CHAPTER 1
RIGHT TO HEALTHCARE

1.1. INTRODUCTION

In 1983, the Indian government launched the National Health Policy which aspired to provide comprehensive public healthcare to poor people with the promise of 'Health for All by the year 2000'.[1] Although substantial improvement of health of India's population has occurred as shown by the doubling of life expectancy during this period, the health outcomes remain inadequate when India is compared with other countries. Health care is far from equitable, accountable, or affordable; government health expenditure is very low and has risen only slightly; and most spending on health care is paid out of pocket and is rising in cost.[2] According to the twelfth Planning Commission report, 39 million Indians are pushed into poverty because of health- related expenses every year.[3]

'Health for All' does not only mean an end to disease and disability, or that doctors and nurses will care for every patient. It means that resources for health are evenly distributed and essential medicines are accessible and available to everyone. Hence, it is essential to understand the concept of health, its philosophical nature, how far health is an enforceable human right, confusions regarding many of the public policy issues and also the ethical concerns that loom over the decisions made by medical practitioners while protecting the rights of patients. As Robert Mordacci, rightly emphasizes this point when he argues that 'the very end of

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1 In 1979, the Thirty-second World Health Assembly launched the Global Strategy for health for all by the year 2000. The Health Assembly invited the Member States of WHO to act individually in formulating national policies, strategies and plans of actions for attaining this goal. See generally, Global Strategy for Health for All by the Year 2000, World Health Organization, Geneva (1981), viewed 10th June 2013, http://whqlibdoc.who.int/publications/9241800038.pdf.

2 K Srinath Reddy, Vikram Patel, Prabhat Jha, Vinod K Paul, A K Shiva Kumar, Lalit Dandona, "Towards achievement of universal health care in India by 2020: a call to action", 377 *Lancet* 760 (2011).

3 Kiran Mazumdar Shaw, "Health Care for All and India Can Do it", *Indiatoday.in*, Oct 12, 2012, viewed 10th June 2013, http://indiatoday.in/story/kiran-mazumdar-shaw-india-healthcare-gdp-on-health/1/224541.html.

medicine depends in great part on our understanding of the nature of health and illness both as objects of medical intervention and as experiences of the person'.[4]

1.2. CONCEPT OF HEALTH

Etymologically, the word 'health' comes from old English word *hal*.[5] The English word literally means 'wholeness, being whole, complete, sound or well'.[6] Taken in its fullness of meaning, therefore, 'health' has come to mean 'completeness and perfection of organization, fitness of life, freedom of action, harmony of functions, vigor and freedom from all strain and unholy corruption'.[7] The ancient Greek word for health is *euexia*, which means to be in a vital and resilient state.[8] The Greek word emphasizes good functioning and the activity of the whole. The Greek and English words for health are unrelated to illness and disease. The medical definition of health states it as 'the normal physical state, i.e., the state of being whole and free from physical and mental disease or pain, so that the parts of the body carry on their proper function'.[9]

The concept 'health' is a highly subjective matter as health and being healthy means different things to different people. For some citizens the main focus is only an absence of disease and they ignore the social determinants of health which may have contributed to illness.[10] For others it is identified with peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity.[11] Therefore, one encounters anthropological, sociological, psychological, and biological theories, as well as combinations of these.[12] Many of the introductory health texts reveals that physical health, mental health, social health, environmental health, spiritual health, and emotional health are some of the commonly discussed dimensions

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4 Robert Mordacci, "Health as an Analogical Concept", 20 *The Journal of Medicine and Philosophy* 477 (1995).

5 Christian Nordqvist, "What Is Health? What Does Good Health Mean"?, *Medical News Today*, viewed 5th January 2013, http://www.medicalnewstoday.com/articles/150999.php.

6 Id.

7 Machteld Huber, *Is health a state or an ability? Towards a dynamic concept of health*, published by The Netherlands Organisation for Health Research and Development and the Health Council of the Netherlands, viewed 5th January 2013, http://www.gezondheidsraad.nl/sites/ default/ files/bijlage%20A1004_1.

8 Id.

9 Critchley,M (ed.), *Butterworths Medical Dictionary*, Butterworths, London (1978), p.784.

10 See, Eibe Riedel, 'The Human Right to Health: Conceptual Foundations', in Andrew Clapham, Mary Robinson, *Realizing the Right to Health*, Ruffer and Rub (2009), p.21.

11 Jonathan Mann, Laurence Gostin, Sofia Gruskin, Zita Lazzarini, Harvey Fineberg, 'Health and Human Rights' in Mann *et al.*, *Health and Human Rights*, Routledge Publishing, London (1999), p. 9.

12 Lennart Nordenfelt, "Introduction," in Lennart Nordenfelt, B. Ingemar B. Lindahl (eds), *Health, Disease, and Causal Explanations in Medicine,* Dordrecht (1984), p. xii.

of health.[13] These, described as the foundation of a good health, are collectively known as wellness.[14]

The above discussion proves that there is no general agreement on what is meant by health and the term health can be interpreted in many ways, and can mean more than just physical health, such as in reference to holistic concepts of the mind and spirit. In the past, health was considered to be the exact opposite of illness. The absence of illness or disease, particularly physical disease, was a sign of good health.[15] Today, health is explained not only in physical terms, but also in social, mental or emotional and, in some cases, spiritual terms.[16] Moreover, one must understand that the concept of health is a developing one. It had kept on changing and had gradually broadened through the passage of history, continuing with the Greeks, Romans, the medieval period, the Renaissance, and the industrialization era until the present day.[17] Sigerist[18] in his highly persuasive definition of health provides that:

> Like the Romans and like John Locke, we think of health as a physical and mental condition…*Mens sana in corpore sano*… But we may go one step further and consider health in a social sense also. A healthy individual is a man who is well balanced bodily and mentally, and well adjusted to his physical and social environment… Health is [not just] the absence of disease: it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts upon the individual.

Health can also be understood in a far more complex and positive sense. The World Health Organization's famously hyperbolic declaration carries the ambivalence deep within its core in when the organization offered the following statement about health: 'Health is a state of complete physical, mental, and social well-being and not

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[13] See generally, Deepak Chopra, *Creating Health: Beyond Prevention, Toward Perfection*, Houghton Mifflin, Boston (1987).

[14] Dinesh P. Sinha, Health care in India and USA, 93 *Current Science* 1349 (2007), p.1350.

[15] D. Porter, "Public health", in W. F. Bynum and R. Porter (eds.), *Companion encyclopedia of the history of medicine*, Vol. 2, Routledge Publishing, London and New York (1993), p.1232.

[16] Id.

[17] Lennart Nordenfelt, "Understanding The Concept Of Health", in T. Ronnoow-Ramussen, B.Peterson, J.Josefsson & D.Egonsson, *Philosophical Papers Dedicated to Wlodek Rabinowicz*, (2007), p.2, viewed 6th Feb 2013,www. Fil.lu.se/hommageawlodek.

[18] Sigerist, Henry Ernest, *Medicine and Human Welfare*, McGrath Publishing Company, Maryland (1970), p.100.

merely the absence of disease and infirmity'.[19] This definition is considered to be too broad and critics have time and again questioned the meaning of various terminologies used by WHO.[20] It is to be specifically mentioned here that the idea that the health should be more than the absence of disease, as a positive concept, has grown increasingly popular in recent years. One source of such interest is the trend towards preventive and community oriented medicine, which rejects the traditional medical focus on persons already ill.[21] Boorse[22] notes that 'it does not change the underlying concept of health as long as what is prevented is still disease. What are positive are the actions of preventive physicians; the kind of health they seek to promote remains the same'. Further, one must also agree with the reality that there is no goal of perfect health to advance towards, but there is also no unique direction of advance.[23] Philosophy flourishes where confusion abounds.[24] The analytical skills of the philosophers would be of great assistance with respect to conceptual analysis. As Peter Caws notes 'philosophy….examines critically everything that may be offered as grounds for belief or action, including its own theories, with a view to the elimination of inconsistency and error'.[25] So, in order to understand the concept of health, we can

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[19] See, http://www.who.int/hhr/en/. At the time, this definition was groundbreaking because of its broadness. It is generally liked because of the aspiration it represents and because of the commonly recognized 'Health Triangle', a combination of physical, mental and emotional, and social well-being. However, over the past 60 years the definition has also often met with criticism, mainly because of the word 'complete', which makes it impracticable, as it is neither operational nor measurable. Although, over the past 60 years, several alternative definitions have been proposed, none has been embraced in the medical discourse as a replacement for the first. The original definition has never been modified or replaced and is generally described as 'honoured in repetition, but not in application'. See generally, World Health Organization, 'World Health Statistics 2008', (2008), viewed 6th January 2013, http://www.who.int/whosis/whostat/EN_WHS08_Full.pdf.

[20] For e.g., What does the WHO mean by 'complete', 'physical', 'mental' and the distinction between physical and mental well-being? Further, what does the WHO have in mind when it employs 'social well-being' to define 'health'? Finally, what is the meaning of 'disease' and 'infirmity' in the WHO's definition of health? These terms need to be explained carefully so that a detailed account of health can be made manifest. *Disease* is the outsider view, usually the Western biomedical definition. It refers to an undesirable deviation from a measurable norm. Deviations in temperature, white cell count, red cell count, bone density, and many others are seen as indicators of disease. *Illness*, on the other hand, means 'not feeling well. Thus it is a subjective, insider view. See, Adnan Ali Hyder, Richard H. Morrow, "Culture, Behavior and Health", viewed 12th Feb 2013, http://64.233.179.104/search? q=cache:COopVeuaYH4J: www.jbpub.com/downloads/076372967.

[21] Christopher Boorse, "Health as a Theoretical Concept", 44 *Philosophy of Science* 542 (1977), p.560.

[22] Id. p.568

[23] Id. p.570.

[24] Peter Caws, *The Philosophy of Science: A Systematic Account*, Van Nostrand, Princeton (1965), p. 5.

[25] Id.

take the assistance of two significant schools of thought on theories of health in the philosophy of medicine.[26] They are discussed below in detail.

1.2.1. The Naturalist School of Thought

According to naturalist, health is the absence of disease and that the term 'disease' can be understood objectively as biological functioning that is statistically less ordinary for the species concerned.[27] Naturalists believe that it is possible to formulate a purely descriptive theory of health.[28] Thus, naturalists deny that values are part of the concept of health, on the ground that health essentially involves only the functional activities of organisms and their parts.[29] For example, naturalists contend that whether a heart is healthy or diseased is an objective matter to be determined by relevant medical scientists. For them, it is entirely a separate matter, whether or not such a condition is of value. In nutshell, a naturalist focuses on a narrow, biological state of affairs which is not subjective to external human values. Michael Ruse[30] rightly describes the naturalist perspective as follows:

> The naturalist approach…attempts initially to approach matters in a non value-laden fashion. In particular, the notion of disease, the concept of disease, is defined without respect to the implications for the bearer—whether they be good or bad, happiness generating or otherwise, or anything else of this emotive nature. Essentially, a healthy state is taken to be one of proper functioning that is to say, proper functioning for the species *Home sapiens*. A diseased state is taken to be one that, in some sense, interferes with this proper functioning.

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[26] It is to be noted that the contents of the various theories too are quite different and often quite difficult to compare.

[27] Lewis, Stephen, *Exploring the Biological Meaning of Disease and Health*, A lecture given by invitation of the Konrad Lorenz Institute, University of Vienna, 10th April 2003, viewed 22nd Jan 2013 http://www.chester.ac.uk/~sjlewis/Presentations/ExploringTheBiologicalMeaningOfDiseaseAndHealth.htm.

[28] Hamilton, R., "The concept of health: Beyond normativism and naturalism", 16 *Journal of Evaluation in Clinical Practice* 323 (2010).

[29] Boorse is one of the most ardent and discerning defenders of a value free naturalistic concept of health, which places an emphasis on the concept of function.

