



Reconciling Intellectual Property Rights with the Right to Healthcare: A Comparative Legal Analysis of Pakistan and India

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ARTICLE INFO	ABSTRACT
Submission: May 21, 2026 Revised: May 30, 2026 Accepted: June 15, 2026 Available Online: June 28, 2026 Keywords: <i>Intellectual property; right to health; TRIPS; Doha Declaration; compulsory licensing; Section 3(d); Article 9; Pakistan; India</i> Corresponding author: Dr. Muhammad Ali Safdar Email: malisafdar@hotmail.com	The rights to health and to IP rights are conflicting. Patent law gives patent holders a monopoly over innovations for a limited period, while the right to health requires the state to ensure that essential healthcare technologies are accessible and affordable to everyone. This is particularly problematic in developing nations, where resources for health care are limited and reliance on patented technologies is heavily concentrated. This article explores how two states with a common colonial legal legacy, and with comparable obligations under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), Pakistan and India, have tried to balance competing claims and make remarkably different assessments of the extent to which they have succeeded. It compares the constitutional foundations of each country, its application of TRIPS and the Doha Declaration, and its application of public-interest provisions, including compulsory licensing and the anti-evergreening provision of Section 3(d) in India. It is because the former has been active in balancing patent protection with access to medicines by design of legislative framework, judicial interpretation, and a pro-industrial policy, while the latter has left most of its legislative instruments unapplied and left the tension unresolved. This difference is not an international legal obligation, says the article, but an institutional choice, and Pakistan can find a better balance between the two within its existing obligations.

Introduction

This conflict between the protection of intellectual property and the right to health is one of the most challenging conflicts in modern law. The basis of patent law is a bargain: the inventor promises to publish the invention, and in return is given a monopoly for a limited period (Shahid et al., 2025). The right to health is based on a different principle: everybody has a right to the conditions required to lead a healthy life, such as access to health goods and health technologies; the state has a duty to ensure access to these goods and technologies (Butt & Razi, 2022). Where the technology at issue is the lifeline of some people, and where the monopoly conferred by the patent is so broad that it is inaccessible to people who need it, the two commitments are at odds.

This conflict is most acutely experienced in developing countries. The cost impact of patent monopoly is borne by patients who have the least means to pay for healthcare in states that rely heavily on imported technologies, have high out-of-pocket costs, and receive limited public health funding (Mehmood, 2024). This has been acknowledged by the international community. The Doha Declaration on the TRIPS Agreement and Public Health, which was agreed in 2001, reaffirmed the need to interpret and

implement the TRIPS Agreement to support the right of states to protect public health and to promote access to medicines for all (World Trade Organization, 2001). But the Declaration did not settle the tension; it simply acknowledged states' ability to balance patent protection with the health need and left it to states to decide how to do this.

Pakistan and India provide an unusually instructive couple to look at how this reconciliation has been sought. The two states have the same legal heritage: the original patent law of each state was based on the Patents and Designs Act 1911 of the colonial era (Allauddin & Anwar, 2022). They are both WTO members and share the same minimum standards as the TRIPS Agreement. They face similar public health challenges, such as high population, increased rates of chronic disease, and high inequities in access to health care (Mehmood, 2024). They both begin the same, and their responsibilities are the same in those aspects. But the two states have come up with significantly distinct compromises between IP and the right to health.

India has come to be seen as a pioneer state in meeting international IP obligations while leaving significant room to ensure public health. India has thus made the reconciliation of patents and access a continuing policy promise, instead of an ad hoc legislative move, via its active practice of compulsory licensing, an obligation of Parliament in Section 3(d) of its Patents Act, and a judicial interpretation of patent law that's willing to read the law through the lens of the public interest (Novartis AG v. Union of India, 2013). On the other hand, Pakistan has become passive. While the categories of public-interest safeguard are the same as in the Patents Ordinance 2000, those provisions have been used, if at all, infrequently, and the constitutional right to health, if it now applies to patent practice, has not yet been invoked (Butt & Razi, 2022).

This article contends that no difference in their international obligations exists to account for the difference between the two states, only a difference in institutional choice. They both possess the same legal instruments, and India has been applying them to resolve the conflicting claims, while Pakistan keeps them dormant and hopes that the tension will cease to be unresolved. The importance of this conclusion is that Pakistan's problems are solvable because there is no need to get out of any international commitments.

