CONCLUSIONS AND SUGGESTIONS
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The right to health falls under the rubric of economic, social and culture entitlements within human rights law. With the founding of the WHO, which promulgated “the enjoyment of the highest attainable standard of health” as “one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” in its Constitution, the right to health was recognized internationally for the first time. This recognition was further reiterated in several international and regional human rights instruments such as the UDHR and the ICESCR. Health as a human right is increasingly being used as a focal point of discussions in international conferences, meetings and councils. This highlights the growing importance of the synergy between health and human rights in addressing pressing social injustices in today’s world. Thus, it is arguable that human rights are changing from a narrow, legalistic focus on civil and political rights to a broader rights approach encompassing economic, social and cultural rights. The affirmation of the right to health is an undeniable attainment of recent decades and is clearly observed at all levels of international and national legal order.

However, the early efforts to protect public health were surrounded with the controversies of human rights violations. To protect the citizens from infectious disease, European states passed the Quarantine law, which were notorious for the ill treatment and cruelty to the patients and sometimes used to be reinforced by the threat of execution. This anti-human right approach to health later changed with the birth of WHO, an international organization with the responsibility of protecting health of the people of the world. The formal declaration of health as a basic human right found place in the UDHR recognizing everyone the right to a standard of living adequate for the health and well being of himself and of his family.

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587 Ibid.
The health problems that India faces are highly complex and challenging. Given the diverse cultures and economic levels of India, it is hard to envision a mandate that would implement the right to health appropriate in all parts of the country. It is still struggling with health hazards of communicable diseases. AIDS, cancer etc are further aggravated by widespread poverty, malnutrition, illiteracy and ignorance. These negative forces are reinforced by the rate at which the large population is growing.\textsuperscript{588} The full realization of Human Right to Health is more a matter of improving the cultural, economic, environmental and socio-political conditions that determine health status than it is a matter of treating illness or injury. Therefore several factors, determining health status causes obstacles in the realization of health.\textsuperscript{589}

The enunciation of a national health policy by the government of India in 1983 raised hopes among those concerned with India’s poor health that the government is serious about its commitment to provide Health for all. The policy was broad in its approach to health needs and possibilities and ambitious in its goals. Besides acknowledging many of the mistakes of the past and calling for their redress, it embodied concepts of social justice and demonstration which have been eclipsed in the process of health development to date.\textsuperscript{590}

Health care as a right is considered desirable universally. Yet all over the world, the private sector dominates the provision of health care. Today health care is fully commodified and people are left to the mercy of the market. What is worrisome about the health care market is that it works as a supply induced demand market. This means that the providers of the care dictate the terms of the market. In the developed countries, while health care may not be stated as a fundamental right, access has been made more or less universal by legislation or some special provisions for those who do not have the purchasing power. Thus fiscal mechanisms have been created in these countries, with an overwhelming proportion of contributions from the state, to assure basic access although the providers may be from the private sector. In a country like

\textsuperscript{588} Ibid.
\textsuperscript{589} Ibid.,p.153.
India, where three fourth of the population still lives in the villages, providing universal access for health care, becomes even more difficult. While public health facilities are reasonably well developed in urban areas, the infrastructure in the rural areas is grossly inadequate. This puts a lot of pressure on the urban facilities, thus imposing their efficiency.  

In conditions of widespread poverty, where family earning are barely adequate to meet two square meals, seeking care from the market becomes a luxury. Yet that is where the poor are often pushed to seek health care because public facilities are ill equipped to serve their needs. Often this has led to serve indebtedness wiping out the few assets a family may own. The national sample survey data shows that after loans for agriculture, the second largest cause of indebtedness is for health care. This is a serious matter and needs urgent attention.

