CHAPTER-II
RIGHT TO HEALTH IN
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“We recognize health as an inalienable human right that every individual can justly claim. So long as wide health inequalities exist in our country and access to essential health care is not universally assured, we would fall short in both economic planning and in our moral obligation to all citizens.”

Prime Minister, Man Mohan Singh, October 2005

(A) INTRODUCTION

There are many factors outside the province of medicine that play a significant role in determining the quality of our lives like poverty, unemployment, malnutrition, deforestation desertification, morality, crime, divorce, human unhappiness and so on. Out of all these, right to be healthy is the most important of all the rights. Without this right, no major change is possible and with this right in hand no change can remain impossible. Health is man’s most precious possession; it influences all his activities; it shapes the destinies of people. Without it there can be no solid foundation for man’s happiness. Health has always been a major concern of people through ages. It is not at all a new concept nor is it the asset of the modernized or western world. Health has always been the intimate part of the Indian society. This chapter discusses briefly the history of origin of health system from the pre-British and British days to the post-independence India and the present scene which will enable us to understand the historic reasons, the compulsions and pressures that have perpetuated a system, even after independence, where health is denied to the majority of our people and illness converted into a lucrative business and industry.

(B) EVOLUTION OF HEALTH RIGHTS IN INDIA

In India health rights can be traced to the early civilization of Harappa and Mohenjo-Daro which when excavated revealed well planned cities with baths and drainage systems. Over the millennia several indigenous systems of medicines have evolved which have emphasized the maintenance of health rather than mere treatment of disease.\textsuperscript{132} The Indian systems of ayurveda and yoga put stress on the maintenance of health rather than the medical treatment. Their holistic approach is concerned not only with the well-being of the physical body but also of the mind and considers the human being as a part of nature. As such health is considered in a larger philosophical and even a spiritual than a mere medical concept. This has been integrated into the daily life of our people as part of their social and religious practices. India has also incorporated several foreign systems of medicine like Unani, Allopathy, and Homeopathy which are largely medically oriented. Though the various systems unfortunately tend to be practiced in isolation by their practitioners, they are highly complementary e.g. Allopathy for communicable diseases and Ayurveda and yoga for diseases of ageing and lifestyle.\textsuperscript{133} However, modern technology has changed this and led to the increasing institutionalization and urbanization of health care facilities in India.\textsuperscript{134}

1. Pre-British Period

Even before Hobbes the Indian epic Mahabharata spoke about the civil liberties of the individual in a political state as has been witnessed in the olden days. Mahabharata illustrates a great deal of rules and regulations even for the rulers. The concept of Dharma was considered as supreme law which governed the sovereignty and the subjects, enumerate basic principles of the theories of rights, duties and freedom. It could be better understood that the Indian society in ancient times remained highly structured and well organized codifying fundamental rights and fundamental duties to the individuals and to the various classes, communities and

\textsuperscript{133} Ibid, p.1.
\textsuperscript{134} P. Ramchandran, “health for all” note 4.
castes. The concept of dharma has been propelled and propagated as an eternal spring to blossom with fragrance in all the disciplines such as morality, law, religion, rules and regulations, spiritual pursuits, and regulating the conduct of the human beings with a forceful liberating tendency to attain happiness without any bondage of discrimination and exploitation.\textsuperscript{135} Comparing the Vedic period, the natural law philosophy remained as an integral part of the indigenous legal, social, moral, religious, cultural, and political system in India. Kautilya in his book Arthshashtra has enumerated exhaustively the civil and legal rights which had been initially formulated by Manu but also illustrated by way of addition a number of economic rights. To quote Kautilya-‘the king shall provide orphan, the aged, the infirm, the afflicted and helpless with maintenance, he shall also provide subsistence to the helpless expectant mothers and also the children they give birth to.\textsuperscript{136}

The Ayurvedic system was probably the first to be recognized as a systematized study of the science of Health and healing using rational methods for diagnosing and treating illness. This has been recorded in two great tomes ‘\textit{Sushruta Samhita}’ and ‘\textit{Charaka Samhita}’. Ayurveda, like yoga and the \textit{siddha} system, not only reflects an entire culture derived from the little traditions of the people, but also highlights other aspects like mental and physical health hygiene. It is a philosophical, spiritual and a physical approach to health and medical care. These well organized and well documented systems have their roots in folk medicines, herbal remedies and nature cure based on the belief that disease can often be prevented and even cured without the aid of medicines. Over the times the medical aspects for the prevention and cure of diseases in India also incorporated other systems of medicine like Unani, Allopathy, and homeopathy.\textsuperscript{137}

2. \textbf{British Period}

The decline of Ayurvedic system, chiefly utilized by the rulers and the elite, had already begun before the British came to India. Further deterioration of the

\textsuperscript{136} Ibid.
\textsuperscript{137} J. Healy & M. Mckee, note 5, p.7.
system resulted with the introduction in the latter half of the 18th century of the allopathic system of medicine introduced by the British rulers. This was introduced in India mainly to serve the requirement of British expatriates to protect their military personnel, sepoys and associated local civilian elite especially from epidemics. With the establishment of several medical colleges in the 19th century, the allopathic system received a further boost in India. Largely based on the British model, it had little relevance to the needs of the Indian society at large.\footnote{138}

In 1835, Macaulay's minutes put an end to the promotion of Indian systems of medicine which were deemed as being unscientific. Sanskrit and Ayurvedic texts were destroyed. By the end of the 19th century a number of Indian doctors had begun to practice the western system of medicine in the major cities, chiefly of a curative nature.\footnote{139} The Montague-Chelmsford reforms attempted to decentralized power and the provinces were given more say in administration of health. However poor funding and bureaucratic mismanagement hampered the proper materialization of the plan. Poor health conditions continued till independence despite various reforms which proved to be superficial, incidental and secondary.\footnote{140}

The nationalist movement under Gandhi tried to revive our indigenous system of Health and medical care and met with some success. It was the father of the nation who advocated a decentralized people-based form rural development based on values and traditions which included the health practices of our civilization. He stressed that people in rural areas should be at the helm of making policy that affected their welfare. He advocated health as a way of life and believed in naturopathy. The stress was on caring rather than curing, using informal methods of education, health and medical practice at the village level.\footnote{141}

The fact that India was not a free state was due to poverty, the crushing burden of taxation, the wasteful expenditure and the drain of wealth. The analysis of the economy of India leads to the inevitable conclusion that basically the poverty was the consequence of the foreign rule, the system of administration introduced by the

\footnotesize{\begin{itemize}
\item \footnote{138} J. Healy & M. Mckee, note 5, pp.7-8.
\item \footnote{139} Ibid, p.8.
\item \footnote{140} Ibid.
\item \footnote{141} Ibid.
\end{itemize}}
British in India. It followed that no improvement in the socio-economic conditions of the people could be expected without a radical change in the character of the government. It was, therefore, necessary to agitate for a change in the government for the introduction of representative system, for the transfer of political power from the British to the Indian hands. Hence, the solution of these socio-economic problems which the country was facing depended on the attainment of self-rule by India.\textsuperscript{142}

### 3. At Independence

India has a long tradition of promoting and protecting human rights. Even before independence, it was in the forefront of the struggle against apartheid. The vision of our nation’s founding fathers who framed our constitution was based on a solid commitment to human rights. It has always been our firm belief that in a truly pluralistic society, like India, growth and welfare of citizens can be ensured only through promotion and protection of human rights.\textsuperscript{143} Ours is a country with a long and diverse history and a vibrant culture. However as an independent nation we are relatively young. Whilst determining the future of our country, the challenge before our founding fathers was to choose a political set up which would ensure a free and independent society and human dignity, freedom and advancement.\textsuperscript{144}

In 1938, the Indian National Congress set up the National Planning Committee. A sub-committee on health under the chairmanship of Col. S.S. Sokhey was formed to access the Health situation and the Health services of the country. In 1943, the health survey and Planning Committee (popularly known as the Bhore Committee) was appointed by the British under the chairmanship of Sir Joseph Bhore, an officer from the Indian civil service.\textsuperscript{145} The health condition of the nation under British rule as was there in 1946 was reviewed by this Committee. The report of this committee was

\begin{itemize}
\item \textsuperscript{144} Ibid.
\item \textsuperscript{145} J. Healy & M. Mckee, note 5, pp. 8-9.
\end{itemize}
published in 1946 on the eve of India’s independence, and the proposals for health programmes provided the following:

- No individual shall fail to secure adequate medical care because of inability to pay for it.
- In view of the complexity of modern medical practice, the health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment.
- The health problem must from the beginning lay special emphasis on preventive work.
- The need is urgent for providing medical relief and preventive health care to the vast rural population of the country.
- The health service should be placed as close to the people as possible in order to ensure the maximum benefit to the community to be served.
- It is essential to secure the active co-operation of the people in the development of the health programme.
- The report in this long term programme recommended a primary health unit for a population of 20,000, a secondary unit for a population of 6,00,000 and a district headquarters organization for a population of 3 million. The committee in its short term programme recommended a primary unit for a population of 40,000, a secondary unit for a population of three million.
- Recommended a three months training in preventive and social medicine to prepare social physicians who could guide the people to a healthier and happier life. This report still continues to be an important document in the field of health care.\(^{146}\)

Although the Indian Constitution does not explicitly mention health or health care as a fundamental right, the justiciability of right to health is based on right to life and liberty.\(^{147}\) The various Directive Principles, which talks about health and health care, are Articles 39, 41, 42, and 47. In addition to the Constitution, there are five main instruments in the Indian legal system that deal with regulation of health care

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\(^{147}\) See Article 21, *The Constitution of India*. 