The article proceeds as follows: It first examines the two legal arguments, the one in favor of patent protection and the right to health as a right, and pinpoints the area of overlap. It then analyzes the international framework provided by TRIPS and the Doha Declaration, and the room it provides for reconciliation. It examines the approaches both countries have taken in the pursuit of reconciliation, based on their constitutional bases, the fulfilment of their international commitments, and public interest protections. It contrasts the two experiences and offers lessons and recommendations for Pakistan.

The Two Competing Legal Claims

IP and health rights are not competing interests as opposed to competing ones; they are competing rights that are both legal and moral. Both are serious, and that makes reconciliation difficult.

The Case for Patent Protection

The incentive theory of innovation is the most commonly used justification for patent protection. In that regard, the process of new technology development takes a significant amount of time, capital, and expertise, with a good part of it being at significant risk of failure, especially for medical technologies. If it could be copied by competition as soon as it's invented, the competition can undercut the innovator and take the benefit of the innovator's investments. Rational actors would, in anticipation of this, invest less in innovations, and society would suffer the loss of innovation that would otherwise have occurred (Shahid et al., 2025). The patent system offers a way to address this issue by providing the inventor with a limited time monopoly to benefit from the invention in return for disclosure of the invention to the public.

The reason is particularly compelling in healthcare product development, where the expense of new medical devices and medicines, and associated risks, are very high, and the technologies that result can directly affect clinical outcomes (Kapoor et al., 2025). This rationale has been given international binding form under the TRIPS Agreement, which stipulates that patent protection must be available for inventions in all fields of technology for at least twenty years (World Trade Organization, 1994). Patent protection, therefore, is not only a policy preference for a state like Pakistan, it also represents an international duty and, beyond, the promotion of foreign investment and the transfer of technology (Allauddin & Anwar, 2022).

But there is a limit to the incentive theory as well that is not hard to miss. It is justified only insofar as it is needed to produce innovation that would not happen without it. It is not a justification for exclusivity beyond that, nor an opinion on who gets what technologies as a result. The theory is not the same as saying that patent rights should be absolute and unconditional, or that they are not subject to any limits in the public interest (Chen, 2024). This is the restricting principle that brings the competing claim in.

The Right to Health as a Legal Entitlement

The right to health is not just a goal; it is a right enshrined in legally binding international instruments and in the domestic constitution. Article 12 of the International Covenant on Economic, Social, and Cultural Rights (1966) states that the right to enjoy the highest possible standard of health through the provision of medical, paramedical, and other health services to all is a right which everyone has (International Covenant on Economic, Social and Cultural Rights, 1966). Pakistan has ratified the Covenant, which means that it owes this duty.

The Committee on Economic, Social and Cultural Rights has made an authoritative elaboration of the right in its General Comment No. 14, which outlines four essential elements of the right: availability, accessibility (both physical and most importantly economic), and acceptability and quality (Committee on Economic, Social and Cultural Rights, 2000). The need for economic affordability has direct consequences for the pricing of patented technologies, in that it sets the limit that a healthcare product that is too expensive for a large proportion of the population is not truly accessible to the right.

In both the states that have been studied, the right to health has a constitutional dimension. While the Constitution does not explicitly provide for a separate right to health, the Supreme Court in Pakistan has interpreted the right to life under Article 9 in a broad sense and determined that this entitles one to a healthy and decent life (Shehla Zia v. WAPDA, PLD 1994 SC 693). Combined with the constitutional guarantees of dignity and the directive principles relating to social welfare, this jurisprudence provides a constitutional, domestic basis for the principle that the state has a duty to provide access to life-saving health care. The right to health is thus not a soft or merely programmatic pledge, but an internationally binding and constitutional obligation.

The Point of Conflict

The two claims intersect at the intersection of price and access. The ability to set prices higher than the level that competition would lead to is the effect of patent protection, and it can be significant, especially if the demand for essential healthcare technology is inelastic, and there is no viable alternative to it (Chen, 2024; Singh et al., 2024). The right to health, which is rooted in its economic affordability, expects that technology to be equally economically accessible to those who require it. Where the price allowed by the patent is higher than the price to be paid by patients and public healthcare institutions, the exercise of the patent right works against the realization of the right to health.