[30] Michael Ruse, "Defining Disease: The Question of Sexual Orientation," in James M. Humber and Robert F. Almeder (eds), *What is Disease?* Totowa (1997), p. 143.

Naturalism has exerted its greatest pull upon normativist philosophers for whom value-freedom is the hallmark of science and who aspire to see medicine become truly scientific.[31]

1.2.2. The Normativist School of Thought

Normativists, insist that medical diagnoses are inherently value-laden.[32] Normativism remains the consensus view among philosophically sophisticated doctors.[33] Their justification is two-fold. First, they claim that, since science itself is littered with values, medical scientists, especially pathologists and physiologists cannot escape incorporating values into their profession. Secondly, normativists claim that the scope of the concept of health is ultimately dependent upon diagnosis and treatment of patients, that too, within a cultural and social context. Therefore, external forces such as culture, environment or historical background may be an influence on a patient, and according to the followers of this philosophy, health should be characterized in relation to our social and individual needs and vital ambitions. This concept explains that human health and human disease are not remote occurrences, even environment and society may influence man in many ways, either by directly causing illness, or in a more indirect and subtle manner such as setting societal goals that may determine the health of the people. Thus, a theory of health should highlight the 'subjective nature of disease experience'. H. Tristram Engelhardt[34] offers the following assessment of the concept of disease within the context of *diagnosis and treatment*:

> Clinical medicine is not developed in order to catalogue diseases *sub specie- aeternitatis*, but in order for physicians to be able to make more cost-effective decisions with respect to considerations of morbidity, financial issues, and mortality risks, so as to achieve various goals of physiologically and psychologically based well-

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[31] Boorse, Christopher, 'Defining Disease', in Humber, James and Robert Almeder (ed.), *What is Disease?*, Totowa, NJ (1997), p.7. Agich, Parsons and Engelhardt, think that the idea of a value-free concept of health is fundamentally misguided because science is value-laden, or because the concept of health includes values associated with medical practice and the broader social environment in which people find themselves. See also, H. Tristram Engelhardt, Jr., "Ideology and Etiology," 3 *The Journal of Medicine and Philosophy* 256 (1976), p. 258.

[32] Hamilton, R., "The concept of health: Beyond normativism and naturalism", 16 *Journal of Evaluation in Clinical Practice* 323 (2010).

[33] Fulford, K.W. M., "What is (mental) disease?': an open letter to Christopher Boorse", 27*Journal of Medical Ethics* 80, (2001), p.83.

[34] H. Tristram Engelhardt, "Clinical Problems and the Concept of Disease" in Lennart Nordefelt, B. Ingemar B. Lindahl (eds), *Health, Disease, and Causal Explanations in Medicine*, Dordrecht (1984), p. 36.

> being. Thus, clinical categories, which are characterized in terms of various warrants or indications for making diagnosis, are at once tied to the likely possibilities of useful treatments and severity of the conditions suspected.

Talcott Parsons [35] argues this normativist position from a *social context* perspective as follows:

> Health may be defined as the state of optimum *capacity* of an individual for the effective performance of the roles and tasks for which he has been socialized. It is thus defined with reference to the individual's participation in the social system. It is also defined as *relative* to his "status" in the society, i.e. to differentiated type of role and corresponding task structure, e.g., by sex or age, and by level of education which he has attained and the like.

A barrier to a generally accepted concept of health is the reason for the fundamental tension between normativists and naturalists. The aim of the naturalist is to advance an objective science-based account of health. That is to say, the naturalist aims for an account grounded in and informed by an objective and presumably empirical account of the state or the nature of organs and organisms, such that it is an account, which in some specified sense makes health status independent of value and culture.[36] Normativists, like Agich, Parsons, and Engelhardt, think that the idea of a value-free concept of health is fundamentally misguided because science is value-laden, or because the concept of health includes values associated with medical practice and the broader social environment in which people find themselves.[37] Normativists, include societal concerns and goals within the scope of medicine and specifically insists that norms are an ineliminable part of the concept of health. Naturalists, in contrast, restrict the scope of medicine to the somatic condition of the human body.

In medicine, theory and practice are conjoined twins. For that reason, it should not surprise us that normativism purchases practical applicability at the expense of

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[35] Talcott Parson, "Definitions of Health and Illness in the Light of American Values and Social Structure," in Arthur L. Caplan, H. Tristram Engelhardt, Jr., and James J. McCartney (eds), *Concepts of Health and Disease: Interdisciplinary Perspectives*, London (1981), p. 69.

[36] See for more discussions on naturalist concept Juan David Guerrero, *Against Naturalist Conceptions of Health: In Defence of Constrained Normativism*, Thesis Submitted To The Faculty Of Graduate Studies In Partial Fulfilment Of The Requirements For The Degree Of Doctor Of Philosophy, Department Of Philosophy Calgary, Alberta August, 2011, viewed 12th May 2013, http://dspace.ucalgary.ca/bitstream/1880/48738/1/2011_Guerrero_PhD_.pdf.

[37] Also see, H. Tristram, Engelhardt, "Ideology and Etiology", 3 *The Journal of Medicine and Philosophy* 256 (1976).

theoretical incoherence, while naturalism gains theoretical clarity at the cost of defining health and disease in ways unrecognizable by most practitioners or patients.

1.3. HEALTH AND HUMAN RIGHTS

Human rights are a set of universal minimum standards that must be met. They are not only about the protection of particular individuals and groups in society but are a practical framework to protect the rights of everyone. Health and Human rights has explicit intrinsic connections.[38] Human rights affect medical practice in several ways. They influence ethical codes[39]; they justify each patient's claim to the best attainable physical and mental health through their emphasis on norms, obligations, and accountability; and health is jeopardized when generic human rights are violated.[40] At the same time, health is a basic requirement for enjoying other human rights and participating in social, economic and political life. For those already more vulnerable due to poverty, inequality or social exclusion, lack of respect or protection of human rights can actually cause or worsen poor health. Moreover, the values enshrined in human rights are a reliable guide for contemporary practice because they are universal and focus on people as rights holders rather than patients. Hence, right to health is a fundamental right of every human being and it implies the enjoyment of the highest attainable standard of health without distinction of race, religion, political belief or social condition. As it is one of the fundamental rights of every human being, governments have a responsibility for the health of their people which can be fulfilled only through the provision of adequate health and social measures.

The traditional notion of healthcare has tended to be individual-centric and has focused on aspects such as access to medical treatment, medicines and procedures[41] The field of professional ethics in the medical profession has accordingly dealt with

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[38] The basic causes of morbidity and mortality in developing countries like malnutrition, inadequate access to clean drinking water, living and working conditions which are hazardous to health, lack of education and the exclusion of many poor and disadvantaged people from essential health service arise out of the failure to meet human rights commitments.

[39] See, World Medical Association, *Medical Ethics Manual*, The World Medical Association, Inc. (2005),p.11,viewed7thJuly2013, http://www.snabber.se/files/vardforalla/ wma_medical_ethics_ manual.pdf.

[40] Eleanor D. Kinney, "The International Human Right to Health: What does This Mean for Our Nation and World?" *34 Ind. L. Rev. 1457 (2001).*

[41] K.G. Balakrishnan, National seminar on the *'Human right to health'* Organized by the Madhya Pradesh State Human Rights Commission (At Bhopal), September 14, 2008, p.2, viewed 12th Oct 2013, http://supremecourtofindia.nic.in/speeches/speeches_2008/right_to_health_-_bhopal_14-9-08.pdf.

the doctor-patient relationship and the expansion of facilities for curative treatment. In such a context, healthcare at the collective level was largely identified with statistical determinants such as life-expectancy, mortality rates and access to modern pharmaceuticals and procedures. It is evident that such a conception does not convey a wholesome picture of all aspects of the protection and promotion of health in society. There is an obvious intersection between healthcare at the individual as well as societal level and the provision of nutrition, clothing and shelter. Furthermore, the term 'public health' has a distinct collective dimension and has an inter-relationship with aspects such as the provision of a clean living environment, protections against hazardous working conditions, education about disease-prevention and social security measures in respect of disability, unemployment, sickness and injury. While professional ethics in the medical profession have retained an individual-centric focus on curative treatment, the evolution of international humanrights norms pertaining to health has created a normative framework for governmental action.[42] It may be useful to quote Jonathan Mann[43], a doctor who led the efforts to develop the interface between health and human rights:

> Modern human rights, precisely because they were initially developed entirely outside the health domain and seek to articulate the societal preconditions for human well-being, seem a far more useful framework, vocabulary, and form of guidance for public health efforts to analyze and respond directly to the societal determinants of health than any inherited from the biomedical or public health traditions.

The incorporation of health concerns in the 'rights' discourse, both at the international and domestic level-recognizes that the legal system bears the responsibility of aiding the medical profession in advancing the 'right to health'.

1.3.1. Right to Healthcare in International Law

In ancient period, diseases were mainly viewed as divine judgments and the belief was that it could only be cured by appeasing Gods.[44] Responsibility in case of disease or illness predominantly fell into the hands of private entities, such as churches and charities. But there are instances where we see public health being

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[42] See generally, Lawrence O. Gostin, "Public Health, Ethics and human rights: A tribute to the late Jonathan Mann", 29 *Journal of Law, Medicine and Ethics* 121 (2001), p.125.

[43] Jonathan Mann et al., *Health and Human Rights: A Reader*, Routledge, New York (1999), p. 444

[44] Rosen, George, *A History of Public Health*, Baltimore: JHU Press (1993), p. 5.

given importance by construction of sewage, drainage systems and baths in ancient Egypt, India and Greece, and by the Inca society in America.[45] But by the middle age one find that medical care was given through hospitals and, States started showing interest in providing medical care by intervening in cases of epidemic or pandemic diseases, by mostly laying down forms of quarantines.[46] A deeper study of this period shows that mostly communal health considerations were given by providing adequate sanitation, particularly in the larger cities.[47]

The concept of modern public health developed during industrial revolution, when unhealthy work and living conditions, caused to a large extent by mass production, led to epidemics and other grave health problems.[48] The spread of epidemics beyond national borders soon elevated these questions to the international level, as they were considered as threats to international trade, and

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[45] Id. pp. 1-3. see also, Brigit C. A. Toebes, *The Right to Health as a Human Right in International Law*, Antwerp: Intersentia (1999), p.7.

[46] Merson, Michael, Robert E. Black and Anne Mills (ed.), *International Public Health: Diseases, Programs, Systems and Policies*, Jones and Bartlett Publishers, Sudbury (2004), p.xxi.

[47] Brigit C. A. Toebes, *The Right to Health as a Human Right in International Law*, Antwerp: Intersentia (1999), p.7.