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The foundation of India’s health policy was laid by the Bhore Commission Report in 1946. The report established primary health care as the foundation for the national health care system, and developed the first patterns for primary health care facilities and health personnel in the public sector. The Bhore Commission enunciated the principle that primary health care is a basic right to which people should not be denied access because of their inability to pay or for other socio-economic reasons. Building on this thinking over the years, India became a strong supporter of the Alma Ata Declaration of 1978, where it committed itself to attaining the goal of ‘Health for All’ based on a primary health care approach.148

India’s health status is characterized by shifting demographics, altered health behaviours and changes in disease patterns. Although significant improvements have been made in reducing infant mortality and increasing the life expectancy of the population in the last half a century, a high proportion of the population continue to suffer and die from communicable diseases, preventable infections, pregnancy and childbirth related complications, malnourishment and so on. There is also the trend in recent years of a rise in the incidence of non-communicable diseases such as diabetes, cancer and cardiovascular ailments.149

4. After Independence

Although the class interests of India’s new rulers came to the fore after independence, yet they had to adopt an egalitarian stance given the democratic urges kindled among the masses and their own egalitarian convictions. This impelled them to take such actions in health and other fields, in the first two decades of independence, which placed the country very high among the newly sovereign countries. An example for this is that of ensuring protection and promotion of health

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149 Ibid.
of the people by placing it in the directive principles of state policy in the constitution of India.\textsuperscript{150}

The health survey and development committee (Bhore committee), which was appointed by the government of India in October 1943 to make surveys of the existing position in regard to health conditions and health organizations in what was then known as British India and to make recommendations for future developments, found that they had to confine themselves mainly to statistics of ill health and death, in the absence of data on positive health.\textsuperscript{151} The Bhore committee submitted its report in 1946 and the recommendations of the committee on health and family planning programme were accepted by the government of India and it was decided that the recommendations should be implemented from the beginning of the fifth five-year plan (1974-79).\textsuperscript{152}

Fifteen years later, the Mudaliar Committee further strengthened public health education in the country by recommending schools of public health in every state to train medical officers, public health nurses, maternity and child welfare workers, public health engineers and sanitarians, dieticians, epidemiologists, nutrition workers, malarialists and field workers. It also recommended degrees in public health in University for non-medical personnel covering general public health, communicable diseases, immunization, environment sanitation, statistics, school health and the teaching of public health principles and hygiene in primary school with practical demonstrations. In addition, one year training in public health for a large number of medical officers to carry out public health/sanitation measures and higher training of MD/PhD to support public health system policy and development were also recommended. While these recommendations were made in an era when public health was seen as a special skill and education of health personnel in these skills were seen as necessary for health system development in India, the first two decades of national health planning saw a series of negative policy trends that prevented the public health

\textsuperscript{151} Govt. of India, \textit{National Health Policy} (New Delhi: Lok Sabha Secretariat, 1985), p. 2.
\textsuperscript{152} \textit{National Health Policy}, note 24, p.10.
system and policy development from reaching its full potential with many of the Bhore and Mudaliar committee recommendations not being operationalized.\textsuperscript{153} 

According to the constitution, health is a state subject, but the Centre definitely has a very crucial role to play by supplementing the resources in the form of running various centrally sponsored programs, implementing State Health Systems Projects, providing Additional Central Assistance in the form of Pradhan Mantri Gramodaya Yojana (PMGY) and also of course providing the overall broad policy directives.\textsuperscript{154} 

The way forward a brief review of the government policies and programs over the last 60 years is a reflection of how the healthcare system responds to health. Since independence, several policies and programmatic interventions have been formulated to meet the health needs of people in the country. Besides, the specific policies that were initiated, the five-year plans, are a statement of the sectoral policies and programs introduced by the Government of India. The progress of the five year plans, from the first introduced in 1951-56 to the eleventh five year plan (2007-12), are indicative of the shifts in the government’s priorities and commitment vis-à-vis specific health issues.\textsuperscript{155} 

\textbf{(C) ROLE OF PANCHAYATI RAJ IN PROMOTING RIGHT TO HEALTH} 

The village panchayats have existed in India since ancient times. These panchayats have been the Centre of social life and an important economic and administrative force in the local village community more through wisdom and consensus than through a majority vote. This system has played a very important role after India’s independence in the improvement of health services in India. Health has been converted into a lucrative business due to the nexus between powers operating within and outside the country while denying even elementary health and medical 

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\item \textsuperscript{154} Workshop on national health accounts in India, Bureau of Planning Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, 31\textsuperscript{st} Oct-1\textsuperscript{st} Nov, New Delhi.
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care to the vast majority who are poor. This policy has also diverted attention from health to inappropriate illness care. Poor, illiterate but intelligent people now have the opportunity to wrest control over their own destiny through the power of the vote provided by *panchayati raj*.

After the independence, Community Development Program was started in 1952. But because it was not attached with the people, therefore it couldn’t prove to be a success story. People took it as a burden put on them by the government. A team, under the leadership of Balwantrai Mehta tried to find out the cause for the failure of this program and came up with the inference that there should be an organization at village level, which would select the true beneficiaries and implement various government programs and schemes.\(^{156}\)

This organization would act as the representative of all the villagers and should ensure the development of the village as well as participation of villagers. In this way Balwantrai Mehta tried to achieve local self-government though Panchayats (the organization). This concept of local self-government was the right step towards decentralized democracy. In this process, the State of Rajasthan for the first time adopted the three leveled structure of Panchayati Raj. Village Level, Intermediate Level and District Level.\(^{157}\) In 1977 Ashok Mehta Committee was set up to review the working of Panchayats. The committee found out that Panchayati Raj is the soul of democracy and therefore it should be empowered with more authority. Those Panchayats which formed after 1977 are known as Second Generation Panchayats. In West Bengal, the Panchayats became more effective after accepting the suggestions made in this report.\(^{158}\)

During the decade of 1990, it was realized that without constitutional power, the self-government can’t be fruitful; therefore the Central Government passed the 73rd Constitutional Amendment Act in 1992, which became effective from 20th April 1993 (from the date of publication in the Gazette of India).\(^{159}\) The panchayati raj

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\(^{157}\) “Panchayati Raj System in Independent India”, note 29.

\(^{158}\) Ibid.

\(^{159}\) Ibid.
institutions in India acquired a constitutional status in 1993 with this constitutional amendment— a landmark in the history of decentralized planning and governance. The panchayati raj act became applicable all over the country. It gave a vision of village level democratic governance and paved the way for rural development to be both participatory and community based. One of the ways adopted by the government has been seeking the help of panchayati in acquiring village lands so that a sub-center or a public health center can be built there. The selection and appointment of voluntary health workers/ guides at the village level was also done with the participation of panchayats.

National health policy-2002 lays great emphasis upon the implementation of public health programmes through local self-government institutions. The structure of the national disease control programmes will have specific components for implementation through such entities. The Policy urges all State Governments to consider decentralizing the implementation of the programmes to such Institutions by 2005. In order to achieve this, financial incentives, over and above the resources normatively allocated for disease control programmes, will be provided by the Central Government.