This is the battle that the rest of the article explores. But it is essential to say exactly what conflict is and isn't. Patent protection is not a perverse or unfair system, nor is the right to health incompatible with IP. It is, on the contrary, that these two claims need to be reconciled, as no one can qualify the innovations as being truly accessible to those who depend on them without compromising the incentive to innovate, or vice versa, that the role of the legal system is to maintain the balance between the two equitably (Darsana, 2025).

The International Framework: TRIPS, Doha, and Space for Reconciliation

For both Pakistan and India, reconciliation between patent protection and the rights to health must happen within, not outside, the framework of the TRIPS Agreement, which are shared by all countries. That is why it is important to understand that context and the room it gives for public health measures are part of the equation when evaluating what states have done—or haven't done to take advantage of the room at their disposal.

The TRIPS Obligation

The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs) entered into force in 1994, and it was a dramatic, unprecedented shift in the international framework of governing intellectual property. It introduced a set of minimum standards of patent protection to all members of the World Trade Organization, including developing countries, which already had lower or more selective patent protection rules in place. It is to make patents available for any invention in all fields of technology, without discrimination, for a period of at least 20 years, and gives the patent holder the exclusive right to make, use, sell, and import the patented invention for a period of 20 years or more.

In many developing countries, this meant a considerable extension of proprietary protection, directly affecting access to healthcare technologies. Some States had indeed sought to make a deliberate choice to exclude pharmaceutical and related products from patentability or to provide less protection for those products, just to ensure that essential health goods were affordable, and to encourage local production (Saleem & Sanjaya, 2023). TRIPS ruled that out and gave countries a blanket

right to patent products, thereby bringing the breadth of exclusivity even closer to where it's most needed: the very areas where the right to health is most at odds with it (Butt & Razi, 2022).

The Doha Declaration and the Preservation of Flexibility

This change was the subject of international debate in the late 1990s, particularly in relation to the availability of antiretroviral medicines, when patented drugs were unaffordable to people in developing countries. In 2001, the members of the WTO adopted the Doha Declaration on the TRIPS Agreement and Public Health as a reply. The Declaration did not change TRIPS, but rather its interpretation in a meaningful way. It confirmed that the Agreement is capable of being interpreted and applied in a way that is compatible with members' right to protect public health and ensure access to medicines for all.

Importantly, the Declaration reaffirmed the right of the members to avail themselves of the flexibilities provided in the Agreement. These include the power to grant compulsory licenses and to define the grounds on which they can be granted, the power to determine when a situation of national emergency or other 'case of extreme urgency' exists, and the right to set up their own regime for the exhaustion of IP rights, and therefore parallel importation. The Declaration then redefined the patent and public health nexus – patent protection would be recognized as a duty, but one that explicitly allows for measures to ensure access to be taken.

Space Left for Reconciliation

The whole of TRIPS and the Doha Declaration is a bounded space, in which the reconciliation of patents and the right to health can be attempted. The barriers are also genuine: members have to offer the same level of protection as patent rights under TRIPS and no longer be able to exclude healthcare technologies from patentability as some used to do. However, there is a lot of leeway within which the members can fall within those limits. They can establish the criteria for patentability, including the novelty and inventive step, that will exclude weak and/or trivial patents. They can offer mandatory licensing and state use for public interest reasons. They can choose an exhaustion regime that allows parallel importation. They can even shape their wider regulatory and industrial policies to promote the affordability and availability of key technologies (Darsana, 2025).

The importance of this limited space is that it places responsibility on the individual state. The flexibility is permissive, and whether it is used and how effectively will be up to each member. The possibilities for different accommodations between patents and access exist here, not because the law mandates them, but because different approaches to discretion in different states may yield them. It is exactly what happened in the case of India and Pakistan. The following sections explore each of these and their respective uses of the space opened by TRIPS and Doha, starting with India, where its approach can be said to have been a model of reconciliation, and then moving to Pakistan, where the space has largely been ignored.

Reconciliation in India

India is now seen as a clear case in the developing world of a State that has managed to balance up the international obligations on patent compliance with a long-term commitment to the right to health. It is built on three factors: a constitutional notion that health is a part of the right to life; a structure of laws that establishes public-interest boundaries in the patent process itself; and a judiciary that is prepared to enforce those boundaries. Reading through each one individually will reveal more about the reconciliation than just the pronouncing of it, as it has been put into practice.