[48] Mckee, Martin, Robin Stott and Paul Garner, "Introduction: A Historical Perspective", in Mckee, Martin, Robin Stott and Paul Garner (ed.), *International Co-operation in Health*, Oxford University Press, Oxford (2001), p. 2.; Aginam, Obijifor, 'The Nineteenth Century Colonial Fingerprints on Public Health Diplomacy: A Postcolonial View', *Law, Social Justice & Global Development Journal*, (2003), viewed13thMay2013,http://www2.warwick.ac.uk/fac/soc/law/ elj/lgd/2003_1/ aginam/ aginam.rtf.; Acemoglu, Daron, Simon Johnson and James Robinson, 'Disease and Development in Historical Perspective', (2002), viewed 13th May 2013, http://econ-www.mit.edu/files/285.It is to be noted that industrial revolution paved way for availability of surplus grain, goods thereby connecting population over vast geographical lands. This no doubt fostered worldwide trade but it also became one of the reasons for the spread of infectious diseases. Take for example, the opening of the Straits of Gibraltar and the development of trade routes across the Eurasian steppe by the Mongols created conditions by which plague spread throughout Europe after 1346. Smallpox, measles, mumps, chickenpox and scarlet fever; the vulnerability of the native populations, who used to live in isolation from the rest of the world, provided a chance for pandemics of these diseases to decimate Caribbean Indians and visit populations in Peru and urbanized societies in Mexico with heavy mortality and morbidity burdens. On the other hand, the Europeans also encountered different diseases in the areas they colonized; for instance, when they attempted to settle or organized expeditions to areas where yellow fever and malaria were prevalent, the European mortality rates were very high. According to Aginam, "…this disease exchange propelled the transnationalisation of disease between the Old and New Worlds, reshaped the contours of colonialism and made disease a visible component of the entire colonial architecture." Since then, the spread of pathogens no longer depends on the speed of a caravan or long sea voyages, transatlantic flights allow tourists, business people, political refugees, migrant workers, and soldiers to travel around the world in hours, with the potential for carrying new diseases with them; and container ships transporting goods from around the world can import everything from trucks to rats and mosquitoes.

were therefore discussed at the first international conferences on sanitation.[49] In 1903, one of these conferences set up the Office International d'Hygiène Publique (OIHP) which was later associated to the League of Nations, and ultimately became the Health Organization of the League of Nations.[50] The Charter of the League of Nations Health Organization provides that state members of the League will endeavor to take steps in matters of international concern, for the prevention and control of disease.[51] The League of Nations endeavored to respond to the universal need of prevention of disease and it extended its operation to all corners of the globe. The concept of primary health care for all was first discussed at a conference convened by this new organization and was later taken up by the United Nations.[52] Issues of health concerning workers were taken up in the International Labour Organization (ILO), founded in 1919.[53] Therefore, notions of a positive right to health had its origin in the Sanitary Revolution of the nineteenth century when public health reformers, also troubled by the economic dislocations of the Industrial Revolution and empowered with scientific advances, pressed for state-sponsored public health reforms.[54]

During the Second World War, the idea of social rights and, in particular, health as a human right, were further developed and institutionalized. The policies of the League of Nations Health Organization were conceptually flawed as undue emphasis was placed on the training of public health administrators who required elaborate institutional structures in order to dispense medical solutions to problems of chronic diseases. The threat of new infections arising as a result of human action

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49 Siddiqi, Javed, *World Health and World Politics: The World Health Organizations and the UN System*, University of South Carolina Press, Columbia (2005), p.15. The first International Sanitary Conference was held at Paris on 23rd July 1851. The main purpose of this conference was not to protect global health, but, to protect national interests so that trade flourished during this period when there was uncontrollable spread of diseases like cholera and yellow fever which could jeopardize international trade affecting countries economically.

50 Id. pp.14-9. The limited staff and funding of the OIHP was insufficient to combat growing global health issues. Therefore, the League of Nations established a new health organization to advise the League on health matters. This new organization set the precedent for the wide-ranging role of the World Health Organisation (WHO).

51 Article 23.

52 Siddiqi, Javed, *World Health and World Politics: The World Health Organizations and the UN System*, University of South Carolina Press, Columbia (2005), p.15.

53 Id.

54 Eleanor D. Kinney, "The International Human Right To Health: What Does This Mean For Our Nation And World", 34 *Indiana Law Review* 1457 (2001), p.1459

demanded new forms of co-operation between human security and public health. The founders of the United Nations as well as the World Health Organization realized that there is a linkage between health, understood as a state of complete physical, mental and social well-being, and the core values of justice and security.[55] In 1944, President Franklin D. Roosevelt listed health as one of the rights needed for economic security without which 'true individual freedom cannot exist'.[56] Thus, in 1945, UN Conference on International Organization at San Francisco explored the possibility of setting up an international health organization.[57] In 1946, the responsibilities of the Office International'd Hygiene Publique were transferred to the new World Health Organization.

The WHO for the first time emphasized that the enjoyment of the highest standard of health is a fundamental right of every human being and it should be made available to all without distinction of race, religion, and political belief, economic or social condition.[58] The definition obligates international co-operation in health issues which includes the improvement of national health in all countries, the dissemination of medical, psychological, and related knowledge throughout the world, and the development of an informed public opinion on health tribulations.[59] The WHO elaborated a number of principles for health development, for instance, governments have a responsibility for the health of their people, and at the same time, people have a right as well as a duty to participate individually as well as

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[55] Lee Jong Wook's, "Global Health Improvement and the World Health Organization: Shaping the Future", 362 *The Lancet* 2083 (2003), p.2085.

[56] Steven D. Jamar, "The International Human Right to Health", 22 *S.U. L. Rev.* 1 (1994), p.3.

[57] At UN Conference in San Francisco the members highlighted the need of international law to continue to play a vital role in international health activities. Consequently, the WHO was born when sixty-one States signed the Constitution of the WHO on the 22nd July 1946. The Constitution of WHO sets forth its overall objective, lists its functions, establishes its central and regional structure, defines its legal status, and provides for co-operative relationships between it, the United Nations and other organizations, both governmental and private, in the area of health. Nine basic principles which are considered to be essential to the happiness, harmonious relation and security of all people are listed in the preamble of the Constitution along with the definition of health.

[58] See, the WHO Constitution, viewed 6th Jan 2013, http://www.who.int/governance/eb /constitution/en/. The Constitution of WHO states that the health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

[59] World Health Organization, 'Proceedings and Final Acts of the International Health Conference, held in New York from 19 June to 22 July 1946', viewed 18th Jan 2013, http://whqlibdoc.who.int/hist/official_records/2e.pdf.

collectively in the development of their own health.[60] These principles further led to self-reliance in health matters at the individual, community and national levels. Thus, State's responsibility for providing health care to the public gained ground, which led to the adoption of suitable health measures and legislations. WHO generally approached health as a set of functional, practical problems rather than as a rights-based problem. [61] The information generated by WHO and its pronouncements on world health must be used indirectly as to infer the scope of the right or fields in which steps should be taken to further or enhance enjoyment of the right.[62] For instance, one of the most important WHO pronouncements, for purposes of understanding the scope of the current health initiatives and the status of rights-based analysis, is the 1981 Global Strategy for Health for All by the Year 2000.[63] The primary focus of the Global Strategy is on primary health care. The purpose of primary health care initiative is attainment of highest possible level of health relative to the country's available resources.[64]. The formula adopted to achieve the said goal includes the language of the Thirtieth World Health Assembly which states that 'all people in all countries should have a level of health that will permit them to lead a socially and economically productive life'. [65] Thus, the text of the WHO Constitution, inspired many human rights instruments to provide greater emphasis on recognizing health as a 'right', thereby 'the right to health' has been subsequently firmly established in numerous instruments. This paved way for more coordinated action in the international health scenario.

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60 World Health Organization, The world health report 1998 - Life in the 21st century: A vision for all (1998), p.15, viewed, 19th June, 2013, http://www.who.int/whr/1998/en/.

61 See generally, Jennifer Prah Ruger, "Global functions at the World Health Organization", 330 *BMJ* 1099 (2005).

62 Steven D. Jamar, "The International Human Right to Health", 22 *S.U. L. Rev.* 1 (1994), p. 44.

63 Id.

64 Id.

65 Resolution WHA 30.43, Global Strategy Part II, P1, p. 31. The Global Strategy provides:
Health for all does not mean that in the year 2000 doctors and nurses will provide medical care for everybody in the world for all their existing ailments; nor does it mean that in the year 2000 nobody will be sick or disabled. It does mean that health begins at home, in schools and in factories. It is there, where people live and work, that health is made or broken . . . . It does mean that there will be an even distribution among the population of whatever resources for health are available. It does mean that essential health care will be accessible to all individuals and families in an acceptable and affordable way, and with full involvement of people. And it does mean that people will realize that they themselves have the power to shape their lives and the lives of their families, free from the avoidable burden of disease, and aware that ill-health is not inevitable.

Of the 30 Articles of the Universal Declaration of Human Rights, Article 25 is concerned with right to health.[66] According to this Article, everyone has right to a standard of living, adequate for himself and his family, including food, clothing, housing, medical care and necessary services. It recognizes the interrelatedness of health and other valuable social ends. This definition deviates from the concept of rights held in the eighteenth and nineteenth centuries, which only restrained the state from actively denying citizens their basic civil and economic rights.[67] It must be mentioned here that health as a 'stand-alone right'[68] was not fully developed in the Declaration, it was deemed enough to include as a specific item of the right to an adequate standard of living for every person.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[69] It is important to note that the Covenant gives both mental health, and physical health equal consideration. This is subject to a number of general qualifications that apply to all social and economic rights such as all the rights protected by this Covenant are to be progressively achieved subject to available resources.[70] Hence, the right to health does not outline distinct actions that the government is to perform or avoid. There is neither a concrete negative

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[66] Art.25(1) states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age and other lack of livelihood in circumstances beyond his control."

[67] Asbjorn Eide, Gudmundur Alfredsson, Goran Melander, Lars Adam Rehof, Allan Rosas, "The Universal Declaration of Human Rights: A Commentary", 17 *Human Rights Quarterly* 398 (1995), p.400.

[68] Steven D. Jamar, "The International Human Right to Health", 22 *S.U. L. Rev.* 1 (1994), p. 22.

[69] Article 12(1) provides for "…the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".
Article 12(2) further states that:
"… The steps to be taken by the States Parties to the present convention to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d)The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

[70] See, Art.2 of ICESCR which states: Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

nor a positive duty.[71] Instead, the Covenant outlines general goals or aims that are to be achieved 'progressively' and at a large scale. The provisions concern general public policies that will produce broad benefits for all and the aims and goals to be achieved are not categorical but conditional on what is achievable or what is possible under available resources. The International Covenant on Economic, Social and Cultural Rights is a legally binding agreement between States and places clear legal obligations on States. It place three types of obligations on States: to respect, to protect and to fulfill. [72] The UN Committee on Economic, Social and Cultural Rights has responsibility for the promotion, implementation and enforcement of this covenant. U.N Committee on Economics, Social and Cultural Rights, General Comment No.14 clarifies how the human right to health can be approached in practice. It states that the right to health is not to be understood as 'right to be healthy'; it includes both freedoms and entitlements.[73] General Comment No.14[74] specifies the freedoms and entitlements as follows:

> The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

General Comment 14 observes that the right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including

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71 e.g., not to inflict intentional pain and suffering, or not to discriminate on grounds of religion.

72 The obligation to respect places a duty on States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect means that States must prevent third parties from interfering with the enjoyment of the right to health. The obligation to fulfill requires States to adopt necessary measures, including legislative, administrative and budgetary measures, to ensure the full realization of the right to health.

73 *The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C, Dec. 4, 2000, ICESR General Comment 14 (2000), viewed 27th June 2013, http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En

74 Id.

sexual and reproductive health.[75] The report specifies that 'progressive realization means State parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of right.[76] It mentions that the normative content of the right to health involves "availability, accessibility, acceptability and quality"[77] of public health and health care facilities, goods, and services. Apart from emphasizing the importance of 'availability, accessibility and acceptability', the ESCR Committee also indicated that 'quality' is an important element in the content of the right to health.[78] It requires health services to be scientifically and medically appropriate and to meet good quality standards. Therefore, the right to health is an inclusive right, extending not only to timely and appropriate health care but also to the underlying determinants of health.[79]

Following the International Bill of Human Rights, the General Assembly and other organs of the United Nations have produced several declarations and treaties addressing the right to health of vulnerable groups such as women, children, and ethnic minorities. The International Convention on the Elimination of All Forms of Racial Discrimination[80], Convention on the Elimination of All Forms of Discrimination against Women[81], Convention on the Rights of the Child are a few

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75 Id.

76 U.N Committee on Economics, Social and Cultural Rights, General Comment 14, para. 31.

77 Id. 'Availability' means functioning of public health and healthcare facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. 'Accessibility' of the right to health is fulfilled when health services are available to the entire population, without discrimination or physical, geographical or economic obstructions. 'Acceptability' requires that health services adhere to the standards of medical ethics and are culturally suitable.