(D) FIVE YEAR PLANS AND HEALTH

The Indian Constitution provides a framework for a welfare/socialist pattern of development. While civil and political rights are enshrined as Fundamental rights that are justiciable, social and economic rights like health, education, livelihoods etc. are provided for as Directive Principles for the state and hence not justiciable. The latter comes under the domain of planned development, which the state steers through the five year plans and other development policy initiatives. Soon after the publication of the report of the Bhore Committee, the country became independent. The new constitution was adopted and the country embarked on a planned economic

161 Ibid.
162 National Health Policy, note 24.
development. The first five year plan of 1951-56 provided for 65.2 crores for health development schemes. The objectives of the First (1951-56) and Second Five-Year (1956-61) Plans were to develop the basic infrastructure and manpower visualized by the Bhore Committee. Though health was seen as fundamental to national progress, less than 5% of the total revenue was invested in health. The following priorities formed the basis of the First Five-Year Plan: provision of water supply and sanitation; control of malaria; preventive health care of the rural population through health units and mobile units; health services for mothers and children; education, training and health education; self-sufficiency in drugs and equipment; family planning and population control. Starting from the first plan, vertical programmes started, which became the centre of focus. The Malaria Control Programme, which was made one of the principal programmes, apart from other programmes for the control of TB, filariasis, leprosy and venereal diseases, was launched. Health personnel were to take part in vertical programmes. However, the first plan itself failed to create an integrated system by introducing verticality.164 “Health” (including water supply and sanitation) was allocated Rs.4672 crores in the second five year plan. Another major shift came in the Third five year Plan (1961-66) where a sum of Rs. 361 crores, out of the total of Rs. 8576.5 crores was earmarked for health. And the family planning received priority for the first time. Increase in the population became a major worry and was seen as a hurdle to the development process. Although the broad objective was to bring about progressive improvement in the health of the people by ensuring a certain minimum level of physical wellbeing and to create conditions favorable for greater efficiency, there was a shift in focus from preventive health services to family planning. During the Fourth Plan (1969-74), efforts were made to provide an effective base for health services in rural areas by strengthening the PHCs. The vertical campaigns against communicable diseases were further intensified. During the Fifth Plan (1974-79), policy-makers suddenly realized that health had to be addressed alongside other development programmes.165 The corresponding plan provisions during the annual plans 1966-1969, fourth fifth and sixth five year plans were of the


165 “Primary Health Care in India: Review of Policy, Plan and Committee Reports”, note 37.
order of Rs. 313.3 crores, 1261.5 crores, 2360.1 crores, and 5753.1 crores respectively.\footnote{National Health Policy, note 24, p.12.} While the broad approaches contained in the successive five year plans, documents and discussions thereon might have generally served the needs of the situation in the past, it was felt that an integrated comprehensive approach towards the future developments of health services was required to be established to serve the actual health needs and priorities of the country. It was in this context that the national health policy (NHP) was evolved by the government.\footnote{Ibid, p. 13.}

The 10th five year Plan aimed at providing essential primary health care, particularly to the underprivileged and underserved segments of our population. It also sought to devolve responsibilities and funds for health care. However, progress towards these objectives has been slow and the targets have been missed. Accessibility remains a major issue especially in areas where habitations are scattered and women & children continue to die on route to hospitals. Rural health care in most states is marked by absenteeism of doctors/health providers, low levels of skills, shortage of medicines, inadequate supervision/monitoring and callous attitudes. There are neither rewards for service providers nor punishments for defaulters. As a result, health outcomes in India are adverse compared to bordering countries like Sri Lanka as well as countries of South East Asia like China and Vietnam.\footnote{Towards Faster and More Inclusive Growth: An Approach to 11th Five year Plan 2007-2012 (New Delhi: Planning Commission, 2006), available at http<www.scribd.com/doc/60527928/11th-Plan-of-the-Planning-Commission> last visited on 10 January 2010.}

Achievement of health objectives involves much more than curative or even preventive medical care. We need a comprehensive approach which encompasses individual health care, public health, sanitation, clean drinking water, access to food and knowledge about hygiene and feeding practice. This is a difficult area because of our sociocultural complexities and also regional diversity. Policy interventions therefore have to be evidence based and responsive to area specific differences. With concerted action including enabling pregnant women to have institutional deliveries and receive nutritional supplements; connecting PHCs and CHCs by all-weather roads so that they can be reached quickly in emergencies; (accessibility to hospital should be measured in terms of travel time, not just distance from nearest PHC); providing
home-based neo natal care including emergency life saving measures etc, we can be on track to reach the Millennium Development Goals for IMR, MMR and for combating diseases by the end of the 11th Plan. To improve the primary health care system, the 11th Plan first lays emphasis on integrated district health plans and second, on block specific health plans. These plans will ensure involvement of all health related sectors and emphasize partnership with NGOs. The NRHM has already been launched to ensure quality health care in rural areas. The next step should be to extend this to make it a Sarva Swasthya Abhiyan that also covers the health needs of the urban poor, particularly the slum dwellers by investing in high caliber health professionals and appropriate technology.\(^{169}\)

Besides reducing the burden and the level of risk of existing, growing and emerging diseases, the 11th Plan also takes care of the special needs of people who are HIV positive, in particular women. The 11th Plan recognizes the feminine face of HIV and accords it the highest priority.\(^{170}\) The 11th Plan continues to advocate fertility regulation through voluntary and informed consent. It will also address the special healthcare needs of the elderly, especially those who are economically and socially vulnerable.\(^{171}\)

(E) HEALTH POLICIES AND PROGRAMMES

1. National Health Policy

One of the fundamental rights of every human being without distinction of race, religion, political belief, etc is the enjoyment of the highest attainable standard of health.\(^{172}\) Owing to a variety of factors like lack of health consciousness, low per capita income, lack of adequate education, non availability of proper sanitary conditions and safe drinking water, the health status of the average Indian leaves much to be desired. It has been endeavour of successive governments in India to

\(^{170}\) Ibid.
\(^{171}\) Ibid.
improve the situation. This is especially so after independence. A National Health Policy (NHP) was first time adopted in 1983. The national health policy of the Indian government is a logical culmination of the consistent efforts, aimed at securing a healthy life for all Indians, pursued by the governments in the recent decades. While many of the achievements in the past, more needs to be done now and in near future.\footnote{National Health Policy, note 24, p. 1.}

The main focus of the National Health Policy was the formulation of an integrated and comprehensive approach towards future development of health services, appropriately supported by medical education and research, with special emphasis on public health centre and related support services.\footnote{Manoj Kumar Sinha, Enforcement of Economic, Social and Cultural Rights- International and National Perspectives (New Delhi: Manak Publications Pvt. Ltd, 2006), p.262.} With the enactment of the 73\textsuperscript{rd} constitutional Amendment Act 1992, panchayati raj institutions were revitalized, and a process of democratic decentralization ushered in, with similar provisions made for urban local bodies, municipalities and nagarpalikas. The importance of panchayati raj institutions also recognized in the tenth five year plan (2002-2007) to ensure local accountability of health care.\footnote{Economic Survey, 2003-04, available at <http://indiabudget.nic.in/es2003-04/esmain.htm> last visited on 15 December 2005.}

The main objective of the national health policy 2002 is to achieve an acceptable standard of good health amongst the general population of the country.\footnote{Ibid.} It is to be achieved through increase in access to the decentralized public health system by establishing new infrastructure in deficient areas and by upgrading the infrastructure in the existing institutions. Moreover, it is biased towards an urban centric specialist based health care by ignoring the pressing needs of health care services.\footnote{Manoj Kumar Sinha, note 47, p-263.} It proposes privatization of secondary and tertiary level care, proposes to use the Indian health facilities, particularly in private sector.\footnote{Ibid.} Such a policy move certainly strengthens a climate subservient to the interests of the rich and powerful in the global health market but denies the minimum health entitlements to the maximum poor sections. Interestingly, the national health policy 2002 is quite explicit in its
acknowledgement of the poor state of affairs in the health sector. It also recognizes globalization as a concern with a critical view of TRIPS and its impacts, envisages regulation of the private health care sector.179

Since the attainment of independence, the country has made significant progress in improving the health status of its people. The planning process has also contributed to the development of a nationwide primary health care infrastructure. While addressing the world health assembly in May 1981, the Late Prime Minister Smt. Indira Gandhi observed: “in India we should like health to go to homes instead of large numbers gravitating towards centralized hospitals. Services must begin where people are and where problems arise.”180

India is a signatory to the Alma-Ata Declaration of 1978 which was aimed at the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead socially and economically productive lives. The objective is sought to be secured through the primary health care approach. The national health policy of India is a blueprint for such concerted action by the government, the private voluntary agencies and the people for the attainment of the ideal of health for all.181

The national health policy aims at taking the services nearest to the door steps of the people and ensuring fuller participation of the community in the health development process. It has been recognized that if the quality of the lives of the people is to be improved, their health status is to be raised. In this perspective, health development is to be viewed as an integral part of overall human resources development.182 The national health policy points to the need of restructuring the health services on the preventive, promotive, and rehabilitative aspects of health care and brings out the need for establishing comprehensive services to reach the population in the remotest areas. The programmes are being implemented through the fullest involvement of the communities. It views health and human development as a vital component of over-all socio-economic development. For the realization of the various objectives the policy indicates specified goals to be achieved by 1985, 1990,

179 Ibid.
180 National Health Policy, note 24, p.1.
1995 and the year 2000. Some of the major steps taken towards this direction are the following:\(^{183}\)

- To shift the emphasis from the curative to the preventive and promotive aspects of health care as well as to take services and supplies nearest to the doorsteps of the people, the many changes have been brought about like establishing centers and sub-centers for every 500 rural population, leprosy control programme, malaria eradication programme, strategy for tackling tuberculosis etc.\(^{184}\)

- Community involvement and participation is the cornerstone of national health policy. It envisages the formation of health committees in every village to project the health needs of the community and be involved in the functioning of health services.\(^{185}\)

- The policy stresses the need of medical research relevant to the needs of the society.\(^{186}\)

A joint panel of the ICSSR and ICMR was appointed in 1978 to study the problem of health in its widest perspective from the medical, social, cultural, economic and political aspects and suggest the possibility of an alternative strategy. This report, under the chairmanship of Prof. V.Ramalingaswami and with late J.P.Naik as the moving spirit, differed from all previous ‘health for all’ reports as it viewed health primarily as an outcome of the overall integrated social and economic development of the entire society. The report commences by stating that “the objective of the National Health Policy should be to provide health for all by 2000 A.D. this implies the provision of a good and adequate health for all citizens and especially for women and children and the poor and underprivileged groups.”\(^{187}\) In 1981 Report, the joint panel clearly stated that the major factors determining the health of the people lie beyond the realm of medical care and are admirably amenable to peoples own effort. It emphasized factors like nutrition, education, water, sanitation, housing, and environment. Without minimizing the role of preventive and


\(^{184}\) National Health Policy, note 24, p.14.

