulatory objective and the real-world complexities of India's diverse healthcare landscape.

Conclusion

The June 2025 judgment validates Kerala's attempt to regulate private healthcare for the common good. It affirms the State's right to set minimum standards in an otherwise unregulated sector. But the real challenge lies ahead—will the government ensure proper execution? This legal battle, fought by one activist and resisted by hospital owners, is a turning point. As clinical establishments come under public scrutiny, the goal must remain clear: healthcare must serve the people, not profit from their vulnerability. The law now offers protection—not just for patients, but for ethical doctors too. The government must now rise to the occasion and shield it from further dilution.