78 U.N Committee on Economics, Social and Cultural Rights, General Comment No.14: The Right to the Highest Attainable Standard of Health, adopted on 11 May 2000, UN Document E/C.12/2000/4, viewed 27th June 2013, http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.

79 Toebes, Brigit, *The Right to Health as a Human Right in International Law*, Hart Publishing, Antwerpen: Intersentia (1999), p.276.

80 Art.5 "… States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin … notably in the enjoyment of the following rights:
(iv) The right to public health, medical care, social security and social services.

81 Article 11.1(f) provides for "the right to protection of health and to safety in working conditions, including safeguarding of the function of reproduction".
Article 12(1) and (2) states that:
"States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning and ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation".

examples. Children, women, persons with disabilities or persons living with HIV/AIDS, face specific hurdles in relation to the right to health.[82] This may be because of biological or socio-economic factors, discrimination and stigma, or, generally, a combination of these. Considering health as a human right requires specific attention to different individuals and groups of individuals in society, in particular those living in vulnerable situations. States should adopt positive measures to ensure that specific individuals and groups are not discriminated against. For instance, they should disaggregate their health laws and policies and tailor them to those most in need of assistance rather than passively allowing seemingly neutral laws and policies to benefit mainly the majority groups.

1.3.2. Right to Healthcare in Regional Documents

In addition to the international instruments, regional documents like European Social Charter[83], African Charter on Human and People's Rights[84],Additional Protocol to the American Convention on Human Rights also known as Protocol of San Salvador[85] were framed, each adapting 'right to health' to their particular, localized aspirations.

European Social Charter requires taking of appropriate measures for the protection of health. The charter does not contain a definition of health such as is found in the Covenant on Economic, Social and Cultural Rights or in the Charter of

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[82] Article 24(1) "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health".

[83] Article 11 provides for an obligation to ensure effective protection of the right to health, "to remove as far as possible the causes of ill health; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; to prevent as far as possible epidemic, endemic and other diseases…"
Art.(13) states "anyone without adequate resources has the right to social and medical assistance"

[84] Article 16 states that
(1) Every individual shall have the right to enjoy the best attainable state of physical and mental health;
(2) State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

[85] Article 10 provides that "Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being".
Article 10(2) provides measures to ensure that right:
(a) Primary health care - that is, essential health care made available to all individuals and families in the community;
(b) Extension of the benefits of health services to all individuals subject to the State's jurisdiction;
(c) Universal immunization against the principal infectious diseases;
(d) Prevention and treatment of endemic, occupational and other diseases.

the World Health Organization. References to more than the mere absence of disease and to inclusion of both mental and physical health were explicitly rejected. Nonetheless, the European Social Charter does reinforce the notion that the right to health is more than a right to medical care and it touches the whole range of causes of ill health**.** This charter also reinforces the focus on preventative measures and education as opposed to merely responding to medical or other health problems.

In contrast to the cautious, narrow European approach, the African Charter provides that 'every individual shall have the right to enjoy the best attainable state of physical and mental health'**.** The paragraph which articulates steps to be taken is quite different insofar as it both establishes a more general obligation on States Parties to 'take the necessary measures to protect the health of their people' and establishes a specific duty on states 'to ensure that people receive medical attention when they are sick'. The African Charter thus emphasizes the centrality of medical attention without limiting the duty to take steps to further the right to enjoyment of health to any specific categories.

Protocol of San Salvador recognizes health as a public good. It adds a new and significant measure not expressed in other instruments, namely 'satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable'. Nonetheless, the Protocol rules out the possibility of submitting individual petitions before the supervisory organs of the Inter-American system with respect to the right to health.

In conclusion, it is to be emphasized here that as most human rights are interrelated and interdependent, the right to health is not confined to health care, but embraces a wide range of socio-economic conditions necessary for people to lead healthy lives, including the underlying determinants of health like nutrition, housing, sanitation, water etc.[86] Even though the term 'right to health' is used as an acceptable shorthand to facilitate its mention during international negotiations and theoretical debates, they all seem to agree that the full articulation 'right of everyone to the highest attainable standard of physical and mental health' is best in line with the

[86] It is to be noted here that at a universal level, it is difficult to be specific about the scope and the core contents of the right to health. No doubt human rights obligates States to take positive action in protecting health of its citizens but as a result of disparity in health levels and needs throughout the world, it is difficult to describe what health services States should provide on the basis of the right to health. However, ideas developed at the international as well as the national level are a good indication of the basic content of the right to health.

international treaty provisions that proclaim not only the right to health care services, but also the right to a number of underlying preconditions for health**,** such as safe drinking water, adequate sanitation, environment health, and occupational health.[87]

1.3.3. Obligation on States in Ensuring Right to Healthcare

The human right to health is just a moral right. Implementation and enforcement of the international right to health is difficult particularly if predicated on customary international law. Implementation requires affirmative action on the part of government, and implicates intervention in the internal domestic affairs of nations. States have the primary obligation to protect and promote human rights. Through their ratification of human rights treaties, State parties are required to give effect to these rights within their jurisdictions. Article 2 (1) of the International Covenant on Economic, Social and Cultural Rights specifically underlines that States have the obligation to progressively achieve full realization of the rights under the Covenant. Further, the United Nations Committee on Economic, Social and Cultural Rights, in its General Comment No. 9, has emphasized that it is up to states as to how they give effect to the rights contained in the International Covenant on Economic, Social and Cultural Rights (ICESCR), including the right to health, but whatever arrangements they choose, must be effective.[88] Taking steps to realize the right to health requires a variety of measures and it varies from State to State, therefore, international treaties do not offer set prescriptions.[89] The Committee on Economic, Social and Cultural Rights has underlined that States should, at a minimum, adopt a national strategy to ensure to all, the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy. Accordingly, individuals must have access to effective judicial or other appropriate remedies at both national and international levels. They must be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen,

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[87] B. Toebes, "The Right to Health", in A. Eide, C. Krause, and A. Rosas, eds., *Economic, Social and Cultural Rights: A Textbook,* 2nd ed., Dordrecht, Nijhoff (2001), p.170.

[88] Committee on Economic, Social and Cultural Rights, *General Comment No. 9 on the domestic application of the Covenant,* 3 December 1998, UN Doc. E/C.12/1998/24, paras. 1 and 2. The Covenant norms must be recognized in appropriate ways within the domestic legal order, appropriate means of redress, or remedies must be available to any aggrieved individual or group, and appropriate means of ensuring governmental accountability must be put in place.

[89] For example, the International Covenant on Economic, Social and Cultural Rights in Article 2 (1) simply states that the full realization of the rights contained in the treaty must be achieved through "all appropriate means, including particularly the adoption of legislative measures".

human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.[90]

Inclusion of health as a positive right in a Constitution improves the legal basis for right-holders to claim health related rights. Many States, therefore has recognized right to health or stipulate State duties with regard to health through their respective Constitutions. The first Constitutional recognition of the right to health was guaranteed by Chile in 1925 under Article 19(9).[91] Since then many countries have come forward to recognize health as a right either explicitly or implicitly under its constitutional provisions.[92] For example, Finland[93], South Africa[94] and Hungary[95] recognized it as part of its general well-being similar in formulation to Article 25 of the Universal Declaration of Human Rights. Right to free medical services is guaranteed under the

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[90] *The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C, Dec. 4, 2000, ICESR General Comment 14 (2000), viewed 12th November 2013, http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.

[91] Art.19 (9) provides - The right to protection of health.
The State protects the free and egalitarian access to actions for the promotion, protection and recovery of the health and rehabilitation of the individual.
The coordination and control of activities related to health shall likewise rest with the State.
It is the prime duty of the State to guarantee health assistance, whether undertaken by public or private institutions, in accordance with the form and conditions set forth in the law which may establish compulsory health quotations.
Each person shall have the right to choose, the health system he wishes to join, either State or private controlled.

[92] Byrne, I., *Enforcing the Right to Health: Innovative Lessons from Domestic Courts*, in *Realizing the Right to Health*, Ruffer & Rub: Zurich (2009), p. 526. Nearly 70% of countries have some form of explicit guarantee regarding health, although this may take a variety of forms.

[93] Section 19 of the Finnish Constitution provides: '(1) Those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care.(2) Everyone shall be guaranteed by an Act the right to basic subsistence in the event of unemployment, illness, and disability and during old age as well as at the birth of a child or the loss of a provider. (3) The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population. Moreover, the public authorities shall support families and others responsible for providing for children so that they have the ability to ensure the well-being and personal development of the children.(4) The public authorities shall promote the right of everyone to housing and the opportunity to arrange their own housing.'

[94] Article 27 of the South African Constitution provides : '(1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights. (3) No one may be refused emergency medical treatment.'

[95] Article 18 of the Hungarian Constitution provides: 'The Republic of Hungary recognizes and shall implement the individual's right to a healthy environment.'

constitution of Guyana.[96] According to Hungarian Constitution every citizen has a right to enjoy the highest possible level of physical and mental health.[97] The Constitution of Haiti provides for direct relationship of health and right to life[98]. Countries like Netherlands[99] and also Haiti[100] puts specific obligation upon the State to achieve health for its citizens. India[101], Philippines[102], Malawi[103], Uganda[104] and

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96 Article 25 of the Guyana Constitution provides: Every citizen has the right to free medical attention and also to social care in case of old age and disability.'

97 Article 70D of the Hungarian Constitution provides: '(1) Everyone living in the territory of the Republic of Hungary has the right to the highest possible level of physical and mental health.(2) The Republic of Hungary shall implement this right through institutions of labor safety and health care, through the organization of medical care and the opportunities for regular physical activity, as well as through the protection of the urban and natural environment.'

98 Article 19 of the Haitian Constitution provides : 'The State has the absolute obligation to guarantee the right to life, health, and respect of the human person for all citizens without distinction, in conformity with the Universal Declaration of the Rights of Man.'

99 Article 22 of the Dutch Constitution provides: '(1) The authorities shall take steps to promote the health of the population. (2) It shall be the concern of the authorities to provide sufficient living accommodation. (3) The authorities shall promote social and cultural development and leisure activities.

100 Article 23 of the Haitian Constitution provides: 'The State has the obligation to ensure for all citizens in all territorial divisions appropriate means to ensure protection, maintenance and restoration of their health by establishing hospitals, health centers and dispensaries.'

101 Article 47 of the Indian Constitution provides: '**Duty of the State to raise the level of nutrition and the standard of living and to improve public health.**- The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.'

102 Article 13 of the Filipino Constitution provides: **Social Justice and Human Rights**:
Section 1. The Congress shall give highest priority to the enactment of measures that protect and enhance the right of all the people to human dignity, reduce social, economic, and political inequalities, and remove cultural inequities by equitably diffusing wealth and political power for the common good. To this end, the State shall regulate the acquisition, ownership, use, and disposition of property and its increments.
Section 2. The promotion of social justice shall include the commitment to create economic opportunities based on freedom of initiative and self-reliance.

103 Article 13(2) of the Malawian Constitution provides : 'The State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving the following goals….To provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care.'

104 Article 14 of the Ugandan Constitution provides: '**General Social and Economic Objectives**: The State shall endeavour to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that-(i) all developmental efforts are directed at ensuring the minimum social and cultural well-being of the people; and (ii) all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits.'

Ghana[105] guarantee right to health through Directive Principles of State Policy which is considered to be non-justiciable rights, though this does not hinder the courts from recognizing and enforcing this right.