In a country like India, where poverty is the core concern of the political economy, establishing health care as a human right, becomes even more important. The new economic policies had a negative impact on the health sector with declining state investments in health care. Rapid increasing prices of medicines and further consolidation of the private health sector with the corporate sector entering the fray in a big way. With the state under pressure to reduce its participation directly in the economy, it is important that the social sectors like health care do not get diluted, but on the contrary strengthened. The state must take the lead in recognizing the health care system as a public-private mix wherein a planned and organized system as of financing is provided and not the market determines how health care is accessed by people. This will only be possible if health care becomes a human right.

Along with the economic accessibility (affordability) towards the health care, information accessibility also helps in the realization of health as a human right. Since the purpose of health education is to ensure a desired health related behavior, therefore a close study of the science of sociology, psychology and anthropology is

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592 Ibid.
593 Ibid.
required in understanding human behavior, then the methodological and socialization
of individual is needed through the health education. Here the importance of close,
friendly and sympathetic attitude has been emphasized on the part of doctors, nurses
etc. while dealing with patients. A successful doctor or nurse puts the patients at ease
and explains as much about the diagnosis, treatment, diet, precautions etc, as possible
not only to win the confidence of the patient, but to ensure proper adherence to the
treatment and all precautions necessary for getting cured or relieved.\textsuperscript{594} It is also
necessary to have a free flow of communication. The two way communication is
particularly of importance in health education to help in getting proper feedback and
to get doubts cleared.\textsuperscript{595} So a continued education is necessary in every community to
help people to identify their health problems and to help them to understand what
steps they have to take for prevention.

Any expectation of a significant improvement in the quality of health services,
and the consequential improved health status of the citizenry, would depend not only
on increased financial and material inputs, but also on a more empathetic and
committed attitude in the service providers, whether in the private or public sectors. In
some measure, this optimistic policy document is based on the understanding that the
citizenry is increasingly demanding more by way of quality in health services, and the
health delivery system, particularly in the public sector, is being pressed to respond.
In this backdrop, it needs to be recognized that any policy in the social sector is
critically dependent on the service providers treating their responsibility not as a
commercial activity, but as a service, albeit a paid one. In the area of public health, an
improved standard of governance is a prerequisite for the success of any health
policy.\textsuperscript{596}

Health is politics, and politics is health as if people matter--this has been a
refrain of such scholars as Rudolf Virchow, Halfdan Mahler, and B. C. Roy. Many
seeds of hope for health were generated during India's struggle against colonial rule.
After Independence, with the changes in power relations, these seeds could not find

\textsuperscript{594} L.Ramchandran and T. Dharmalingam, \textit{Health Education: A New Approach} (New Delhi: Vikas
\textsuperscript{595} Ibid.
\textsuperscript{596} See National Health Policy 2002.
the appropriate soil to nurture them. Power relations influence health service development, which is a socio-cultural, economic, political, organizational, and managerial process with epidemiological and sociological dimensions. Even within the power structure, however, a carryover of the democratic process of the pre-Independence era has created a pro-people ambience. Despite considerable difficulties and shortcomings, India has developed an endogenous, alternative body of knowledge more suited to the prevailing social, cultural, economic, and epidemiological conditions. This has formed the content of alternative approaches to education, practice, and research in public health, strikingly similar to the Alma-Ata Declaration. The response to this declaration of self-reliance by the world's poor, together with the earlier specter of population explosion, brought together the political leadership of all hues, the bureaucrats, and foreign agencies to impose prefabricated programs on the people. The result was a decimation and decay of the health service system, causing considerable suffering to the poor. The remedy is a return to the heritage of the alternative approaches that emerged during the early years of independence.  

The existing state of public health in the country is so unsatisfactory that any attempt to improve the present position must necessarily involve administrative measures of such magnitude as may well seem to be out of all proportion to what has been conceived and accomplished in the past. This seems to us inevitable, especially because health administration has so far received from governments but a fraction of the attention that it deserves in comparison with other branches of governmental activity. We have provided for the establishment of a health organization which will bring remedial and preventive services within the reach of the people, particularly of that vast section of the community which lies scattered over the rural areas and which has, in the past, been largely neglected from the point of view of health protection on modern lines.