The Constitutional Foundation

India's patent and access strategy is based on a constitutional jurisprudence that has interpreted the right to life as a right to access. The Supreme Court of India has always understood that the right to life guaranteed by the Constitution is not only limited to living as a mere animal but also includes enjoying life in a manner worthy of human dignity, which involves access to health care (Saleem & Sanjaya, 2023). This constitutional sense has influenced the reading of ordinary legislation, including patent law, which provides a criterion by which the scope of private rights is determined. If patent rights are claimed in a way that could hinder access to life-saving therapy, the right to life in the Constitution grounds for interpretation of the patent statute in the public interest.

Legislative Design: Section 3(d) and the Prevention of Evergreening

The most unique aspect of Indian patent law is the term '3(d) invention' in the Patent Act 1970, which was added to the Act as a part of the changes made in Indian Patent Law to ensure its TRIPS compliance in 2005. The provision excludes the possibility of obtaining a patent on new forms of a known substance unless the new form is significantly different in properties with respect to efficacy (Saleem & Sanjaya, 2023). It aims to stop what is called evergreening, where a "patent owner" gets "patents"

on a minor, and often trivial, variation of an original product and thus locks in a monopoly well beyond its legitimate expiration date.

This is a conscious exercise of TRIPS' discretion in defining patentability in Section 3(d). TRIPS do not specify the rigor with which the conditions for patentability (an invention, an inventive step, and industrial application) must be met. India had adopted a high threshold for patentability of incremental changes to the products to exclude weak claims, thus reducing the patent term and the availability of affordable alternatives (Singh et al., 2024). The evolution of the provision has taken place, however, mostly in the pharmaceutical sphere, but the essence behind it, the fact that the patentability requirements themselves can be a tool of public-health policy, applies to technologies in healthcare in general.

Judicial Enforcement: Novartis AG v Union of India 2013

The concept of reconciliation, reflected in Section 3(d) of the Act, was put to the test and stood validated in the landmark case Novartis AG v Union of India 2013. Novartis, the pharmaceutical company, wanted a patent for a tweaked version of a cancer drug, and objected to the refusal of that patent as well as to the validity of Section 3(d) itself on the grounds that this did not comply with TRIPS. The Supreme Court of India dismissed the challenge, stating that the modified form does not exhibit the additional effectiveness as required under Section 3(d) of the Act and thus is not patentable (Novartis AG v. Union of India, 2013). In this way, the Court upheld the validity of the discretion under TRIPS exercised by India in Section 3(d) and gave effect to the public interest objective of access to affordable medicines.

The importance of the decision is more than the facts. It proved that the public-interest protection measures which India had provided were not just words on paper but enforceable limits which the courts were prepared to uphold, given a strong and well-resourced opposition. One of the key factors that has ensured India's patent and access compromise has stood the test of time is the judiciary's willingness to put it into practice. Judicial willingness to put the legislative design into action has been a major factor behind India's persistent reconciliation of patents and access (Saleem & Sanjaya, 2023).

Enforcement of compulsory licensing

India has also been more ready to use compulsory licensing as a real tool of policy than most developing countries. The Patents Act allows for the grant of a compulsory license in cases where the reasonable requirements of the public have not been met, cases where the patented invention is not available to the public at a reasonably affordable price, and cases where the patented invention is not worked in India (Singh et al., 2024). Its possibility of being invoked, and on some occasions, India has invoked it, has given the state room to maneuver vis-à-vis patent holders, as well as a clear message that patent rights exist on the premise of the public interest.

Assessment

All these features indicate that India's balance between patents and the right to health does not depend on any one mechanism; rather, a combination of constitutional principles, legislative design, and judicial enforcement plays an integral role. The constitutional right to life provides guidance; Section 3(d) provides legislation; and the judiciary is ready to uphold it. This has enabled India to be compliant with its international obligations while giving it space to preserve open access, which is what Pakistan's more passive strategy would have to be assessed against (Darsana, 2025).

Reconciliation in Pakistan

In contrast, Pakistan is a country with a different story. It shares the same constitutional foundation, it is subject to the same international commitments, and it has a patent law that includes the same types of public-interest protection. But the process of reconciliation, which India managed through the active implementation of these elements, has not taken place in Pakistan. The patent vs. freedom of health divide, in the context of Pakistan, is still not fully resolved, and looking at the reason behind this gives a clear idea that it is not about tools, but whether they are utilized or not.