\(^{185}\) Ibid, p.17.


curative medicine, it advocated an alternative strategy based on an overall integrated approach.

The national health policy also reiterated the reports critique of the then existing health system in the following terms. “The proliferation of the present approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in urban or rural areas furthermore the continued emphasis on the curative approach has led to a neglect of preventive, promotive and rehabilitative aspects of health care. The existing approach, instead of improving awareness and building up self reliance, has tended to enhance dependency and weaken the community’s capacity to cope with its problems over the years the planning process has largely become oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programs”.\(^{188}\) “Health is a function not only of medical care but of the overall integrated development of society- cultural, economic, educational, social and political. Health also depends on a number of supportive services- nutrition, improvement in environment and health education. Health education should become an integral part of all general education and should receive adequate emphasis….”\(^{189}\)

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

\(^{188}\) J. Healy & M. Mckee, note 5, pp.15-16.
\(^{189}\) Ibid, pp. 27-28.
improved standard of governance is a prerequisite for the success of any health policy.\textsuperscript{190}

2. **National Youth Policy**

The National Youth Policy, 2003 reiterates the commitment of the entire nation to the composite and all-round development of the young sons and daughters of India and seeks to establish an All-India perspective to fulfill their legitimate aspirations so that they are all strong of heart and strong of body and mind in successfully accomplishing the challenging tasks of national reconstruction and social changes that lie ahead. The earlier National Youth Policy was formulated in 1988. The socio-economic conditions in the country have since undergone a significant change and have been shaped by wide-ranging technological advancement. The National Youth Policy - 2003 is designed to galvanize the youth to rise up to the new challenges, keeping in view the global scenario, and aims at motivating them to be active and committed participants in the exciting task of National Development.\textsuperscript{191}

National Youth Policy has been developed with thrust on youth empowerment and gender justice. Objectives of the policy include increased access of young people to all information and services including reproductive health, promotion of social environment to prevent HIV/STD, drug abuse etc. as well as provision of opportunities for education, skill development and employment of youth.\textsuperscript{192}

The policy recognizes that a holistic approach towards health, mental, physical and spiritual, needs to be adopted after careful assessment of the health needs of the youth. As per the youth population projections (based on the 1991 Census), about 21.4\% of the total population in 1996 was estimated to be in the age group of 10-19 years; of these, about 78.4\% lived in the rural and the remaining (21.6\%) in the urban areas. The mean age of marriage in the rural areas was 21.56 years for males.

\textsuperscript{190} Govt. of India, \textit{National Health Policy} (New Delhi: Lok Sabha Secretariat, 2002).


and 16.67 years for females. In the urban areas, the mean age for marriage was 24.32 years for males and 19.92 years for females. In other words, most women in India are married during the age of adolescence. The areas of focus of this Policy, in so far as health of the youth is concerned, are: General Health; Mental Health; Spiritual Health; AIDS, Sexually Transmitted Diseases, Substance Abuse; and Population Education. The Policy recognizes that a growing population is a serious national problem that has negated many of our achievements in the field of development. The youth have an important role to play in this sphere and can create greater awareness in this regard through community programs.193

3. National Population Policy

Every civilized nation with a vision of planned development must have a national population policy. The economic and environmental consequences of excessive demographic growth are alarming and justify prophylactic and health perspectives designed to moderate and discipline the birth rate, so that the health of mother and child, the well-being of family and community, the promotion of sustainable development, lasting peace and social security without a struggle for survival, may be achieved.194 In this regard, Government should intensify its efforts towards strengthening health promotion and disease prevention. In addition, increased budgetary allocation and better focused and targeted investments are needed in the areas of safe motherhood and child survival.

Specifically, government needs to focus more efforts on skilled attendance at birth, functional referral system, antenatal care, emergency obstetric care, neonatal care, family planning, reproductive health commodity security, adolescent reproductive health such as youth friendly services, strengthening the weak and vulnerable health system (infrastructure, equipment, drugs and supplies) as well as paying special attention to human resources for health services. Community mobilization and empowerment as a means of building capacities at grass root levels especially for households and communities to improve homestead hygiene, safe water

and sanitation, nutrition and food security should be implemented and given the attention that they deserve. The goal to achieve adequate quality health care services for the entire population, such as Primary Health Care (PHC), is likely to be more difficult given the high population growth rate and poverty levels in the country. The situation is compounded by the prevailing high fertility, high unmet need for family planning, and the HIV/AIDS epidemic. The country must be prepared to expand and improve the quality of health services such as public-private partnerships to cater for the growing population if the economic growth is to be sustained.

Efforts made over the years for improving health standards have been partially neutralized by the rapid growth of the population. It is well recognized that population stabilization measures and general health initiatives, when effectively synchronized, synergistically maximize the socioeconomic well-being of the people. Government has separately announced the ‘National Population Policy – 2000’. The principal common features covered under the National Population Policy-2000 and NHP-2002, relate to the prevention and control of communicable diseases; giving priority to the containment of HIV/AIDS infection; the universal immunization of children against all major preventable diseases; addressing the unmet needs for basic and reproductive health services, and supplementation of infrastructure. The synchronized implementation of these two Policies – National Population Policy – 2000 and National Health Policy-2002 – will be the very cornerstone of any national structural plan to improve the health standards in the country.195

4. National Policy for the Aged

In India governments concern for the elderly began with India’s participation in the World Assembly Conference in Vienna in 1982 where India adopted the United Nations international plan of action on ageing. This plan focused on the government’s role in adopting programmes for the care and protection for the elderly, synchronizing these with the changing socio economic conditions of the society. One of the early interventions was the introduction of pension schemes that were applicable to a

minority of the elderly along with other welfare measures. The government has promised to set up an inter-ministerial committee to implement the National Policy on Older Persons which was released by the Government of India in January 1999, in the International Year of Older Persons.\footnote{Indrani Gupta, Purnamita Dasgupta, Maneeta Sawhney, “Health of the elderly in India: Some Aspects of Vulnerability”; p-21, available at<www.corecentre.co.in/Database/Docs/DocFiles/elder_india.pdf> last visited on 15th march 2010.} Reiterating the mandate enshrined in Article 41 of the Constitution of India, the Policy has brought the concern for older persons on top of the National Agenda. The National Policy on Older Persons while promising to safeguard their interest in terms of financial security, health, legal, social and psychological security, also envisages a productive partnership with them in the process of development by creating opportunities for their gainful engagement and employment. The National Policy on Older Persons recognizes special health needs of the older persons to be met through strengthening and reorienting the public health services at Primary Health Care level, creation of health facilities through non-profit organization like trust/charity, etc., and implementing health insurance.\footnote{Satyendra Prakash, “Policies and Programmes on Population Ageing: Indian Perspective”, available at <http://www.unescap.org/ESID/psis/meetings/Ageing_Change_Family/India.pdf> last visited on 5th May 2010.}

Due recognition is being given to the needs of the increasing proportion of aged population in our country and a draft National Policy for the Aged has also been developed more recently which covers major thrust areas like economic support, shelter and productive role of the aged in developmental activities in addition to health.\footnote{Ibid.} The Government of India announced a National Policy on Older Persons in January, 1999. This policy provides a broad framework for inter sectoral collaboration and cooperation both within the government as well as between government and non-governmental agencies. In particular, the policy has identified a number of areas of intervention; financial security, health care and nutrition, shelter, education, welfare, protection of life and property etc. for the wellbeing of older persons in the country. Amongst others the policy also recognizes the role of the NGO sector in providing user friendly affordable services to complement the endeavours of the State in this direction. While recognizing the need for promoting productive ageing, the policy also emphasizes the importance of family in providing vital non formal social security
for older persons. To facilitate implementation of the policy, the participation of Panchayati Raj Institutions, State Governments and different Departments of the Government of India is envisaged with coordinating responsibility resting with the Ministry of Social Justice & Empowerment.\textsuperscript{199}

5. National Mental Health Programme

A National Mental Health Programme was launched in 1982, keeping in view the heavy burden of mental illness in the country and the inadequacy of the health system to meet the specific mental health needs. This programme aimed to shift the basis of practice from the traditional (psychiatric) services to community care. However, in reality, the National mental health program is only a footnote to the national health policy, and does not offer any (fiscal or technical) support for building community initiatives. In practice, the treatment of mental health problems is still heavily relying on the bio-medical model and is limited to the dispensing of drugs. Mental health care services are limited to those diagnosed with severe illness, where the patient is treated as a ‘societal burden’. The pattern of institutional care, especially for women, reeks of neglect and paternalism and requires gender sensitive cross-referral systems.\textsuperscript{200}