It is to be specifically mentioned here that UK, Australia, Canada, New Zealand does not explicitly address a right to health care. When there is no express mention of the constitutional protection of social rights, the technique to be adopted by the respective countries is to resort to adopting expansive definitions of civil rights some of which tend to be widely if not universally guaranteed under domestic law, e.g. right to life or right not to be subjected to cruel, inhuman or degrading treatment. Moreover, the right to health has clear links to many other rights, not just economic and social but also civil and political rights, for example, the right to life and the right not to be subjected to torture or cruel, inhuman or degrading treatment, and the right to information[106]. The Indian legal system is one of the few State systems in the world to have subjected social rights to this type of judicial scrutiny. By creating a mechanism for guaranteeing social rights through litigation, India has opened the door towards the full realization of social rights for Indian citizens who have been historically deprived of basic human needs.[107] The Indian Constitution has given the Court broad powers to develop an appropriate method to enforce and protect fundamental rights.[108] The Court has used this power to foster a public interest litigation system dedicated to help Indian citizens to achieve their constitutional rights.[109] The Court has used the 'fundamental

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105 Article 34 of the Ghana Constitution provides: (1) The Directive Principles of State Policy contained in this Chapter shall guide all citizens, Parliament, the President, the Judiciary, the Council of State, the Cabinet, political parties and other bodies and persons in applying or interpreting this Constitution or any other law and in taking and implementing any policy decisions, for the establishment of a just and free society. (2) The President shall report to Parliament at least once a year all the steps taken to ensure the realization of the policy objectives contained in this Chapter and, in particular, the realization of basic human rights, a healthy economy, the right to work, the right to good health care and the right to education.

106 See, for example, the decision of the European Court of Human Rights in *Guerra* v *Italy* (1998) 26 EHRR 357 with respect to the lack of available information on a facility which threatened the health of the applicants.

107 Sheetal B. Shah, "Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India", *32 Vand. J. Transnat'l L. 435(*1999), p.466.

108 Id. p.468.

109 See, *People's Union for Democratic Rights* v *Union of India,* A.I.R. 1982 S.C.1473, 1476. People's Union for Democratic Rights addressed a letter to Hon'ble Mr. Justice Bhagwati complaining of violation of various labour laws of those employed at Asiad project by the respondents' and sought interference by the Supreme Court to render social justice by means of appropriate directions to the affected workmen. The Supreme Court treated the letter as a writ petition and issued notice to the Union of India, Delhi Administration and the Delhi Development Authority for redressal of the complaint.

right to life' provision in the Constitution to require the State to provide social services.[110] In addition to the Constitutional protection, at the national or State level, legislations have also been enacted to protect the health of the population.

To summarize, the right to health represents an international legal obligation of states to promote and protect the health of their populations.[111] The provision of medical treatment, the ready availability of health care, and public health are issues of national concern.[112] The current definitions of the right to health, however, do not provide detail on actual state obligations.[113] Beyond the general affirmations expressed in international treaties, there has been no attempt to define the precise content of the right to health or to develop proper enforcement standards for its implementation.[114] Implementation of the right involves resource allocation and policy decisions that are based on social, political, and economic priorities in a country.[115] Therefore, implementation of the right remains dependent on national conditions and resources and rests mainly with State actors.[116]

1.4. RIGHT TO HEALTHCARE IN INDIA

Healthcare in India was never a top priority after independence. The initial onus was on agriculture, infrastructure and military. This led of a neglect of social sectors like health and education. Most of the services provided thereon were preventive, for instance, vaccinations against various ailments and very few curative healthcare services were provided. India along with other WHO member Nations pledged the, 'Health for All by the Year 2000' at Alma-Ata in 1978; and in the same year signed the International Covenant for Economic, Social and Cultural Rights, accordingly the State is obliged to achieve the highest attainable standard of health. In fact, it wasn't until 1982-83 that the National Health Policy

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110 Article 21 provides that, 'no person shall be deprived of his life or personal liberty except according to procedure established by law'.

111 Sheetal B. Shah, "Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India", 32 *Vand. J. Transnat'l L.* 435 (1999), p.455.

112 See, Steven D. Jamar, "The International Human Right to Health"**,** 22 *S.U. L. Rev.* 1 (1994), p.3.

113 See, Allyn Lise Taylor, "Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health"**,** 18 *Am. J.L. & Med.* 324 (1992), p.327.

114 Id. p.327-28.

115 Steven D. Jamar, "The International Human Right to Health**",** 22 *S.U. L. Rev.* 23 (1994), p.52.

116 Allyn Lise Taylor, "Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health"**,** 18 *Am. J.L. & Med.* 301 (1992), p.311.

was endorsed by Parliament. Recently, the health care industry in India has scaled up its offer of superior quality of medical services with emphasis on specialties and super specialties. Technology driven health care services offered by some of the corporate hospitals are undoubtedly comparable to international standards. However, the health situation in our country continues to be dismal. The available health care services particularly those in the private sector are only accessible to those who can afford the cost. Nevertheless, those who cannot afford are also driven to the private health care sector owing to the fact that the government hospitals are no longer in a position to cater adequately to the health care needs of the people. In other words, the role of the State in the context of health care is fast shrinking, at the same time; market players are experiencing phenomenal expansion.

India has undertaken several measures to promote human rights based approach with regard to health and nutrition in its Five Year Plans, policies and programmes. However, despite adopting a multi-pronged approach towards strengthening availability, affordability and accessibility to health care services, several challenges continue to remain. For instance, against the global average of 14.2, the physician density of India per 10,000 populations stands poorly at 6.5.[117] India's nursing and midwifery density of 10 per 10,000 populations is not even half the global average of 28.1.[118] The worst indicator of health care in India comes with the density of hospital beds per 10,000 population which stands at 9 against the global average of 30.[119] The doctor-population ratio in rural areas is 3:10,000, while it is 13:10,000 in urban areas.[120] Besides, just 26 per cent doctors work in rural areas, serving 72 per cent of the population.[121] India's Economic Survey, 2013 points to the fact that even though the country's spending on health has increased by 13 per cent, it nonetheless has the lowest public health spending as a proportion of its GDP.[122] The High Level Expert Group constituted by the

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117 Curtain Raiser**,** *NHRC National Conference on Health Care as a Human Right***,** 31st October, 2013, viewed, 22nd Nov 2013, http://nhrc.nic.in/disparchive.asp?fno=12994.

118 Id.

119 Id.

120 Id.

121 Id.

122 Id. Afghanistan, for instance, spends 7.6 per cent of its GDP on healthcare, Bhutan 5.2 per cent, Haiti 6.9 per cent, Iraq 8.4 per cent, Nepal 5.5 per cent, Rwanda 10.5 per cent, Sudan 6.3 per cent while the United States spends 17.6 per cent, Canada 11.3 per cent, the United Kingdom 9.6 per cent and Australia 8.7 per cent.

Planning Commission and chaired by Professor Srinath Reddy proposed Universal Health Coverage for all citizens.[123] The challenge for the nation is to translate into reality this vision of accessible, affordable and equitable health care for all. In this light one must acknowledge the role played by judiciary. With the advent of public interest litigation, a large number of issues concerning the poor and marginalized are being taken up in courts across the land. Though judicial pronouncements may not have the same breadth as statutory laws, they constitute the law as applicable in given situations. Besides, judicial pronouncements give legitimacy, recognition and social acceptance to various ideas which can be used for strengthening rights based campaigns around issues. The judiciary has shouldered the responsibility in two different ways in the context of health care, namely, recognizing and enforcing right to health care as a fundamental right and regulating health care delivery.

1.4.1. Constitutional Guarantees

India is a party to ICESCR and has undertaken to realize the right to the highest attainable standard of health. The Right to Health and healthcare in India is not enshrined as a Fundamental Right, but is included within the ambit of the Directive Principles of State Policy. Essential premise of Directive principles of State Policy is to provide direction to various State Governments to undertake and initiate required measures in the interests of the community. The obligation of the State to ensure creation and sustaining of conditions congenial to good health is cast by the Constitutional directives contained in Articles 39(e)[124], 39(f)[125], 42[126] and 47[127] in Part IV of the Constitution of India.

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123 K. S. Jacob, "Health care for all", *The Hindu*, January 26, 2012.

124 Art. 39 (e) states that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength.

125 Art. 39 (f) states that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment.

126 Art.42 provides for just and humane conditions of work and maternity relief The State shall make provision for securing just and humane conditions of work and for maternity relief.

127 Art.47 states that it is the duty of the State to raise the level of nutrition and the standard of living and to improve public health The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health

The Constitution assigns predominant responsibility to States for providing health care services. In terms of distribution of sectoral responsibilities in the federal set up, health is a State subject. However, a number of items related to health are listed in the concurrent list, and thus the Central Government has had enough scope to influence the context and the prospects in the health sector through its policies, budgetary allocation etc. The State legislature is, empowered to make laws with respect to public health and sanitation, hospitals and dispensaries.[128] Both the Centre and the States have power to legislate in the matters of social security and social insurance, medical professions, and, prevention of the extension from one State to another of infectious or contagious diseases or pests affecting man, animals or plants.[129] There is a considerable amount of legislation, both by the Central and State Governments respectively, which deal directly with the subject matter of health and health care.[130]

Further, the Constitution of India recognizes the responsibilities of Municipalities [131] and Panchayats [132] in realizing the goal of right to healthcare.

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[128] See, State List: Entry 6.

[129] See, Concurrent List:

16. Lunacy and mental deficiency, including places for the reception or treatment of lunatics and mental deficients
18. Adulteration of foodstuffs and other goods.
19. Drugs and poisons, subject to the provisions of entry 59 of List I with respect to opium
20 A.Population control and family planning
23. Social security and social insurance; employment and unemployment.
24. Welfare of labour including conditions of work, provident funds, employers' liability, workmen's compensation, invalidity and old age pensions and maternity benefits
25. Education, including technical education, medical education and universities, subject to the provisions of entries 63, 64, 65 and 66 of List I; vocational and technical training of labour.
26. Legal, medical and other professions
30. Vital statistics including registration of births and deaths.

[130] For example, Medical Termination of Pregnancy Act, 1971, Mental Health Act, 1987, Central Mental Health Authority Rules, 1990, State Mental Health Authority Rules, 1990, National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999, The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Rules, 1996, The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994, Transplantation of Human Organs Act, 1994, Bio-Medical Waste (Management and Handling) Rules, 1998 and Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954 etc.

[131] Article 242 of the constitution provides that the legislature of a State may by law, endow the municipalities with such powers and authority as may be necessary to enable them to function as institutions of self government and provide with respect to the performance of functions and implementation of schemes as may be entrusted to them including those in relation to the matters listed in the Twelfth Schedule to the Constitution which include at item 6, 'Public health, sanitation conservancy and solid waste management'.

[132] Similar provision is made for the panchayats under Article 243-G read with the Eleventh Schedule (item 23), of the Constitution.

Accordingly, various municipal laws prescribe duties of such local authorities in the sphere of public health and sanitation which include establishment and maintenance of dispensaries, expansion of health services, regulating or abating harmful or dangerous trades or practices, providing supply of water, vaccination, cleansing public places and removing noxious substances, disposal of night soil and rubbish, providing special medical aid and accommodation for the sick in the time of dangerous diseases, taking measures to prevent the outbreak of diseases etc. Whenever there is failure of these statutory obligations of the local authorities, the citizens can approach the High Court under Article 226 of the Constitution for seeking a mandamus to get the duties enforced. There is, however, a significant difference between local government authorities and the State health authorities, the latter having enormous powers to make available financial resources and make key appointments. Healthy alliances between the two types of authorities are crucial, if health is to be effectively promoted.

1.4.2. Legislative Initiatives

In India, there has never been an attempt to legislate a comprehensive law covering the major aspects of health and healthcare. All the existing laws have been formulated in response to a specific situation or an issue. For instance, India has social security laws that protect health interests of a selected class of the workforce, like the Factories Act, the ESIS Act and Maternity Benefit Act; laws to deal with healthcare establishments like the Hospital and Clinical Establishment Registration Acts of different states; laws to deal with epidemics like the Epidemic Diseases Act, the Notifiable Disease Act and the various state Public Health Acts; laws to prevent quackery, professional misconduct and malpractice like the Medical Council of India Act, the Organ Transplantation Act; laws to assure quality like the Drugs and Cosmetics Act and the Prevention of Food Adulteration Act, the Blood Banks Act; laws to deal with negligence like COPRA, the MTP Act for abortion, the PCPNDT Act to prevent sex-selective discrimination; laws for environment health like the Prevention of Pollution Act, the Biological Diversity Act, the Hazardous Substances Act, laws for occupational health like the Workmen's Compensation Act, etc. Thus, legislation covers all dimensions of health and healthcare so that the issues and concerns of access, provision of adequate infrastructure, discrimination, negligence, malpractices, quackery,

healthcare systems, quality standards, occupational and environmental health problems, reproductive health issues, violation of rights, allocation of resources, professional conduct, rights of patients, and protection against epidemics etc. can be taken care of. The problem, however, with the existing legislation is that it is piecemeal and addresses its objectives without contextualizing them in the overall context of the human right to health.[133] Further, they deal with specific situations or for specific persons but do not have a generic applicability.