The field of health and human rights was developed in the context of advocacy and action. If the field is to flourish, it must continue to grapple with not only the


598 See Bhore Committee Report, 1946.
conceptual framework of health and health and rights interplay but also with their practical and effective application to the real world. We are at a stage in history where political will to do something progressive is conspicuous by its absence. We may have constitutional commitments and backing of international law but without political will to do something nothing will happen. To reach the goals of right to health and healthcare civil society will have to be involved in a very large way and in different ways. The initiative to bring healthcare on the political agenda will have to be a multi-pronged one and fought on different levels. The idea here is not to develop a plan of action but to indicate the various steps and involvements that will be needed to build a consensus and struggle for right to healthcare.

Improving knowledge and understanding of health is an indispensable step in promoting health-supportive action. Creating social economic and environmental conditions that are conducive to health is also essential. These can be a reality only when there is a heightened awareness of health matters among policy makers, politicians, economic planners and the public alike, and when this awareness is transformed into policies, legislations and favorable allocations of resources for health. For it a three fold strategy may be adopted i.e. advocacy for health, social support and empowerment of people. These strategies together constitute a powerful instrument for promoting healthy lifestyles and creating conditions conducive to health, though each strategy has its own distinctive characteristics and primary focus.

Advocacy for health is equally important. The aim of advocacy is to generate public demand, place health issues high on the public agenda and effectively convince those who are influential- policy makers, elected representatives, professionals, political and religious leaders and interest groups- to act in support of health. Advocacy directed at policy makers and decision makers should aim at strengthening political commitment to health, promoting social policies conducive to positive action for health and supporting systems that are responsive to peoples need and aspirations. It focuses on creating supportive environments, facilities and conditions that make people’s health choice easier and more feasible. Advocacy directed at professionals,

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public figures and service providers should seek to make them sensitive to peoples need and demands as well as to the desirability of reorienting health systems and services accordingly. Advocacy directed at the public should help to create interest and support for positive health action. It should aim to make health a higher public priority, to stimulate discussion and debate, and to generate public demand and pressure for healthy policies and a healthy environment. Advocacy directed at academic leaders should aim to stimulate interest in study of the aspects of policy and other factors that facilitate progress in health. Academic leaders can be important allies in providing sound scientific backing, with facts and figures, for making a persuasive case for health and health supportive policies.\(^\text{600}\)

Social support for Health should also be emphasized. Strategies for strengthening social support should aim at two important targets. The first consists of community organizations and institutions that encourage healthy lifestyles as a social norm and foster community action for health. The second target comprises systems that provide the infrastructure for health care services and related development activities that have an influence on health. So the health sector must use all channels through which people express their concerns and demand for health. The media can also play an important role in increasing both public awareness and support for publication. A wide variety of social institutions, professional association and voluntary organizations are also engaged in health-related activities at community level and in promotional efforts at political and professional levels. Strategies for social support should aim to initiate and maintain close partnership with these organization and groups, fostering working alliances between them for complementary and coordinated action for health protection and promotion.\(^\text{601}\)

The strategies of empowerment equip individuals, families and communities with the knowledge and skills that will enable them to take positive action for health and make sound health choices. Individual and collective choices depend on a supportive physical, social and economic environment as well as accessible services and facilities. Information, communication and health education is at the heart of the

\(^{600}\) Ibid., p. 12.

\(^{601}\) Avanish Kumar, note 2, pp. 194-195.
Strategies of empowerment for health should be directed at the public and policy-makers alike. They should also use available and credible channels to stress the social and personal values of health. Strategies should be implemented at local and national levels, as well as in the home, school, workplace and other community settings. Empowerment strategies should help people to learn how specific choices of behavior can affect their own health, as well as the health of their families and communities. This includes not only communicating health knowledge but also helping people to recognize beliefs, attitudes, opinions and skills that influence healthy lifestyles. These skills help people to mobilize resources to meet their needs and aspirations and to influence the physical, social, cultural and environmental conditions that affect their health.