The Government of India also launched the District Mental Health Programme in 1996-1997 under the recommendation of the Central Council of Health and Family Welfare. The programme, initially launched in 4 states, was extended to 22 districts in 20 states by the year 2000 with a grant assistance of Rs. 22.5 lakhs each\textsuperscript{28}. The goal was to develop a community-based approach that has been neglected despite the programme commitment towards it. The other objectives were to impart public education in mental health to increase awareness and reduce stigma, early detection and treatment through both OPD and indoor services, and providing data from the


community to the state and central levels for future planning of mental health programmes.\textsuperscript{201}

The main objectives of National Mental Health Programme are prevention and treatment of mental and neurological disorders and their associated disabilities;\textsuperscript{202} use of mental health technology to improve general health services\textsuperscript{203}; and application of mental health principles in total national development to improve quality of life.\textsuperscript{204} It seeks to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population.\textsuperscript{205} The policy also encourages application of mental health knowledge in general health care and in social development.\textsuperscript{206} The promotion of community participation in the mental health services development and to stimulate efforts towards self-help in the community has been also emphasized.\textsuperscript{207}

6. **National Rural Health Mission**

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health

\begin{footnotesize}
\textsuperscript{201} N.B. Sarojini and others, note 73.
\textsuperscript{203} Ibid.
\textsuperscript{204} Ibid.
\textsuperscript{205} Ibid.
\textsuperscript{206} Ibid.
\textsuperscript{207} Ibid.
\end{footnotesize}
centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.\textsuperscript{208}

The Goal of the Mission is to improve the availability of and access to quality
health care by people, especially for those residing in rural areas, the poor, women
and children.\textsuperscript{209} It aims to restructure the delivery mechanism for health towards
providing universal access to equitable, affordable and quality health care that is
accountable and responsive to the People’s needs, reducing child and maternal deaths
as well as stabilizing population, and ensuring gender and demographic balance. The
Mission is an articulation of the government’s commitment to raise public spending
on health from 0.9\% of India’s gross domestic product (GDP) to 2-3\% of GDP and
aims to undertake architectural correction of the health system. The Mission will
enable the system to effectively handle increased allocation and promote policies that
strengthen public health management and service delivery in the country. Wide
ranging stakeholder consultations were held over a six-month period with state
governments, the Planning Commission, the National Advisory Council, other
government ministries/departments, health professionals and nongovernmental
organizations (NGOs) to draw up the Mission strategy.\textsuperscript{210}

7. National Nutrition Policy

India’s concern for nutrition has been as old as her civilization. Its holy books
and other ancient scriptures contain guiding principles for nutrition and health. In the
post independent India there has been an unequivocal commitment to the cause of
nutrition through Constitutional provisions. The Constitution of India states explicitly
in Article 47 that the "State shall regard the raising of the level of the nutrition and the
standard of living of its people and the improvement of public health among its

\textsuperscript{208} Govt. of India, \textit{National Rural Health Mission- 2005-2012}, available at <
\textsuperscript{209} Ibid.
\textsuperscript{210} S. K. Satpathy and S. Venkatesh, “Human Resources for Health in India’s National Rural Health
Mission: Dimension and Challenges”, \textit{Regional Health Forum}, Vol. 10, No. 1, p. 30 available at
Widespread poverty resulting in chronic and persistent hunger is the single biggest scourge of the developing world today. The physical expression of this continuously re-enacted tragedy is the condition of under-nutrition which manifests itself among large sections of the poor, particularly amongst the women and children. Under nutrition is a condition resulting from inadequate intake of food or more essential nutrient(s) resulting in deterioration of physical growth and health. 

(F) HEALTH COMMUNICATION POLICIES

While the words "information", "education", and "communication" have individual meanings, when grouped together as "IEC", they are familiar to many within the field of health communication. However, the definition and scope of IEC can vary. The National Health policy 1983 emphasised IEC as the core communication strategy. The Ministry of Health & Family Welfare realized that IEC needs to be used for improvement of Health care facilities and as well as creating a positive notion about the health care providers. The necessity to create a sustainable demand for health care was recognised as the elementary responsibility of IEC. In brief, IEC was given a special focus in the document.

The seventh five year plan gave priority to the health communication as an important component of health services. The plan formulated schemes to strengthen health education bureaus, training of medical and paramedical personnel in health education etc., and proposed to implement them with added emphasis. The efforts in the Seventh Plan basically directed to develop and strengthen health education as an essential component of health services in the country. This was supported by adequate budgetary provision. Measures were initiated to actively involve social and preventive medicine as well as community medicine departments of the medical colleges, to strengthen health education training programmes for medical teachers, para-medical personnel etc.

211 “Achievements in the field of nutrition during the last fifty years”, available at <http://www.wcd.nic.in> last visited on 4th May 2010.

National health policy-2002 further envisaged an IEC policy, which maximizes the dissemination of information to those population groups which cannot be effectively approached by using only the mass media. The focus would therefore be on the inter-personal communication of information and on folk and other traditional media to bring about behavioural change. The IEC programme would set specific targets for the association of NGOs/Trusts in such activities. In several public health programmes, where behavioural change is an essential component, the success of the initiatives is crucially dependent on dispelling myths and misconceptions pertaining to religious and ethical issues. The community leaders, particularly religious leaders, are effective in imparting knowledge which facilitates such behavioural change. The programme will also have the component of an annual evaluation of the performance of the non-Governmental agencies to monitor the impact of the programmes on the targeted groups. The Central/State Government initiative will also focus on the development of modules for information dissemination in such population groups, who do not normally benefit from the more common media forms. 213 It is clear from the above statement that in spite of realising the necessity of IEC for information dissemination it was also accepted that too much of dependence on Mass communication eliminates a sizable number of target audience.

National health policy-2002 also envisages giving priority to school health programmes which aim at preventive-health education, providing regular health check-ups, and promotion of health-seeking behaviour among children. The school health programmes can gainfully adopt specially designed modules in order to disseminate information relating to ‘health’ and ‘family life’. This is expected to be the most cost-effective intervention as it improves the level of awareness, not only of the extended family, but the future generation as well. 214

The National Population Policy 2000 reiterated the importance of the role of IEC. It stated that Information, education and communication (IEC) of family welfare messages must be clear, focused and disseminated everywhere, including the remote corners of the country, and in local dialects. This will ensure that the messages are

213 Govt of India, National Health Policy- 2002, p.12
214 Ibid.
effectively conveyed. These needs to be strengthened and their outreach widened, with locally relevant and locally comprehensible media and messages. On the model of the total literacy campaigns which have successfully mobilised local populations, there is need to undertake a massive national campaign on population related issues, via artists, popular film stars, doctors, vaidyas, hakims, nurses, local midwives, women's organizations, and youth organizations.\textsuperscript{215} It emphasized on involving civil society for disseminating information, counselling and spreading education about the small family norm, the need for fewer but healthier babies, higher female literacy and later marriages for women. Civil society could also be of assistance in monitoring the availability of contraceptives, vaccines and drugs in rural areas and in urban slums. It laid down great emphasis on sensitising the field level functionaries across diverse sectors (education, rural development, forest and environment, women and child development, drinking water mission, cooperatives) to strategies, goals and objectives of the population stabilisation programmes.

As far as health is concerned, there has been a wide production and dissemination of information in India, related to various schemes. But most of them suffer from extreme transmission loss. A huge communication industry strives on health communication. The health communication policy of the government also suffers from the malaise of routine exercise. As a huge amount of fund has been earmarked for the communication exercise, it has been more deprived of the originality that is required to communicate to the uneducated and the marginalised. However, how much of the benefits actually percolate to the target is a matter of enquiry.

\textbf{(G) TRIPS, INDIAN PATENT ACT AND RIGHT TO HEALTH}

Price regulation in the pharmaceutical sector is an important instrument of public policy for promoting equity in access to health care. At present about 65 per cent of the Indian population lack access to essential life saving medicines despite India being recognized as a global drug manufacturer.\textsuperscript{216} The Pharmaceutical Policy

\textsuperscript{216} N.B. Sarojini and others, note 73, p. 17.
(PP) 2002 of the Government of India (GOI) emphasized upon diluting drug price control by suggesting criteria for price control that will reduce the basket of price control to a bunch of irrelevant 30 or so drugs. The kinds of drugs that would be left under price control are mostly irrelevant to public health. Even the Drug Price Control Order of 1995 conspicuously omitted drugs for anemia, diarrhea, the majority of drugs for tuberculosis, hypertension and diabetes, and all drugs for cancer.