1.4.3. Health Plans and Policies on Right to Healthcare

The Indian Constitution provides a framework for a welfare and socialist pattern of development. Though, the development paradigm adopted by the political leadership and the state had a social dimension, it also supported private sector growth. For instance, while private pharmaceutical industry got subsidy and support for its growth, drug price control helped keep the prices on a leash. 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 non-justiciable. The latter comes under the domain of planned development, which the State steers through the Five Year Plans and other development policy initiatives.

1.4.3.1. *Five Year Plans*

Five Year Plans form an important portion of the planning process inIndia. These are formulated, executed and monitored by the Planning Commission of India, which is an institution in the Government of India, headed by the Prime Minister. For the Five Year Plans the health sector constituted schemes that had targets to be fulfilled. Each plan period had a number of schemes and every subsequent plan added more and dropped a few.

During the first two Five Year Plans the entire focus of the health sector in India was to manage epidemics.[134] Mass campaigns were started to eradicate

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[133] Ravi Duggal, "Towards Establishing the Right to Health and Healthcare" in Mihir Desai, Kamayani Bali Mahabal, *Health Care Case Law in India*, CEHAT (2007), p.174.

[134] See, First Five Year Plan, Planning Commission, Government of India, viewed 5th Dec 2013, http://planningcommission.nic.in/plans/planrel/fiveyr/1st/1planch32.html.; see also, Second Five Year Plan, Planning Commission, Government of India, viewed 5th Dec 2013, http://planningcommission.nic.in/plans/planrel/fiveyr/2nd/welcome.html.

various diseases. Countrywide campaigns with a techno-centric approach were launched against malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera. National programs were launched to eradicate communicable diseases. For instance, the National Malaria Eradication Programme (NMEP) was started in 1953 with aid from the Technical Cooperation Mission of U.S.A. and technical advice from W.H.O. These programmes however, depended on international agencies like UNICEF, WHO and the Rockefeller Foundation for supplies of necessary chemicals and vaccines. The policy with regard to communicable diseases was dictated by the imperialist powers as in the other sectors of the economy. Along with financial aid came political and ideological influence. Experts of various international agencies decided the entire policy framework, programme design, and allocation of financial resources. During the two plan periods urban areas continued to get over three-fourth of the medical care resources whereas rural areas received 'special attention' under the Community Development Program (CDP).[135] To evaluate the progress made in the first two plans and to draw up recommendations for the future path of development of health services the Mudaliar Committee was set up in 1959.[136] The report of the committee recorded that the disease control programmes had some substantial achievements in controlling certain virulent epidemic diseases. Deaths due to malaria, cholera, smallpox etc. were halved or sharply reduced and the overall morbidity and mortality rates had declined. According to the report the death rate had fallen to 21.6 per cent and birth rate had risen to 42 per cent for the period 1956-61.[137] However, the programmes launched to prevent tuberculosis did not achieve the desired result. The Mudaliar Committee further admitted that basic health facilities had not reached fully to the people living in rural areas and thus, half of the population in India is still deprived of basic health care. The primary health care (PHC) programme was not given the importance it should have been given right from the start of the planning process. Moreover, the cause of various diseases was social, i.e. inadequate nutrition, clothing, and housing, and the lack of

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135 Id.

136 Ravi Duggal, Health Planning in India, viewed 5th Dec 2013, http://www.cehat.org/go/uploads/Publications/ a168.pdf.

137 See generally, Report of The Health Survey and Planning Committee (1959-1961), viewed 7th Dec 2013, http://nihfw.org/NDC/DocumentationServices/Reports/Mudalier%20%20Vol.pdf.

a proper environment and unfortunately these basic issues were ignored.[138] The Centre, however, through the Planning Commission was investing more in preventive and promotional programs whereas the state governments focused its attention on curative care and thus it seemed that centre and state were not working hand in hand to achieve the said goal and this continues till this date.

The Third Five Year Plan[139] launched in 1961 discussed the problems affecting the provision of PHCs, and directed attention to the shortage of health personnel, delays in the construction of PHCs, buildings and staff quarters and inadequate training facilities for the different categories of staff required in the rural areas.[140] The Third Five Year Plan also highlighted the inadequacy of health care institutions, doctors and other personnel in rural areas as being the major shortcomings at the end of the second Five Year Plan. However, no mention was made of any specific steps to be taken to overcome these shortcomings. Only lip service was paid to the need for increasing auxiliary personnel but in the actual training and establishment of institutions for these people, inadequate funding became the constant obstacle. The Third Five Year Plan, however, was successful in the establishment of medical colleges, preventive and social medicine and psychiatric departments, completion of the All India Institute of Medical Sciences and in implementation of schemes for upgrading departments in Medical Colleges for post graduate training and research.[141] This plan also took effort in suggesting a realistic solution to the problem of insufficient doctors for rural areas and proposed that a new short term course for the training of medical assistants should be instituted. Assistants who had worked for five years at a PHC could complete their education to become doctors and continue in public service'.[142] However, the Medical Council and the doctors lobby opposed this and hence it was not taken up seriously during the plan period.

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138 Leena V Gangolli, Ravi Duggal, Abhay Shukla, *Review of Healthcare In India*, Centre for Enquiry into Health and Allied Themes (2005), viewed 5th Dec 2013, www.cehat.org.

139 Third Five Year Plan, Planning Commission, Government of India, viewed 5th Dec 2013, http://planningcommission.nic.in/plans/planrel/fiveyr/3rd/welcome.html.

140 Id.

141 Id.

142 Id.

The Fourth Plan continued on the same lines as the third plan.[143] It lamented on the poor progress made in the PHC programmes and recognized again the need to strengthen all primary health care centers. It pleaded for the establishment of effective machinery for speedy construction of buildings and improvement of the performance of PHCs by providing them with staff, equipment and other facilities. For the first time PHCs were given a separate allocation of funds. This plan for the first time identified that population growth is the central problem for slow growth rate in India and hence, family planning was given highest priority. A separate Department of Family Planning was constituted at the Centre and its job was to co-ordinate family planning programmes at the Centre and in the States. The facilities for IUCD insertions and sterilizations were provided not only free but also with compensation to the individuals for out-of-pocket expenses, conveyance and loss of wages. It was also during this period that water supply and sanitation was separated from medical care, and allocations were made separately under the sector of Housing and Regional development.

It was in the Fifth Plan[144] that the government ruefully acknowledged that despite advances in terms of the infant mortality rate going down and life expectancy going up, the number of medical institutions, functionaries, beds, health facilities etc, were still inadequate in the rural areas. Thus, the government acknowledged that the urban health structure had expanded at the cost of rural sectors.[145] The main objective of the Fifth Five Year Plan was to increase the accessibility of health services to rural areas through the Minimum Needs Programme (MNP) and correcting the regional imbalances; removal of deficiencies in district and sub-division hospitals; control and eradication of

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143 See generally, Fourth Five Year Plan, Planning Commission, Government of India, viewed 5th Dec 2013, http://planningcommission.nic.in/plans/planrel/fiveyr/4th/welcome.html.

144 Fifth Five Year Plan, Planning Commission, Government of India, New Delhi (1974-79), viewed 8th Dec 2013, http://planningcommission.nic.in/plans/planrel/fiveyr/5th/welcome.html.

145 This awareness is clearly reflected in the objectives of fifth Five Year Plan which were as follows: 1. increasing the accessibility of health services to rural areas through the Minimum Needs Programme (MNP) and correcting the regional imbalances. 2. Referral services to be developed further by removing deficiencies in district and sub-division hospitals. 3. Intensification of the control and eradication of communicable diseases. 4. Affecting quality improvement in the education and training of health personnel. 5. Development of referral services by providing specialists attention to common diseases in rural areas. This was envisaged through the MNP which would 'receive the highest priority and will be the first charge on the development outlays under the health sector.

communicable diseases; improving quality of education and training of health personnel and providing more specialists in rural areas. The plan further envisaged that the delivery of health care services would be through a new category of health personnel to be specially trained as multi-purpose health assistants. However, the infrastructure target still remained one PHC per CDP Block as in the First Five Year Plan. The Kartar Singh Committee appointed in 1973 recommended the conversion of uni-purpose workers, including auxiallary nursing widwifery (ANMs), into multi-purpose male and female workers. It recommended that each pair of such worker should serve a population of 10,000 to 12,000. Hence the multi-purpose worker (MPW) scheme was launched with the objective of training the existing cadre of vertical programme workers and the various vertical programmes were to be fully integrated into the primary health care package for rural areas.[146] Another major innovation in the health strategy was launched in 1977 by creating a cadre of village based health auxiliaries called community health workers. These were part time workers selected by a particular village, trained for three months in simple primitive and curative skills both in allopathic and indigenous systems of medicine. They were to be supervised by MPWs, and the programme was started in 777 selected PHCs where MPWs were already in place. This scheme, however, was adopted on the recommendations of the Srivastava Committee[147] which was essentially a committee to look into medical education and manpower support. The committee proposed to rectify the dearth of trained manpower in rural areas. The main recommendation of the committee was to have part-time health personnel selected by the community from within the community. They would act as a link between the MPW at the sub-centers and the community. With regard to medical education the committee cried for a halt to opening of new medical colleges. The committee emphasized that there was no point in thinking that doctors would willingly go to rural areas because there were a number of socio-economic

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146 Kartar Singh Committee Report on Multipurpose Worker under Health and Family Planning, MoHFW, New Delhi(1973), viewed 8th Dec 2013, http://nihfw.org/NDC/DocumentationServices/Reports/Kartar%20Singh%20Committee%20Report.pdf.

147 See generally, Srivastava Committee Report on Health Services and Medical Education, MoHFW, New Delhi (1975), http://nihfw.org/NDC/DocumentationServices/Reports/Srivastava%20Committee%20Report.pdf.

dimensions to this issue. Thus, their option for rural areas was the Community Health Worker (CHW) scheme.[148] This attitude was clearly supportive of the historical paradigm that rural and urban areas had different health care needs that, urban populations need curative care and rural populations preventive. The suggestions by the committee is discriminatory since inherent in this paradigm is deprivation for the rural masses. The committee pointed out that the over-emphasis on provision of health services through professional staff under State control has been counterproductive. As thrust on professionals by State is devaluing and destroying the old traditions of part-time semi-professional workers, which the community used to train and proposed that with certain modifications they too can continue to provide the foundation for the development of a national programme of health services in our country. This is also essential as the new professional services provided under State control are inadequate in quantity and unsatisfactory in quality. This very direct statement from the committee that was set up to review medical education and its related components assumes significance because it showed that the investment on health care had not been reaching the people. It must be mentioned here that in 1967 the Jain Committee report[149] on Medical Care Services too had made an attempt to devolve medical care by recommending strengthening of such care at the PHC and block or taluk level as well as further strengthening district hospital facilities.[150] The Jain Committee also suggested integration of medical and health services at the district level with both responsibilities being vested in the Civil Surgeon and Chief Medical Officer.[151] But recommendations of this Committee, which is the only committee since Independence to look at medical care and also for the first time reported on strengthening curative services in rural areas, were not considered seriously.