Policy level advocacy for creation of an organized system for universal healthcare and research to develop the detailed framework of the organized system: ‘policy-making process’ is necessary for the implementation of health and human right. Both preventive and curative health policies are being devised at the community, national, regional and international levels all over the world without the application of this very insightful approach. We must generalize the role of human right activists and health specialists working together to practice a public health policy from both the human right and health perspective in order to optimize both sets of concerns.

The creation of ‘norm-setting environment’ is also necessary. Professional associations are engaged in this process but efforts could be broadened and depend. For example, the American College of Physicians adopted a policy on sanctions and health and human right after being convinced of the need to do so by the International Association of Bio-ethics and Physicians for Human Rights. A second norm-setting environment concerns the legislature. Parliaments draft laws and elaborate principles that affect health and human right. A magnificent example is happening in South Africa, where legislation on these principles is being drafted. Parliamentarians and

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603 Avanish Kumar, note 2, pp. 194-195.
their staff are not likely to reinvent these on their own; we need to bring the ideas to them. Intergovernmental organizations constitute a third norm setting environment where the principles can be adopted in the form of resolutions and normative instruments (i.e. conventions and recommendations). The technique of counter-reports or shadow reports, submitted to CESCR and the complaint procedure would also be useful.  

Linked with such strengthening of the public health system, to institutionalize accountability would require a legal and constitutional framework to assure health services as a Right. The definition of ‘essential services’ i.e. the range of services that would be ensured for all citizens as a legal entitlement, has been an issue of severe political contention in all countries wherever the ‘universal access package’ has been defined. Once a legal right to health care is considered, the same tussle may be expected to take place in India, and the task of the health movement would be to make sure the range of services is as comprehensive as possible, and to ensure that the services required by various marginalized sections and groups with special needs are definitely included.

The above processes would obviously necessitate mechanisms for substantially raising public finances for the public health system, through general taxation along with various forms of special taxation for health security. Corporations and employers in both organized and unorganized sectors could be required to contribute substantially to the general health system, even as their employees including unorganized workers receive good quality health care coverage from a strengthened health system. Ending subsidization of the private medical sector and effectively taxing this sector, especially its upper end; a special health security on all financial transactions above a certain level; and preferential taxation of industries with negative health impacts are some other measures that have been suggested. As a form of cross-subsidizations, universal social insurance with premiums being integrated with the taxation system may be seriously considered. However, there have to be

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606 Abhay Shukla, Review of Health Care In India (Mumbai: Centre for Enquiry into Health and Allied Themes, 2005), pp. 326-327.
mechanisms to ensure that the significant proportion of the population that is poor, and already pays indirect taxes, is exempted from such premiums. At the same time, in a universal system, the well-to-do sections would need to be brought under its ambit comprehensively and effectively. Since insurance is based on the principle of cross subsidization, with the well subsidizing the sick and the rich subsidizing the poor, any system of insurance that only targets the poor cannot be genuinely effective. Targeted approaches will not work, since a health system only for the poor usually lands up becoming a poor health system.\textsuperscript{607}

There must be more detailed examination of an amendment to the Constitution, guaranteeing the right to health. The judiciary has clearly read into Article 21, Right to Life, the right to health. It in fact has gone deeper into the meaning of health and has substantiated the meaning of the right to life. The question that must be discussed more thoroughly is whether an amendment to the Constitution, which will state the fundamental right to health, is desirable. Enumerated rights have an edge over wider interpretations of existing rights, as States can be held accountable for violations. However, with the extensive case law that is available is it not possible to use what is available to ensure that health care, facilities and condition ensuring health are fundamental rights of every citizen? If the case law reflects the ability of the courts to read the meaning of ‘health’ in very wide sense (everything from the responsibility of the municipal corporation to provide sanitation facilities down to access to emergency medical treatment has been interpreted in the right to health) then why not use the instrument of case law to confer rights? It is this question that must be examine in the light of the recent amendment guaranteeing primary education for all. The process that led to the amendment must be looked at critically as well as how the implementation of it is currently taking place.