The Trade Related Intellectual Property Rights (TRIPs) agreement has influenced the drug pricing and policy in a negative way for India.\textsuperscript{217} The issue of drugs has shifted from the realm of health to the realm of trade – a situation made worse by the rise of multinational pharmaceuticals that are trying to control and own knowledge in the name of intellectual property rights. In reality, the provisions under the TRIPS agreement undermine some of the very processes that helped India become one of the leading countries in drug manufacturing with some of the lowest prices in the world. The effect is exemplified in the attempts of the government to reformulate the pharmaceutical policy and amendment of the Indian Drug and Cosmetics Act (1948) to reduce the number of drugs under price control, and make space for clinical trials respectively in the name of liberalization. For India it would mean wiping out of the Indian public sector, small scale sector and overpricing of a large number of essential and life saving drugs and the already vulnerable population be exposed to the unethical experimentation by the drug companies. In short, we have reached a state of ‘poor health at high costs’.\textsuperscript{218}

The World Health Organization (WHO) reported that one third of the world’s population lacks reliable access to required medicines and the situation is even worse in developing countries, which are finding it increasingly difficult to finance medicines as expenditure on medicines has been growing steadily.\textsuperscript{219} In India, over 80 per cent of health financing is borne by patients. Thus, the price of medicines is a crucial determinant of the health of citizens. Inadequate distribution systems also

\textsuperscript{217} Ibid.
\textsuperscript{218} N.B. Sarojini and others, note 73, p.17.
affect the availability of medicines. The pharmaceutical industry obtains higher profit with greater margins than other industries, and it has been argued that these margins are far beyond the sums required to finance research and development.\textsuperscript{220} The Doha declaration affirms that the TRIPS Agreement does not and should not prevent members from taking measures to protect health.

Health policies encompass a number of elements, from prevention to cure and access to drugs. While all elements are important, the question of access to drugs stands out in the context of the TRIPs Agreement.\textsuperscript{221} While access can be affected at the practical level by the introduction of patents on medicines, there are more general issues concerning the compatibility between human rights and intellectual property. Intellectual property law has traditionally dealt mainly with technical issues related to scientific and technological development. Treaties such as TRIPs thus hardly envisage patents in relation to other fields of law. There is, for instance, no attempt in TRIPs to delineate the relationship between patents and the human rights to health. Patent treaties only recognize that there should be a balance between the rights that are conferred to an inventor and the broader interests of the society in having access to the results of scientific advances.\textsuperscript{222}

Equally, human rights treaties have not devoted significant attention to the impacts of intellectual property on the realization of specific rights such as the right to health. However, the relationship has been considered in general terms.\textsuperscript{223} Access to drugs generally requires their availability and affordability. There is thus a strong link between economic poverty and access to drugs. A group of international organisations recently estimated that less than 10 per cent of people living with HIV/AIDS in developing countries have access to antiretroviral therapy. The HIV-AIDS epidemic across the globe, and particularly in African countries, has devastated entire countries. The epidemic has served to focus on the inhuman conduct of global pharmaceutical MNCs who continue to sell drugs to treat HIV-AIDS at 20-50 times their actual cost by seeking shelter under laws mandated by the TRIPS agreement. In fact it was left to

\textsuperscript{220} Ibid.
\textsuperscript{221} Philippe Cullet, “Patents Bill, Trips and Right to Health”, Economic and Political Weekly, vol. XXXVI/43, 27\textsuperscript{th} October 2001, p.4049.
\textsuperscript{222} Ibid.
\textsuperscript{223} See Article 15, International Covenant on Economic, Social and Cultural Rights.
Indian companies like Cipla to offer these drugs at vastly reduced prices and thereby provide some succour to those affected by HIV-AIDS. The conduct of these MNCs has also led to an upsurge of public opinion the world over, including in the US and EU, questioning its rationale, particularly in the area of public health. Organisations such as the Medecens Sans Frontieres (Doctors without Borders) have provided a powerful voice to this upsurge and soon became a global force contending the rationale of the new IPR regime. These developments ultimately resulted in the Doha Declaration on TRIPS Agreement and Public Health (November 2001) seeking to limit, to some extent, the damage done by the TRIPS agreement and its underlying philosophy.224

India follows the incorporation theory. This means that a treaty does not become law until enacted by the Parliament. Following the WTO ministerial conference, the joint parliamentary committee on the Patents (Second Amendment) Bill, 1999 finalized its report in December and submitted an amended version of the amendments to parliament. The recently passed legislation must therefore be analyzed in the context of the declaration on the TRIPS Agreement and public health (Doha Declaration) and other relevant factors. By giving greater credence to WTO deadlines than democracy, India is prepared to jeopardize its sovereignty. The WTO is not the only treaty that India has to comply with. The Supreme Court decisions culminating in and following225 have directly imported many human rights into the life and liberty provisions of Article 21, including the right to health. The WTO cannot over-ride these obligations. India this way is also putting its sovereignty, status, prestige and obligations at risk. Medicine without social justice is unacceptable. Patents are not a gift for drug companies to exercise power without responsibility. Given the importance of the issues at stake, the debate concerning the impact of medical patents on access to drugs is unlikely to subside in the near future even though the Patents (Amendment) Act, 2002 has just been adopted. This still leaves several years for


225 Vishakha and others V. State of Rajasthan and others, AIR 1997 SC 3011.
further open debate concerning the final response to be given to TRIPS in the Health sector.\(^{226}\)

**II) ROLE OF EQUITY IN HEALTH CARE**

Equity deserves a prominent position in health care policy making on both the national and international level. Equity has been a stated or implied goal of health policy in many countries and international health organizations for decades. At Alma-Ata in 1978, a global health strategy was launched by the World Health Organization’s (WHO’s) World Health Assembly with the goal of Health for All by the Year 2000. Health equity is an implicit priority in Health for all, and was particularly prominent in WHO’s Health For All strategy for Europe. The European Health For All strategy for the twenty-first century identified promotion of equity and improvement of health as guiding principles. WHO in Geneva launched a global initiative on Equity in Health and Health Care from 1995–1998. Equity concerns were also prominent in parts of the 2000 Millennium Declaration, which gave rise to the Millennium Development Goals. Although impressive overall gains were achieved in life expectancy and child survival during the second half of the twentieth century, inequities in health status and in health systems between more and less privileged groups within and between countries have persisted, and in many regions and Countries are widening.\(^{227}\)

Health equity has also emerged as an important theme in research and advocacy. Pursuing equity in health “reflects a concern to reduce unequal opportunities to be healthy associated with membership in less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women; and rural residents. In operational terms, pursuing equity in health means eliminating health disparities that are systematically associated with underlying social disadvantage or marginalization”\(^{228}\). The unequal distribution of the social and

\(^{226}\) Ibid.


\(^{228}\) Ibid.
economic determinants of health, such as income, employment, education, housing and healthy environments remains the primary policy problem for reducing health inequities. Striving for equity in health care is one aspect of the wider concept of equity in health status, and implies that health care resources are allocated and received according to need, and financing is according to ability to pay.

Adequate progress in narrowing gaps, particularly where resources are limited, requires frameworks that will ensure attention to the needs of those with the greatest health needs and the least resources. Over the last few decades WHO has considered health and health services in their social, cultural and economic context. WHO defines health systems as “all the activities whose primary purpose is to promote, restore or maintain health”. Health systems are not only producers of health and health care, but also “purveyors of a wider set of societal norms and values”. Health systems in many countries, however, have been unable to introduce or sustain improvements in health equity. One obvious reason — as a recent synthesis of research on vulnerability to human immunodeficiency virus (HIV), tuberculosis and malaria infection has noted — is that health systems, and the people who use them, exist within social contexts that exert a powerful influence on people’s chances to be healthy. Social values and political processes determine the allocation of resources (wealth, power and opportunities to acquire them) for health. 229 This makes it unlikely that equity will be achieved without confronting the entrenched interests and political and economic processes that give rise to inequalities in the distribution of health determinants. One measure of equity, therefore, is the extent to which public policy and authority are structured to serve public interests and justice, as reflected in part by the degree to which non-élite groups can influence the allocation of resources for health. Research and interventions that focus only on the technical, clinical or financial dimensions of health interventions and systems generally lose sight of these structural (political and economic) and social dimensions 230.

Evidence suggests that the impressive health gains achieved over recent decades are unequally distributed and have largely failed to reach the poor and other

229 Ibid.
230 Ibid., p. 949.
marginalized or socially excluded groups. Persistent and growing inequalities in health are increasingly evident, both between and within countries. For example, the poorest 20% of the global population are roughly 10 times more likely to die before the age of 14 than the richest 20%. Poverty has multiple dimensions. These dimensions include not only low income, but also lack of access to services, resources and skills; vulnerability; insecurity; and voicelessness and powerlessness. Poverty and other forms of social exclusion—such as gender, race, ethnicity, and age, place of residence, employment status, and sexual orientation—are strong determinants of health.\textsuperscript{231}

Evidence points to a two-way relationship between poverty or inequity and health. In the “vicious cycle”, poverty breeds ill-health, while ill-health causes more poverty. In the “virtuous cycle”, higher income is linked to good health, and good health is linked to higher income and welfare. These positive and negative links operate both at the individual and the societal level. Although the poor (and other socially excluded groups) need health services more, they tend to use health services less. This phenomenon is known as the “inverse care law”, which states that “the availability of good medical care tends to vary inversely with the need for it in the population served.”\textsuperscript{232} The poor and other excluded groups use health services less because they typically face multiple barriers to access to services, including geographical barriers; financial barriers; socio-cultural attitudes, such as those related to gender or ethnicity; lack of knowledge and awareness; and the poor quality or lack of responsiveness of the health system.