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148 Community health workers (CHW) are members of a community who are chosen by community members or organizations to provide basic health and medical care to their respective community.

149 See, Ravi Duggal, Health Planning in India, viewed 5th Dec 2013, http://www.cehat.org/go/uploads/Publicatons/a168.pdf.

150 Id.

151 Id.

The Sixth Plan was to a great extent influenced by the Alma Ata Declaration of Health for All by 2000.[152] The plan conceded that 'there is a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and super specialization and highly trained doctors which is availed of mostly by the well to do classes. It also realized that it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services'.[153] The plan emphasized the development of a community based health system. The strategies advocated were for providing health services to the rural areas on a priority basis; training of large number of first level health workers selected from the community and supervised by MPWs and medical officers of the PHCs; expansion of curative facilities in urban areas would be permitted only in exceptional cases dictated by need or priority. The plan stressed that horizontal and vertical linkages had to be established among all the interrelated programmes, like water supply, environmental sanitation, hygiene, nutrition, education, and family planning. This plan like the earlier ones made lot of radical statements and recommended progressive measures. No concrete action was taken to implement the suggested schemes. Whatever new schemes were introduced the core of the existing framework and ideology remained untouched. The National Health Policy (NHP) of 1983 was announced during the Sixth plan period.

The Seventh Five Year Plan recommended that 'development of specialties and super specialties need to be pursued with proper attention to regional distribution'[154] and such 'development of specialties and training in super specialties would be encouraged in the public and the private sectors'.[155] The plan also talked of improvement and further support for urban health services, biotechnology and medical electronics, and support for population control. The plan also called for special attention to AIDS, cancer, and coronary

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152 See, Sixth Five Year Plan, Planning Commission, Government of India, New Delhi, (1980-85), viewed 8th Dec 2013, http://planningcommission.nic.in/plans/planrel/fiveyr/6th/welcome.html.

153 Id.

154 See, Seventh Five Year Plan, *Sectoral Programmes of Development*, Planning Commission, Vol. II, Government of India, New Delhi (1985-90).

155 Id.

heart diseases.[156] This plan period witnessed boom of diagnostic industry and corporate hospitals.

The Sixth and the Seventh plans were different from the earlier plans in one respect. They no longer talked of targets. Both the Plans argued that the success of the plan depends crucially on efficiency, quality and texture of implementation and the means to realize them was privatization of the health sector. However, various studies carried out to analyze the success of the plan period has observed that, though the infrastructure was in place in most areas, they were grossly underutilized because of poor facilities, inadequate supplies, poor managerial skills of doctors, faulty planning of health programs and lack of proper monitoring and evaluatory mechanisms. Further, the system based on the 'health team concept' failed to work because of the mismatch of training and the work allocated to health workers, inadequate transport facilities, non availability of appropriate accommodation for the health team and an unbalanced distribution of work-time for various activities.

On the eve of the Eighth Five Year Plan[157] the country went through a massive economic crisis. The Plan got pushed forward by two years. In fact, keeping with the selective health care approach the eighth plan adopted a new slogan – instead of 'Health for All by 2000 AD' it chose to emphasize 'Health for the Underprivileged'. This plan mainly supported privatization of hospitals and clinics and also gave emphasis on maintenance of minimum standards and suitable returns for the tax incentives.[158] During the Eighth Plan resources were provided to set up Education Commission for Health Sciences, and a few states even set up the University for Health Sciences as per the recommendations of the Bajaj Committee report of 1987. The initiative was to bring all health sciences together, provision for continuing medical education and improvement of medical and health education through such integration. During the Eighth Plan period a committee to review public health was also set up. It was called the Expert Committee on Public Health Systems. This committee made a thorough appraisal of public health

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156 Id.

157 Eighth Five Year Plan, Vol II, Planning Commission, Government of India (1992), http://planningcommission.nic.in/plans/planrel/fiveyr/8th/default.htm.

158 Id.

programs and found that India was facing a resurgence of most communicable diseases and there was need to drastically improve disease surveillance in the country. In fact, the recommendations of this committee formed the basis of the Ninth Plan health sector strategy to revitalize the public health system in the country to respond to its health care needs in these changed times.

The Ninth Five Year Plan[159] by contrast provides a good review of all programs and has made an effort to strategize on achievements attained in the previous plan periods and learn from them in order to move forward. It was refreshing to note that reference was made of Bhore Committee report and an effort was made to contextualize the present scenario in the recommendations that the Bhore Committee had made. In its analysis of health infrastructure and human resources the Ninth Plan suggested the consolidation of PHCs and Sub centres (SCs) and recommended this as an important goal under the Basic Minimum Services program. Given that it is difficult to find physicians to work in PHCs and CHCs the Plan suggested creating part-time positions which can be offered to local qualified private practitioners or offer the PHC and CHC premises for after office hours practice against a rent. It also suggested placing mechanisms to strengthen referral services and evolved State specific strategies because each State were at different levels of development and have different health care needs. The Ninth Plan has also shown concern for urban health care. It also noted the absence of primary health care and complete reliance on secondary and tertiary services even for minor ailments and thus suggested for provision of primary health care services, especially in slums, and providing referral linkages at higher levels. Critical of the poor quality of data management, the Plan recommended drastic changes to develop district level databases so that more relevant planning is possible in future. The Ninth Plan proposed to set up at district level a strong detection cum response system for rapid containment of any outbreaks that may occur. The Plan had also proposed horizontal integration of all vertical programs at district level to increase their effectiveness and to facilitate allocation of resources. It reviewed the population policy and the family planning program. The Ninth Plan

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[159] Ninth Five Year Plan, Planning Commission of India, Government of India (1997), viewed 5th Dec, 2013, http://planningcommission.nic.in/plans/planrel/fiveyr/9th/vol2/v2a7-1.htm.

had also made provisions to speed up the proposals put forth in Bajaj Committee. It also reviewed the 1983 National Health Policy in the context of its objectives and goals and concludes that a reappraisal and reformulation of the NHP is necessary so that a reliable and relevant policy framework is available for not only improving health care but also measuring and monitoring the health care delivery systems and health status of the population in the following two decades. Taking a lead from the Ninth Plan, the Ministry of Health and Family Welfare took up the task of formulating a new health policy.

Thus, on the eve of the Tenth Plan[160], the Draft National Health Policy 2001 was announced and for the first time feedback was invited from the public. The approach paper to the tenth Five-year Plan maintained the continuum from the ninth Plan. It laid emphasis on reorganization and restructuring of existing health care infrastructure, including the infrastructure for delivering ISM&H services, at primary, secondary and tertiary care levels, so that they have the responsibility of serving population residing in a well defined geographical area and have appropriate referral linkages with each other. The powers were delegated to Panchayati Raj Institutions (PRIs) so that there is local accountability of the public health care providers, and problems relating to poor performance could be sorted out locally.[161] The Plan recognized the need for horizontal integration of all aspects of the current vertical disease control programmes including supplies, monitoring, IEC, training and administrative arrangements; so that they become an integral part of health care; in order to facilitate this the States were to speedily implement the recommendation regarding horizontal integration of ongoing vertical programmes, including the suggestion that there should be a single health and family welfare society at state and district levels.[162] The plan also gave suggestion for appropriate orientation and skill upgradation through continuing medical education (CME) programmes, mainstreamed and utilized in improving access to health care coverage under the national programmes for the practitioners in Indian Systems of Medicine and Homeopathy in the country. Data from National Sample Survey

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[160] See, generally, Tenth Five Year Plan, Vol.II, Planning Commission, Government of India (2002-2007), viewed 6thDecember 2013, http://planningcommission.nic.in/ plans/planrel/ fiveyr/10th/10defaultchap.htm.

[161] para 3.67.

[162] para 3.68.

Organization (NSSO) indicated that escalating health care costs is one of the reasons for indebtedness not only among the poor but also in the middle-income group. Thus, there was a proposal for choosing appropriate mechanisms by which cost of severe illness and hospitalization can be borne by individual or organization or State.[163]

The Eleventh Five Year Plan[164] provided an opportunity to restructure policies to achieve a New Vision based on faster, broad-based, and inclusive growth.[165] The objective of the Eleventh Five Year Plan was to achieve good health for people, especially the poor and the underprivileged.[166] In order to achieve this, the plan proposed to have a comprehensive approach encompassing individual health care, public health, sanitation, clean drinking water, access to food, and knowledge of hygiene, and feeding practices.[167] The Plan also facilitated convergence and development of public health systems and services that are responsive to health needs and aspirations of people. Thrust was also given on reducing disparities in health across regions and communities by ensuring access to affordable health care.[168] The Eleventh Five Year Plan gave special attention to the health of marginalized groups like adolescent girls, women of all ages, children below the age of three, older persons, disabled, and primitive tribal groups. It viewed gender as the cross-cutting theme across all schemes.[169] To achieve all the objectives laid down in the plan, aggregate spending on health by the Centre and the States was increased significantly to strengthen the capacity of the public health system to do a better job.[170] Also large share of resources was allocated for health programmes in critical areas such as HIV/AIDS. The contribution of the private sector in providing primary, secondary, and tertiary services was enhanced

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163 Approach Paper To The Tenth Five Year Plan (2002-2007), Planning Commission Government Of India, New Delhi, 1st September, 2001, viewed 25th December, http://planningcommission.gov.in/plans/planrel/appdraft.pdf.

164 See generally, Eleventh Five Year Plan (2007-12), Social Sector, Volume II, Planning Commission, Government of India, Oxford University, New Delhi (2008).

165 See, Eleventh Five Year Plan(2007-12), Social Sector, Volume II, Planning Commission, Government of India, Oxford University, New Delhi (2008), para 3.1.6.

166 Id.

167 Id.

168 Id.

169 Id. para, 3.1.7.

170 Id. para, 3.1.8.

through various measures including partnership with the government.[171] The important time-bound Goals for the Eleventh Five Year Plan was reduction in Maternal Mortality Ratio (MMR) to 1 per 1000 live births; reduction in Infant Mortality Rate (IMR) to 28 per 1000 live births; reduction in Total Fertility Rate (TFR) to 2.1; provision for clean drinking water for all by 2009 and ensuring no slip-backs; reducing malnutrition among children of age group 0–3; reducing anemia among women and girls by 50%; raising sex ratio for age group 0–6 to 935 by 2011–12 and 950 by 2016–17. During this plan period National Rural Health Mission was launched by the Central Government. A review of the health outcome of the Eleventh Plan and of NRHM is constrained by lack of end-line data on most indicators. Analysis of available data reveals that though there has been progress, except on child-sex ratio, the goals have not been fully met. Despite Central efforts through the flagship of NRHM, wide disparity in attainments across States outlines the need for contextual strategies.

The enormity of the challenge in health was realized when the Eleventh Plan was formulated and an effort was made to increase Central Plan expenditures on health. The increase in Central expenditures has not been fully matched by a comparable increase in State Government expenditures. Therefore, the Twelfth Plan proposes to take corrective action by incentivizing States. As an input into formulating the Twelfth Plan strategy, the Government has relied on the High Level Expert Group (HLEG) set up by the Planning Commission to define a comprehensive strategy for health for the Twelfth Five Year Plan.[172] Based on the HLEG report and after extensive consultations within and outside the Government, as well as a close review of the actual performance of the sector during the Eleventh Plan period, a new strategy for health is being spelt out in the Twelfth Plan towards rolling out Universal Health Coverage, a process that will span several years. The Twelfth Plan faces a colossal task of putting in place a basic architecture for health security for the nation. It must build on what has been achieved through the NRHM and expand it into a comprehensive NHM. Since the

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171 Id.

172 Faster, Sustainable and More Inclusive Growth, An Approach to the Twelfth Five Year Plan, Planning Commission, Government of India, October 2011, viewed, 6th December 2013, www.planningcommission.nic.in.

primary responsibility for health care rests with the States, the strategy needs to effectively incentivize State Governments to do what is needed to improve the public health care system while regulating the private health care system, so that together they can work towards addressing the management of delivery of preventive, promotive and curative health interventions. This is not a task that can be completed within one Plan period. It will certainly span two or three Plan periods, to put the basic health infrastructure in place.