Implementation requires affirmative action on the part of government, and implicates intervention in the internal domestic affairs of nations. Given the diverse cultures and economic levels of the nations of the world, it is hard to envision a mandate that would implement right to health that would be appropriate to all nations. But for the realistic implementation three major approaches may be taken: First,

\textsuperscript{607} Abhay Shukla, Ibid., p. 327.
defining universal outcome measures for measuring the compliance with the core state obligations of human right to health. It would also indicate where countries need to concentrate on efforts to meet their obligations under the international human right to health. The UN and the WHO already appreciate the possibilities of reported data on outcome measures in monitoring compliance of states with international human right obligations. Second, systematic reporting to responsible international bodies for monitoring progress, implementation and compliance with international human right obligations. If a country meets these universal outcome measures specified in a systematic reporting system, responsible international bodies as well as domestic constituencies will assume that implementation and compliance have occurred. The approach mitigates the need for international bodies to delve deeply into the internal affairs of nations to assure implementation and compliance. The WHO has begun reporting country’s health statistics on a comparative basis, such as in ‘World Health Report-2000’. The WHO published its first comparative analysis of the world’s health systems. Third, civil rights violations need to be highlighted, such as discrimination against protected groups that inhibit access to health care services. Here the special needs of the vulnerable and high-risk groups, who are least able for geographical, political, social or financial reasons, has to be paid attention and to be given high priority. It is necessary to identify systematically those, who are at highest risk, for providing continuing care to them and to eliminate factor contributing ill health.608

The crisis in the health sector has induced governments in many developing countries to review the relationship of the public sector to the private sector. Specifically, policy makers are exploring mechanisms to promote complementary involvement of the private sector in the delivery of health care. The WHO now strongly supports the promotion of public-private partnerships with the caveat that such partnership should be mutually beneficial and must always benefit health. So the responsibilities of the public and private sectors have to be fixed. To fulfill their responsibilities, they must redouble their efforts, on a continuous basis, to reduce the world’s burden of illness, injury and disability.609

608 See Alma-Ata Declaration, Recommendation 8.
609 Avanish Kumar, note 2, p. 198.
Priorities and approaches to health solutions must be individualized and must be contextualized within local realities. Since health right has little meaning without availability of health care infrastructure in adequate quantity as per the need and location of the population, at least the basic requirements to maintain a reasonable standard of health must be provided. Furthermore, if infrastructure is in place it may not necessarily mean that it is accessible to the people, especially the poor. Thus differences based on location (rural-urban and distance), purchasing power (pricing), ethnicity, race and caste, gender etc. must also be eliminated so that access is not hampered due to any form of discrimination or conditionality.\textsuperscript{610}

Access to health care must exist irrespective of the capacity to pay. Often it is seen that infrastructure is in place and access too is reasonable, but user charges/fees prevents use of such services by the poor. The success of health care as a right is critical to the condition of affordability and hence any direct payments at the point of receiving care will necessarily be discriminatory. Any charges for health care must be collected indirectly on the principle of payment according to capacity that is through direct progressive taxation and charges, and/or insurance premiums. Further, availability, accessibility and affordability have little meaning if the quality of care provided is compromised in any way. Quality of care not only means in terms of well-defined standards and good practices but also satisfaction of the client\textsuperscript{611}. For example, health practitioners must not allow economic incentives to result in the over or under treatment of patients and must comply with all codes of medical ethics, including guidelines for medical or genetic research in human subjects\textsuperscript{612}. Hence health care services must be sensitive to this, including being culturally appropriate or acceptable.

Public health measures must respect basic civil and political rights. The main purpose of health profession is to provide relief to suffering; the prevention and treatment of illness and the promotion of health. So the health care reform efforts must be oriented towards responding to the needs of population and the pursuit of


\textsuperscript{611} Ibid.