Reducing health inequities requires a range of strategies, tailored to the needs of the specific situation, including: prioritizing underserved areas or populations and the health conditions that affect them the most, using targeted approaches where needed; investing in primary health care; redistributing health services and personnel equitably; reducing the out-of-pocket costs of seeking health care for the poor; improving information and communication to stimulate demand; improving health systems responsiveness; in monitoring and evaluation, collecting, analyzing and using

\textsuperscript{231} “Equity and Health”, available at <http://www.wpro.who.int/health_topics/equity> last visited on 20\textsuperscript{th} December 2009.
\textsuperscript{232} Ibid.
information that is disaggregated by socio-economic position, sex, age, ethnicity/race, geographical location or other relevant indicators of social exclusion; and undertaking health equity-focused research and analysis to identify context-specific issues and their solutions.233

Though equity in health and health care has been a long-term guiding principle of health policy in India, with a commitment to provide for the needs of individuals who are poor and underprivileged inequalities still exists in health care in India.234 Despite improvements in access to health care, inequalities are related to socioeconomic status, geography, and gender. In India, individuals with the greatest need for health care have the greatest difficulty in accessing health services and are least likely to have their health needs met. One of the examples of such inequalities can be found in the immunization coverage. In 2005–06, immunisation coverage among scheduled tribes and scheduled castes was 31·3% and 39·7%, respectively, compared with 53·8% among other castes, and absolute inequalities between these castes increased with time. Further coverage remains higher in urban areas (58%) than in rural areas (39%), although absolute and relative urban-rural differences have decreased with time. The absolute gender gap has increased from 2·6% in 1992–93 to 3·8% in 2005–06. Similar patterns in inequalities have been noted for antenatal care coverage. Rates of admission to hospital also vary by gender, wealth, and urban or rural residence.235

Further evidence of such inequalities is reflected in the World Health Survey India (2003)236 report reveals that the availability of health professionals per 100,000 population is greater among urban population compared to rural, among higher income quintile compared to lower income quintile. Physicians are three times higher in urban areas compared to rural areas. The primary work location of the health professionals indicates that almost four-fifth of the physicians (79 percent) are

233 Ibid.
working in private health facilities, whose services are available only to those who can afford their fees. Similar inequities can be also seen in budgetary allocation for public health in urban and rural areas.

(I) FINANCING HEALTHCARE

Financing is the most critical of all determinants of a health system. The nature of financing defines the structure, the behaviour of different stakeholders and quality of outcomes. It is closely and indivisibly linked to the provision of services and helps define the boundaries of the system’s capability to achieve its stated goals. Health financing is by a number of sources: (i) the tax-based public sector that comprises local, State and Central Governments, in addition to numerous autonomous public sector bodies; (ii) the private sector including the not-for-profit sector, organizing and financing, directly or through insurance, the health care of their employees and target populations; (iii) households through out-of-pocket expenditures, including user fees paid in public facilities; (iv) other insurance-social and community-based; and (v) external financing (through grants and loans).237

The right to health recognizes personal responsibility; all members of society have responsibilities regarding the realization of the right to health. But the state has the ultimate duty to provide the environment in which you can undertake your responsibility. Even after six decades of Independence the Indian State has failed to provide its citizens the basic requirements like food security, health care, housing and education, which are the basis for reasonable human existence. Due to rampant poverty and lack of social equity large sections of population have been denied adequate nutrition, clean drinking water and sanitation, basic education, good quality housing and a healthy environment, which are all prerequisites for health. A highly inequitable health system has denied quality health care to all those who cannot afford it.238 Escalating health care costs constitute an important cause for indebtedness

among the poor and middle-income groups, and lead to the impoverishment of 2.2% of the population annually.

The way a health system is financed is a key determinant of population health and well-being. In many countries, including India, the level of spending is still insufficient to ensure equitable access to basic and essential health services and interventions. Hence, one of the key policy issues is how to ensure adequate and equitable resource mobilization for health. India is one of the 192 Member States that adopted the resolution on ‘Sustainable health financing, universal coverage and social health insurance’ at the World Health Assembly in May 2005.

Despite poor health indicators, government spending on health care is well below what is needed. Low revenue collections, competing demands for revenues, and relatively low spending priority are often cited as contributing to this insufficient spending. In 2009, it was estimated that India’s total expenditure on health was 4.13% of GDP (out of which 1.10% was public), while at the same time out-of-pocket expenditure on health reached as much as 80% of personal expenses, mostly for outpatient treatment (74%) and drugs (72%). The estimated health expenditure in India for the year 2001-02 was approximately Rs 108,732 crore, accounting for 4.8% of the GDP at current market price. Out of this, Central, State and local Governments together spend one-fourth of the total health expenditure. The share of other central ministries is estimated to be about 2.42% of total health spending in the country. An estimated 2.2% of total health spending comes from the local government. Local governments’ resources for health are through transfers from State Governments and their own resources. The estimate involves only spending by municipalities and not Panchayati Raj institutions as the share of Panchayati Raj institutions are a miniscule part of the health budget, since a substantial part of the panchayat’s are mostly composed of either Central or State transfers. Over 80 per cent of the health expenditure in India is in the private sector, while in most developed societies more than 80 per cent of health expenditure is borne by the exchequer.

Health insurance is one of the various financing options being considered in India to decrease indebtedness.\textsuperscript{240} At present, health insurance coverage in India is extremely limited, especially outside the formal sector. In India, the share of healthcare expenditure borne by insurance companies is now less than 3 per cent. But there is a build-up for a significant expansion of the health insurance business. WHO in partnership with MOFHW, GOI and others has been supporting capacity building initiatives and facilitating exchange of experiences. This has resulted in the development of an operational guide for the planning and implementing health insurance in the country, development of training manual on health insurance coupled with organization of capacity building programmes for managers and planners.

People living below poverty line require financial protection for the treatment of serious ailments such as cancer, kidney failure, heart, trauma and burns etc. In order to improve access of such people to quality medical care, Government initiated a pilot project in May 2004 to partly pay for hospitalization and treatment from Chief Minister’s Relief Fund (CMRF). During the period from 14.05.2004 to 17.07.2008, Rs. 425 crores was provided from the Fund in 1.25 lakhs such cases. This, however, did not help 30 percent of rural poor, being unable to meet balance expenses. From the experience gained, it was felt that this assistance could be institutionalized through a Health Insurance Scheme for easy access by poor across the State. Government accordingly set up Aarogyaasri Health Care Trust and implemented a Community Health Insurance Scheme to begin within three districts from 1st April, 2007 and later extended it to all other districts in five phases. Diseases covered included heart, cancer, Neuro-surgery, Renal, Burns and Poly-trauma cases etc.\textsuperscript{241}

Even after 60 years of planned development, there is a serious mismatch in India between the declared objectives of universal healthcare through the public health system on the one hand, and the actual level of public health expenditure on the other. This mismatch between objectives and resources is at the heart of the inadequacies and inequities of the health system. Insufficient public expenditure


\textsuperscript{241} “Health India 2009 Award for Government Policy Initiative of the Year”, available at <http://www.eindia.net.in> last visited on 1st may 2010.
results in out-of-pocket or self-financing.\textsuperscript{242} This is both regressive and iniquitous as well as leads to pauperisation. Data from the 52nd Round National Sample Survey (NSS) of 1995-1996 (Table II) reveal that over 40 per cent households borrow or sell assets to finance hospitalization expenditures, and this had increased to 52 per cent in the 60th Round in 2004.\textsuperscript{243}

Thus, if India has to improve healthcare outcomes and equity in access then increasing public health expenditures will be critical. Apart from this, the healthcare system will need to be organized and regulated in the framework of universal access. The mismatch between the declared objective of universal healthcare through the public health system and the actual level of expenditure remains serious. In India, meanwhile, problems related to the financing of healthcare continue to be politically insignificant and publicly invisible.\textsuperscript{244} Enhanced public spending can be used to introduce universal medical insurance that can help to substantially reduce the burden of private out-of-pocket expenditures on health. Increased public spending can also contribute to quality assurance in the public and private sectors through effective regulation and oversight. In addition to an increase in public expenditures on health, the Government of India will, however, need to introduce specific methods to contain costs, improve the efficiency of spending, increase accountability, and monitor the effect of expenditures on health. The Government of India has made a commitment to increase public spending on health from less than 1\% to 3\% of the gross domestic product during the next few years. Increased public funding combined with flexibility of financial transfers from centre to state can greatly improve the performance of state-operated public systems.