The Constitutional Foundation

There is a constitutional basis in Pakistan with which a reconciliation might be built, like that of India. While the Constitution does not contain a separate right to health, Article 9 provides that no person shall be deprived of life except "as per law," and the Supreme Court, in its wide interpretation of the right to life, has also found health to be a fundamental right. In *Shehla Zia v. WAPDA* 1994, the Court had the opportunity to interpret the right to life as not just a right to live but the quality and dignity of life as well, which served as a basis for including access to basic health care in the scope of Article 9. This jurisprudence, coupled with the constitutional protection of dignity and the principle of direction on the promotion of social welfare, provides

a domestic constitutional framework for the concept that the state has a duty to ensure access to life-saving health care (Butt & Razi, 2022).

Thus, there is no material weakness in the constitutional structure of Pakistan compared to India. The missing link in India is that the constitutional principle was not applied to the interpretation and functioning of patent law. The right to life has recently been extended in the sphere of environmental protection and public services, yet it has not been extended into the area of intellectual property, where it has not been realized as an instrument for determining the balance of private rights and public access (Allauddin & Anwar, 2022). The constitutional resource is there, but it has yet to be leveraged towards the problem.

Patents Ordinance 2000 and its Safeguards

Pakistan fulfilled its TRIPS obligations by enacting the Patents Ordinance 2000, which superseded the colonial era Patents and Designs Act 1911, and provided a modern system of patent protection that was based on novelty, inventive step, and industrial applicability (Allauddin & Anwar, 2022). The Ordinance also contained the main public interest provisions allowed under TRIPS, such as compulsory licensing and government use of patented inventions.

From a theoretical perspective, Pakistan is armed with much the same set of tools as India. The key difference is in use. The compulsory licensing and government-use provisions of the Ordinance have been invoked very little and have had little impact on access to healthcare technologies (Butt & Razi, 2022; Mehmood, 2024). Nor does the Ordinance have anything like Section 3(d) of India (which made patentability in India hinge on the conventional patentability criteria and prohibited incremental patenting); indeed, the criteria for patentability in the Ordinance are more favorable for incremental patenting. The safeguards in existence are not translated into workable mechanisms, and the discretion that is left open under TRIPS is not used to the detriment of access.

The Gap between the Constitutional Promise and Patent Practice

The outcome is a large discrepancy between constitutional promises and patent practice. The Constitution-level commitment of Pakistan is to the right to life, which has been interpreted as entitling the person to a dignified life. On the patent law level, the commitment has made no visible difference: patent rights are treated as commercial rights, mostly outside of the constitutional and human-rights considerations that might make them valid (Butt & Razi, 2022). There is no interface between the two laws, the constitutional one in the fundamental-rights arena and the patent one in the commercial/industrial/trade-driven arena.

There are several reasons for this passivity. Pakistan's implementation of TRIPS was more a compliance-based approach, designed to meet the obligations of the international community and to encourage foreign investment, than to build a domestic balance between innovation and access (Shahid et al., 2025). There has been a lack of clear procedures for invoking the safeguards, limited institutional capacity, and an unwillingness to challenge powerful patent holders, leading to a "cautious" attitude of identifying the flexibilities in principle but not in practice (Mehmood, 2024). The result is that India has been trying to balance patents with the right to health, which has been left to continue in Pakistan.

Assessment

The Pakistani experience has proved that public interest protections for a patent alone are not enough to balance the right to health and IP. Pakistan has the constitutional framework, the interpretive leap, and the flexibility on the international front, but not the institutional resolve and the will to apply the right to health in the realm of patent governance. The difficulty with reconciliation is not that it is not legally competent, but that it is not used. The following comparative analysis and recommendations will uncover this, which is significant because it means that the solution isn't to find new abilities, but to harness the ones that Pakistan already has (Darsana, 2025).

Comparative Analysis

Following the study of the approach of the two countries towards reconciliation of patent protection with the right to health, it is now possible to draw the two experiences together. Comparisons can be instructive just because there are so many things that remain the same in both states. If the starting conditions and the obligations to which each state is subject are identical, the difference may be due with some confidence to the choices that each state has made rather than to factors outside its control.