\textsuperscript{612} The IOWA City Appeal on Advancing the Human Right to Health”, available at \texttt{<http://www.glphr.org/downloads/appeal.pdf>}, last visited on 12\textsuperscript{th} April 2010.
corporate profit and personal fortune should not distort priorities in care-giving. The privatization and corporation of health care must not be allowed to result in the destruction of national health care systems. Thus the provision of health care must be excluded from the commercial model that seeks to commodity health\textsuperscript{613}.

The wide margin between public resources for health and the demands of the population is a common challenge to health authorities in developing countries. In some of the advanced developing countries, which have enjoyed economic boom in recent years, the health services have grown and are meeting many of the public demands. In poorer nations, especially those that have experienced marked economic decline, there is increasing pressure on public spending for health and other social sectors. Under these circumstances, policy-makers are exploring approaches to increase the resources available for health, allocate the limited resources to target priority conditions and groups, and promote equity. In the least developed countries, it is critically important to increase the financial resources if the health sector is to provide basic essential services. Many countries that previously offered health services at no cost or highly subsidized rates are now imposing fees on users at the point of delivery. The aim should be to generate additional income for use by the public sector, to enable the public sector to redistribute resources in favour of the poor, and to achieve increasing self-reliance for sustainable community health programs. The main objective of user fees should be to generate resources that can be used to expand the quantity and improve the quality of health services\textsuperscript{614}. User charges would enable the public sector to allocate the resources by withdrawing subsidies from those who can afford to pay and redirect the savings to expand cost-effective public health services to the poor. In progressively increasing the funds allocated for health, the governments should give first priority to the extension of primary health care to the under-served communities. It should encourage and support various ways of financing primary health care and also take measures to maximize the efficiency and effectiveness of health-related activities in all sectors\textsuperscript{615}.

\textsuperscript{613} Ibid.
\textsuperscript{615} Alma-Ata Declaration, Recommendation 17.
It is the time to realize that health is a global issue. It should be considered as an essential component of the continuing globalization process that is reshaping interaction between countries in terms of world trade, services, foreign investment and capital markets. A wonderful opportunity now exists to build a new international partnership for health based on social justice, equity and solidarity, which the world in the 21st century will so urgently need. Therefore the entire world community, all governments, the political parties, the organizations of various section of the people, the NGO’s and the medical professionals should unite to achieve ‘Health For All’, without any discrimination, during the first quarter of the 21st century i.e. by the year 2025616.

Apart from the above concrete suggestions we should also include the following to achieve the target fully:

- Lobbying with the medical profession to build support for universal healthcare and regulation of medical practice.
- Filing public interest litigations on right to healthcare to create a basis for constitutional amendment.
- Lobbying with parliamentarians to demand justifiability of directive principles.
- Holding national and regional consultations on right to healthcare with involvement of a wide array of civil society groups.
- Running campaigns on right to healthcare with networks of peoples organizations at the national and regional level.
- Bringing right to healthcare on the agenda of political parties to incorporate it in their manifestoes.
- Pressurizing international bodies like WHO, Committee of ESCR, UNCHR, as well as national bodies like NHRC, NCW to do effective monitoring of India’s state obligations and demand accountability.
- Preparing and circulating widely shadow reports on right to healthcare to create international pressure.

616 Avanish Kumar, note 2, p. 201.
The above is not an exhaustive list. The basic idea is that there should be widespread dialogue, awareness raising, research, documentation and legal/constitutional discourse. India has developed an action plan towards facilitating the realization of this agenda collaboratively with a range of civil society actors through a national initiative on right to health and healthcare in India. To make the above-mentioned recommendations feasible a number of policy decisions have to be taken. In our endeavour to achieve the ultimate objective of universal access to basic health care for all, there is a need to spell out structural requirements or the outline of the model, which will need support of the legislation. The structure, terms and conditions should be clearly incorporated in the legislative framework.