\textbf{(J) ORGANIZATION OF THE HEALTHCARE SYSTEM}

According to India’s Constitution, services are divided into “lists” which specify who is responsible for them and empowered to pass legislation on them: the

\textsuperscript{242} Latest estimates based on National Accounts Statistics indicate that private expenditures on healthcare in India are about Rs.1650 billion and 99 per cent of this is out-of-pocket. See CSO 2006, New Delhi: National Accounts Statistics, CSO, Govt. of India; 2006, available at<mospi.nic.in/national_accounts_division_index.htm>.
\textsuperscript{243} NSSO – 2004, Report No. 507, 60th Round (New Delhi: NSSO, Govt. of India, 2006).
\textsuperscript{244} N. J. Kurian, “Financing Health Care in India”, \textit{The Hindu}, January 15, 2010.
Union list for the Central (federal) government, the State list, and the Concurrent List for tasks deemed the shared responsibility of the Central and State governments. Union laws override those made by the states for items in the concurrent list. The health-related provisions in the union list relate to port quarantine, research, and scientific and technical education. The concurrent list includes ‘prevention of the extension from one State to another of infectious or contagious diseases or pests’, and other issues with wider national ramifications such as food and drugs, family planning, medical education, and vital statistics.\(^{245}\)

Constitutionally, health care delivery in India is largely the responsibility of the provincial states. However, the center exercises a great deal of power through fiscal control. The relative financial strength of the central government—rooted in constitutional fiscal provisions—has given it significant leverage to determine the end use of its devolved funds to the states. Using its financial and political leverage, the central government can persuade the states to work towards specific health objectives and priorities, and provide the necessary technical support for this. The central government is in charge of defining policies and providing a national strategic framework, financial resources, and medical education. Although states account for 75 to 90 percent of public spending on health, most of these funds go to salaries and wages, making states dependent on the central government’s fund for nonwage items such as drugs and equipment.

The healthcare services’ organization in the country extends from the national level to village level. From the total organization structure, we can slice the structure of healthcare system at national, state, district, community, PHC and sub-centre levels. The organization at the national level consists of the Union Ministry of Health and Family Welfare. The Ministry has three departments, viz. – Health, Family Welfare, and Indian System of Medicine and Homeopathy, headed by two Secretaries, one for Health and Family Welfare and the other for ISMH. In addition, the MoHFW has 2 additional secretaries (both in DH), 8 joint secretaries and 30 officers of the rank

of Director excluding technical advisors.\textsuperscript{246} The department of Health is supported by a technical wing, the Directorate General of Health Services, headed by Director General of Health Services (DGHS).

The Department of Health broadly deals with public health, medical services, medical education, food and drug standards, professional councils, and international aid and health research. The Department of Family Welfare is primarily responsible for family planning and maternal and child health. Although not specified in the business rules, the Department of Health traditionally deals with health policy and that of Family Welfare deals with rural health infrastructure.\textsuperscript{247} The DISMH deals with all matters relating to alternative systems of medicine (i.e., Ayurveda, Siddha, Unani, Homeopathy, Naturopathy and Yoga). The MoHFW’s Department of Health is supported in its work by a vast network of autonomous research and training institutions which are spread all over the country but administratively under the central government.

By and large, the organizational Structure adopted by the State is in conformity with the pattern of the Central Government. The State Directorate of Health Services, as the technical wing, is an attached office of the State Department of Health and Family Welfare and is headed by a Director of Health Services. However, the organizational structure of the State Directorate of Health Services is not uniform throughout the country. For example, in some states, the Programme Officers below the rank of Director of Health Services are called Additional Director of Health Services; while in other states they are called Joint/Deputy Director, Health Services. But regardless of the job title, each programme officer below the Director of Health Services deals with one or more subject(s). Every State Directorate has supportive categories comprising of both technical and administrative staff. In the state of Bihar, Madhya Pradesh, Uttar Pradesh, Andhra Pradesh, Karnataka and others, zonal or regional or divisional set-ups have been created between the State Directorate of


Health Services and District Health Administration. Each regional/zonal set-up covers three to five districts and acts under authority delegated by the State Directorate of Health Services. The status of officers/in-charge of such regional/zonal organizations differs, but they are known as Additional/Joint/Deputy Directors of Health Services in different States.248

In the recent past, states have reorganized their health services structures in order to bring all healthcare programmes in a district under unified control. The district level structure of health services is a middle level management organization and it is a link between the State as well as regional structure on one side and the peripheral level structures such as PHC as well as sub-centre on the other side. It receives information from the State level and transmits the same to the periphery by suitable modifications to meet the local needs. In doing so, it adopts the functions of a manager and brings out various issues of general, organizational and administrative types in relation to the management of health services. The district officer with the overall control is designated as the Chief Medical and Health Officer (CM & HO) or as the District Medical and Health Officer (DM & HO). These officers are popularly known as DMOs or CMOs, and are overall in-charge of the health and family welfare programmes in the district. They are responsible for implementing the programmes according to policies laid down and finalized at higher levels, i.e. State and Centre. These DMOs/CMOs are assisted by Dy. CMOs and programme officers. The number of such officers, their specialization, and status in the cadre of State Civil Medical Services differ from the State to State. Due to this, the span of control and hierarchy of reporting of these programme officers vary from state to state.

At the Taluka level, healthcare services are rendered through the office of Assistant District Health and Family Welfare Officer (ADHO). Some specialties are made available at the taluka hospital. The ADHO is assisted by Medical Officers of Health, Lady Medical Officers and Medical Officers of general hospital. These hospitals are being gradually converted into Community Health Centers (CHCs). For a successful primary healthcare programme, effective referral support is to be

provided. For this purpose one Community Health Centre (CHC) has been established for every 80,000 to 1,20,000 population, and this centre provides the basic specialty services in general medicine, pediatrics, surgery, obstetrics and gynecology. The CHCs are established by upgrading the sub-district/taluka hospitals or some of the block level Primary Health Centers (PHCs) or by creating a new centre wherever absolutely needed.

At present there is one Primary Health Centre covering about 30,000 (20,000 in hilly, desert and difficult terrains) or more population. Many rural dispensaries have been upgraded to create these PHCs. Each PHC has one medical officer, two health assistants – one male and one female, and the health workers and supporting staff. For strengthening preventive and promotive aspects of healthcare, a post of Community Health Officer (CHO) was proposed to be provided at each new PHC, but most states did not take it up. The most peripheral health institutional facility is the sub-centre manned by one male and one female multi-purpose health worker. At present, in most places there is one sub-centre for about 5,000 populations (3,000 in hilly and desert areas and in difficult terrain).  

(K) CONCLUSION

Healthcare in India is the responsibility of constituent Indian states. The Constitution charges every state with "rising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002. Although India has eradicated mass famines, half of children in India are underweight, one of the highest rates in the world and nearly double the rate of Sub-Saharan Africa. Water supply and sanitation in India continue to be abysmal; only one of three Indians has access to improved sanitation facilities such as toilet. India's HIV/AIDS epidemic is a growing threat. Cholera epidemics are not unknown. The maternal mortality in India is the second highest in the world. 

249 Ibid.  
250 National Health Policy, 2002, note 63.  
Providing healthcare and disease prevention to India’s growing population of more than a billion people becomes challenging in the face of depleting resources. 2.47 million People in India are estimated to be HIV positive. India is one of the four countries worldwide where polio has not as yet been successfully eradicated and one third of the world’s tuberculosis cases are in India. According to the World Health Organization 900,000 Indians die each year from drinking contaminated water and breathing in polluted air. As India grapples with these basic issues, new challenges are emerging for example there is a rise in chronic adult diseases such as cardiovascular illnesses and diabetes as a consequence of changing lifestyles. There are vast disparities in people’s health even among the different states across the country largely attributed to the resource allocation by the state governments where some states have been more successful than others. Better efforts are needed by the local governments to ensure that the health services provided are actually reaching the poor in worst-affected areas.

In an era where health risks assume a transnational character, it is important for all countries to ensure effective engagement at an international level. Over the last decade, we have all heard of the threats posed by infectious diseases such as the Mad Cow disease, SARS and Avian-Flu. The growth of HIV/AIDS continues unabated despite increasing investment in AIDS control measures such as awareness campaigns, the provision of contraceptives and increased supply of Anti-retroviral drugs. In such a scenario, the importance of the international human rights discourse cannot be understated. Governmental and private measures at the domestic level need further support from international collaborations such as the transfer of medical technology, personnel and medicines. The ‘right to health’ cannot be conceived of as a traditional right enforceable against the state. Instead, it has to be formulated and acknowledged as a positive right at a global level – one which all of us have an interest in protecting and advancing. Establishing people’s Right to health care.

252 Ibid
253 Ibid
254 Ibid
255 Ibid
256 National seminar on the ‘Human right to health, Organized by the Madhya Pradesh State Human Rights Commission (At Bhopal) - September 14, 2008, Address by Justice K.G. Balakrishnan,
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.257

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. 258