Points of Convergence

Both systems are quite similar in many ways. India and Pakistan have both inherited the same colonial patent law, the Patents and Designs Act 1911, and it has taken decades for the law to be phased out of both nations (Allauddin & Anwar, 2022). They are both members of the World Trade Organization and subject to the same minimum requirements of TRIPS, both of which extended product patents to all technology fields for twenty years (World Trade Organization, 1994). Both also included in their laws the public-interest protection features that the TRIPS allows, such as compulsory licensing and government use. And both have a constitutional history in which the right to life was interpreted broadly enough to provide a basis for the right to health (Saleem & Sanjaya, 2023; Shehla Zia v. WAPDA, 1994). Formal legal endowment is very comparable between the two states.

Points of Divergence

It is not that the two states have different things; it is what they have done with their things. India has embraced the process of reconciling patents with access as its constitutional principle, as its legislative safeguards, and as its judicial institutions, and has leveraged each of them. It introduced Section 3(d), upheld it in court in *Novartis*, and will allow for compulsory licenses when access is an issue (*Novartis AG v. Union of India*, 2013; Singh et al., 2024). In Pakistan, which has the same kinds of tools, such provisions have been little used: the compulsory licensing provisions have received little use; there is no equivalent of section 3(d); and the Pakistani constitutional right-to-health jurisprudence has not been applied to patent law (Butt & Razi, 2022; Mehmood, 2024).

The pattern is uniform in all aspects of comparison. Where India has been active, Pakistan has been passive, and where India has merged its legal resources towards the end of access, Pakistan has left them in disjointed and disconnected compartments. It is not a question of whether the state has the power of reconciliation or not, but whether it has exercised that power or not.

Institutional Choice, Not Legal Constraint

The key point of this comparison is that the difference between the two outcomes is one of institutional choice, not of necessity of law. This is not due to different international commitments, as these are the same. It is not due to a different constitutional basis, because both States interpret their right to life in a broad sense. Nor can it be said to be due to different statutory measures, since both had the same regulatory measures. The difference lies in the exercise of discretion; India has chosen to do so with TRIPS and its own constitution; Pakistan has not so far (Darsana, 2025).

This conclusion is of importance for two reasons. First, it identifies the cause of Pakistan's problem as an institutional problem and not some external obstacle, so that the problem is something that Pakistan can solve on its own if it chooses to. Second, it lays the ground for a real possibility of reconciliation as envisioned in international law, as India has proven in practice. Pakistan is not asked to do anything new or legally questionable; it is asked to do something that a comparable nation with a comparable situation has already demonstrated can be accomplished. Next comes the lessons that can be drawn from this comparison and the reforms they call for, which are the topics of the next section.

Lessons and Recommendations for Pakistan

The comparisons in this article have a definite lesson, and in one sense, a hopeful lesson. This gap exists because Pakistan simply chose it, rather than the law forcing it. Therefore, Pakistan can overcome this gap without renegotiating any international commitment. The reforms to be adopted are directly based on the components that have made India's reconciliation between patents and right to health successful and are tailored to the Pakistani context. They're not calls for diminishing patent protection but calls for restoring the balance that the patent system was always designed for.

Public Safeguards Activated

The easiest reform to make is also the least radical, since it doesn't need additional powers to be granted by legislation. The compulsory licensing and government-use provisions in the Patents Ordinance 2000 are already in place, but what they lack is a mechanism for implementation. Pakistan should have a definite procedure for invoking these provisions, which also should outline how an application can be made, who would be able to decide it, when it would be decided, and on what basis. If a safeguard cannot be put into practice, then it provides no protection; otherwise, if it is provided for, then it would become a live instrument of access (Butt & Razi, 2022). A state's position vis-à-vis patent holders is enhanced by the availability of these mechanisms, even if they are not used, as demonstrated by India's experience.

Adopting a Public-Interest Patentability Standard

A clause resembling India's Section 3(d) should be seriously considered by Pakistan. Currently, the Pakistani patentability criteria are solely conventional, thereby allowing the evergreening of minor variations and the subsequent monopolies beyond the term that entitles to true innovation (Allauddin & Anwar, 2022). An anti-evergreening provision that mandates a significant improvement to be patentable is a sensible way to tighten up the patentability bar in the public interest without excluding innovation. As India has seen, such a clause is perfectly viable under TRIPS, and has undoubtedly been tested in the case of Novartis (Novartis AG v. Union of India, 2013).