Can the goal of ‘Health for All’ can be achieved in the present socio-economic system, in the context of systemic exploitation responsible for massive poverty and structural inequities, in the broader setting of large scale global expropriation, mediated by trade and facilitated by global financial institutions? One answer would be, ‘Health for All’, in its fullest and most humane sense – requiring, among other conditions, comprehensive nutritional and food security (linked to livelihood security), universal access to safe drinking water and sanitation, provision of healthy housing and local environments, universal healthy working conditions and a safe general environment, access to health related education and information for all, and an equitable, gender just social milieu, free from violence - should remain our larger vision. While definite progress can be made towards achieving these goals in the present socio-economic situation, this is unlikely to be achieved in entirety within the globally defined, economic and social framework prevailing in India today.

The achievement of a strengthened public health system, which is more accountable to ordinary citizens, is a potentially achievable goal to fight for within the existing system. Similarly, the health movement must lend it strength and voice to movements for improving health related entitlements such as nutritional services and food security, clean drinking water, sanitation and safer environmental and working conditions, which may be achieved to certain extent. Such struggles can lead to some concrete improvement in the situation of the working people, and of various deprived and marginalized sections of society. It can also be one channel for people to assert
their strength, by demanding that public institutions work for them effectively. This can become one of many arenas of public organization and mobilization, of assertion of people’s power.

In this broader context, the ‘Right to Health care’ and certain other health related rights are potentially at least partially achievable in the current social framework. However, achievement of the ‘Right to Health’ for all, in its fullest comprehensive sense, which constitutes our larger vision, is inextricably linked with larger social transformations. Hence the struggle for public health, in its deepest sense necessitates that health activists also engage with such a larger vision and broader struggles. Keeping this in mind, the struggle for health rights must move on to link with several other struggles for the rights to food, water, education, housing, livelihood and social justice in various forms, not only because these rights are extremely germane to the improvement of health, but also because the struggle for health rights must form one strand of a much larger struggle to challenge the dominant social order. Establishing people’s Right to health care, even in a partial form, may be one of the platforms for developing people’s awareness and strength, and for beginning to shape certain incipient models of the future within the present. But moving further, a broader movement needs to take shape, to present coherent alternatives in myriad spheres of life, to give people capacity and hope, to challenge the dominant system, and to nurture the tender saplings of the future, even in the harsh world of today. Only such a movement can also dream of replacing the current unhealthy and inequitable socio-economic system, by one that is far more just, humane and healthy, in the world of tomorrow.617

To conclude, it is evident that the neglect of the public health system is an issue larger than government policy making. The latter is the function of the overall political economy. Under capitalism only a well-developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy (which directly benefit capital accumulation) is more urgent (from the business perspective) than the social sectors, hence the latter get only a residual attention by the state. The policy route to

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617 Abhay Shukla, note 22, p. 330.
comprehensive and universal healthcare has failed miserably. It is now time to change gears towards a rights-based approach. The opportunity exists in the form of constitutional provisions and discourse, international laws to which India is a party, and the potential of mobilizing civil society and creating a socio-political consensus on right to healthcare. There are a lot of small efforts towards this end all over the country. Synergies have to be created for these efforts to multiply so that people of India can enjoy right to healthcare.⁶¹⁸

The Right to Health in India is not enshrined as a Fundamental Right, but is included within the ambit of the Directive Principles of State Policy. What is needed to ensure Health for All on an equitable basis is the political will, which would necessitate a constitutional amendment and incorporate health within the ambit of Fundamental Rights. At the international level of analysis, there is an urgent need to ensure that there is a consensus to include health within the ambit of civil and political rights, as the fulfillment of either the civil and political rights as well as the economic, social and cultural rights are mutually reinforcing. Health as a human right needs to be justifiable under international law. The eradication of small pox in the late 1970s has shown that a strong political commitment and adoption of country specific strategies is bound to yield rich results, and would pave the ultimate road to achieve the dream of health for all.⁶¹⁹

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