The application of the Right to Health to Patent Governance

In addition to the targeted statutory changes, it might be advisable for Pakistan to take the next step that India also took, which is to make the right-to-health jurisprudence meet patent law. But the broad interpretation of the right to life given in other circumstances in Article 9 of the Convention affords a foundation for claiming that patent rights should be administered in the context of respect for the right to health (Shehla Zia v. WAPDA, 1994; Darsana, 2025). This can be done by legislation, by the giving of administrative guidance, incorporating health considerations into the patent decision-making process, or, in the appropriate case, by taking the case to the constitutional court to challenge the compatibility of patent practice with the right to health. The important thing is that the two sets of laws should no longer be considered working in isolation.

Strengthening Institutional Capacity and Coordination

Finally, the reforms outlined above are likely to have little effect if the institutions responsible for implementing them can't do so. In large part, Pakistan's passivity has been due to a lack of administrative capacity and to the lack of coordination among the authorities involved in intellectual property, healthcare regulation, and public health (Shahid et al., 2025). The state should thus develop its capacity to administer the safeguards and create a system for coordination between the relevant authorities so that patent policy does not operate in isolation from the health goals it seeks to achieve. For India, the core of the process of reconciliation was the convergence of legislative, judicial, and administrative bodies within their respective spheres of operation on a single objective; for Pakistan, this kind of convergence, if it is to occur, is much less dramatic.

All these recommendations are based on the key findings of this article. The conflict between intellectual property and the right to health is not as intractable as it is often made to seem, and, for the most part, solutions to the conflict can be found within the legal order in place in Pakistan. What is needed is not new powers but training and mobilization of existing powers, based on constitutional affirmation of the right to health and in the light of the experience of another neighboring state that has demonstrated reconciliation within the same international limitations.

Conclusion

This article has started from the tension at the very heart of IP law in the healthcare sector: between the right to patent and the right to access. This article began with the tension between the patent rights of the patent holder, based on the need to encourage innovation, and the rights of the patient, based on the right to access healthcare. Both claims cannot be ignored. The incentive to innovate is genuine and is also legally binding with Pakistan under international law, whereas the right to health is also a legal right as enshrined in international instruments which Pakistan is a signatory to, and as enshrined in the broad reading of the right to life in the Constitution. The function of any legal system is not to decide between these claims, but to reconcile them, while maintaining the incentivizing power to come up with new ideas and to make sure that the technologies it creates are available to those who rely on them.

The comparison of Pakistan and India reveals that this reconciliation is very hard but possible, and that this is a choice that can be made. Both states inherited the same colonial law tradition, have the same obligations under the TRIPS Agreement, have the same types of public-interest protection, and the same constitutional tradition in which the right to life was interpreted to include the right to health. Where they differ is in the use they have made of these common resources. It has imported its constitutional principle, its legislative protections, and its judicial mechanisms into a single instrument for the reconciliation of patents with access, has found a constitutional basis for excluding weak patents in Section 3(d), has treated compulsory licensing as a real instrument of policy, and has constitutionalized policies on the protection of access to medicines. With identical resources, Pakistan has left them largely untouched and has allowed the tension to remain unchecked, and the constitutional right to health to remain uncorrelated to patent law.

Thus, the main finding in this article is that the distinction between the two states is not one of law but of choice of institutions. The non-reconciliation of IP with the right to health in Pakistan cannot be blamed on the international obligations of Pakistan,

which India shares. Nor can it be blamed on the lack of constitutional basis or statutory tools on which India is also short of. This is because Pakistan has not used its discretion as provided in TRIPS and the Constitution of Pakistan. The diagnosis has an optimistic implication. The root of the problem is Pakistan's institutional practice itself, so is the solution too. The reforms needed are, for the most part, not new powers, but activation of powers already at the disposal of those seeking the changes: the dormant safeguards need to have a workable procedure, a public-interest patentability criterion needs to be adopted, and the right to health needs to be given a new role in patent governance, and the institutional capacity needs to be built to sustain these measures.

The parallels with India show that it is possible to reconcile, within the limits of international law, and that a developing state, under the same rules as the developed, has already demonstrated the way. In a country where access to a life-saving technology could make the difference between life and death, the balance of patent rights and the right to health matters is not just a matter of good policy, but a constitutional and human rights obligation the state has already assumed. The conflict between the two assertions is not imaginary, but not insurmountable either, or the way to overcome the conflict is in the hands of Pakistan, for the most part. The ability to reconcile them is not what is missing; it's the resolve to do it.

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