When we consider the fact that even after sixty years of planning three-fourth of the population still lives at the subsistence level or below it, and industrial development has reached a level that has generated employment in the organized sector for only about ten per cent of the work-force[173], it becomes clear that the bulk of planning has not benefited the vast majority in any significant way. While planning contributed substantially in the development of the economic infrastructure, by contrast the contribution of the five-year plans to the social sectors is abysmally poor; less than one fifth of the plan resources have been invested in this sector.[174]Health, water supply and education are the three main sub-sectors under social services. Health care facilities are far below any acceptable human standard. We have not even reached half the level in provision of health care that most developed countries had reached between the two world wars. Curative health care services in the country are mostly provided by the private sector to the extent of two-thirds and preventive and promotive services are almost entirely provided by the State sector. Planning should have given an equal emphasis to social services, especially health, water supply and sanitation, education and housing which are important equalizing factors in modern society. These four sub-sectors should have received at least half of the resources of the plans over the years. Only that could have assured achievement of the goals set forth in the Directive Principles. From the above discussion it is evident that the Five year plans to which large resources were committed has not helped uplift the masses from their general misery, including the provision of health care

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173 Id.

174 Id.

1.4.3.2. *National Policies*

A policy document is essentially the expression of ideas of those governing to establish what they perceive is the will of the people. These may not necessarily coincide for various reasons and influences that impinge upon both the rulers and the ruled. Implementing a policy, especially if it seeks to significantly change the status quo, necessarily requires a political will. Whether the political will is expressed through action depends on both the electorate and the social concerns of those occupying political office. A health policy is thus the expression of what the health care system should be so that it can meet the health care needs of the people.

It took thirty-five years after Independence for the government to make a health policy statement in 1982-83. But this does not mean that India did not have a health policy in all these years. There was a distinct policy and strategy for the health sector, albeit an unwritten one. This was reflected through the Five Year Plans of the Central government, this despite the fact that health is a State subject. At the State level, however, there is no evidence of any policy initiatives in the health sector. The Central government through the Council of Health and Family Welfare and various recommendations of Committee has shaped health policy and planning in India.

The most comprehensive health policy ever prepared in India was on the eve of Independence in 1946. This was the 'Health Survey and Development Committee Report' popularly referred to as the Bhore Committee.[175] The terms of reference of this committee, were to carry out a broad survey of the position in regard to health conditions and health organization in British India, and recommendations for future development. This Committee prepared a detailed plan of a National Health Service for the country, which would provide a universal coverage to the entire population free of charge through a State run health service. The report laid emphasis on social orientation of medical practice and high level of

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[175] See, Report of The Health Survey and Planning Committee, Vol.1, Aug 1959-Oct 1961, Govt. of India Ministry of Health, viewed 7th June 2013, http://nihfw.org/NDC/DocumentationServices/Reports/Mudalier%20%20Vol.pdf. In 1943, in the midst of World War II and in succession to the Quit-India movement the Government of India (Central Government of British India Provinces) announced the appointment of the Health Survey and Development Committee under the chairmanship of Sir Joseph Bhore. This committee is popularly referred to as Bhore Committee.

public participation.[176] The salient recommendations of Bhore Committee are integration of preventive and curative services at all administrative levels; Primary Health Centres for 40,000 population as short term goal; Primary Health Centres with 75 beds for each 10,000-20,000 population as long term goal; formation of Village Health Committee; provision of Social Doctor; inter-sectoral approach to health services development; three months' training in preventive and social medicine to prepare social physicians.[177] The Bhore Committee further recognized the vast urban- rural disparities in the existing health services and hence based its plan with specifically the rural population in mind. It recognized the merits of Primary Health Care Approach. Thus, the importance of primary health care was recognized by India three decades before the Alma Ata declaration.[178]

The responsibility of the State to provide comprehensive primary health care to its people as envisioned by the Alma Ata Declaration led to the formulation of India's first National Health Policy in 1983.[179] The National Health Policy (NHP) recommends 'universal, comprehensive primary health care services which are relevant to the actual needs and priorities of the community at a cost which people can afford'.[180] The policy emphasized the role that could be played by private and voluntary organizations working in the country to support government for integration of health services. Providing universal health care as a goal is a welcome step because this is the first time after the Bhore Committee that the government is talking of universal comprehensive health care. The salient features of the 1983 health policy were[181]:

- It was critical of the curative-oriented western model of health care,
- It emphasized a preventive, promotive and rehabilitative primary health care approach,

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176 Id.

177 Id.

178 India is a signatory of the Alma Ata declaration. This further emphasized Government of India's commitment to provide health for all of its citizens.

179 Prior to that health activity of the state were formulated through the Five Year Plans and recommendations of various Committees. The first five year plan launched Community Development Programme for the all-round development of rural areas.

180 National Health Policy, Government of India, Ministry of Health & Family Welfare, New Delhi(1983),viewed7th Dec2013, http://www.communityhealth.in/~commun26/wiki/images/6/64/Nhp_1983.pdf.

181 Id.

- It recommended a decentralized system of health care, the key features of which were low cost, deprofessionalisation (use of volunteers and paramedics), and community participation,
- It called for an expansion of the private curative sector which would help reduce the government's burden,
- It recommended the establishment of a nationwide network of epidemiological stations that would facilitate the integration of various health interventions, and
- It set up targets for achievement that were primarily demographic in nature.

During the decade following the 1983 NHP rural health care received special attention and a massive program of expansion of primary health care facilities was undertaken in the Sixth and Seventh Five Year Plans to achieve the target of one PHC per 30,000 populations and one sub centre per 5000 population.[182] This target has more or less been achieved, though few States still lag behind. However, various studies looking into rural primary health care have observed that, though the infrastructure is in place in most areas, they are grossly underutilized because of poor facilities, inadequate supplies, insufficient effective person-hours, poor managerial skills of doctors, faulty planning of the mix of health programs and lack of proper monitoring and evaluatory mechanisms.[183] Further, the system being based on the health team concept failed to work because of the mismatch of training and the work allocated to health workers, inadequate transport facilities, non-availability of appropriate accommodation for the health team and an unbalanced distribution of work-time for various activities. In fact, many studies have observed that family planning, and more recently immunization, gets a disproportionately large share of the health workers' effective work-time. Among the other tasks listed by the 1983 health policy, decentralization and deprofessionalization have taken place in a limited context but there has been no community participation. This is because the model of primary health care being implemented in the rural areas was not acceptable to the people as evidenced by their

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182 Id.

183 See, Ravi Duggal, *Health Planning In India*, viewed 5th Dec 2013, p. 19, http://www.cehat.org/go/uploads/Publications/a168.pdf.

health care seeking behaviour. The rural population continues to use private care and whenever they use public facilities for primary care it is the urban hospital they prefer.[184] The above analysis clearly indicates that the NHP 1983 did not reflect the ground realities adequately. The tasks enunciated in the policy were not sufficient to meet the demands of the masses, especially those residing in rural areas.

The National Population Policy was announced in the year 2000.[185] The immediate objective of NPP was to address the unmet needs of contraception, health care infrastructure, and health personnel, and to provide integrated delivery for basic reproductive and child care services.[186] It envisaged development of one-stop integrated and coordinated service delivery at the village level for basic reproductive and child health services through a partnership of the government with voluntary and non-governmental organizations.[187] It is definitely an improvement from its predecessors but the underlying element remains population control and not population welfare.

Twenty years after the first health policy, the second NHP (2002) was presented.[188] The NHP sets out a new policy framework to achieve public health goals in the socio-economic circumstances prevailing in the country. The approach aims at increasing access to the decentralized public health system by establishing new infrastructure in deficient areas and upgrading the infrastructure of existing institutions. It sets out an increased sectoral share of allocation out of total health spending to primary health care. The draft document realizes that the greatest impediment in achieving the set goals of NHP 1983 were factors outside the formal healthcare delivery system such as the fiscal crisis.[189] It also expresses its concern over wide variations in health indices across regions as even in better performing states the overall indicators

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184 Id.p.18.

185 See, National Population Policy, viewed 3rd July 2013, http://india.unfpa.org/drive/NationalPopulation Policy2000.pdf.

186 Id.

187 Id.

188 The NHP 2002 recognized the noteworthy successes in health sector since the enunciation of the first NHP in 1983. These successes include eradication of small pox and guinea worm, the near eradication of polio, and progress towards the elimination of leprosy and neonatal tetanus.

189 V. Mohanan Nair, "Draft National Health Policy 2001: A leap forward in assessment but limping in strategies", 15 *The National Medical Journal of India* 215 (2002), p.216.

mask the reality of differentials across regions.[190] The equity considerations which the policy emphasizes are also relevant in the current context as the inequitable distribution of services has worked to the disadvantage of the poor and still worse is the case of women, children and marginalized sections such as coastal, tribal and migrant populations.[191] The policy recommends an increase in public health expenditure from the present 0.9% of GDP to 2% in 2010.[192] The document is vague about the actual devolution of responsibility and financial powers to Panchayati Raj Institutions (PRIs) and relocation of accountability to appropriate levels of local self-governments.[193] In the absence of such clarity there is danger of the primary healthcare system becoming a collector-driven exercise, which is controlled by the Centre, thereby defeating the entire effort at decentralization.[194] The policy talks about using Indian health facilities to attract patients from other countries. It also suggests that such incomes can be termed 'deemed export' and should be exempt from taxes. The policy also talks of encouraging the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages. Further, the document refers to the valuable contributions made by the private sector and the need to encourage more such contributions. While it is often critical of the public health system, there is no criticism of the ills of the unregulated private medical care system, though reference is made to the need to develop regulatory norms. The NHP 2002, however, needs to be lauded for its concern for regulating the private health sector through statutory licensing and monitoring of minimum standards by creating a regulatory mechanism. Many prescriptions of the policy favour strengthening of the private health sector. Hence, NHP 2001 is a dilution of the role of public health services envisaged in the earlier policy and is unabashedly promoting the private health sector.

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190 Id.

191 Id.

192 Amit Sen Gupta, "National Health Policy 2002: A brief critique", 15 *The National Medical Journal Of India* 215 (2002).

193 Id.

194 Id.

In 2005, the Government of India launched the National Rural Health Mission, with the goal of improving the availability of and access to quality healthcare by people, particularly in rural areas.[195] NRHM is visualized as an architectural correction of the Indian public health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country. This scheme brought with it an influx of government funds that were aimed at increasing the outlays for public health from 0·9% of gross domestic product in 2005 to 2–3% by 2012.[196] The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care, especially to the poor and vulnerable sections of the community.[197] The National Rural Health Mission also aims to revitalize the public sector in health by increasing funding, integration of vertical health and family welfare programmes, employment of female accredited social health activists in every village, decentralized health planning, community involvement in health services, strengthening of rural hospitals, providing untied funds to health facilities, and mainstreaming traditional systems of medicine into the public health system.[198] The National Rural Health Mission is the most ambitious public health programme in India's history, with several unique components that distinguish it from previous national programmes; most notable is that it is centrally financed but implemented in the districts. It covers the entire country, with special focus on eighteen states that have fairly poor infrastructure and demographic indicators.[199] The plan of action of the Mission aims at reducing regional imbalances in health outcomes by relating health to determinants of good health viz. sanitation, nutrition and safe drinking water, pooling resources, integration of organizational structures, optimization of health manpower, including Ayurveda, Unani, Siddha and Homeopathy (AYUSH), decentralization and district management of health program akin to Sarva Shiksha Abhiyan, community participation and ownership of assets, induction of management and finance personnel into the district health system, and

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195 See, National Rural Health Mission, viewed 3rd July 2013, http://nrhm.gov.in/.
196 Id.
197 Id.
198 Id.
199 Id.

operationalizing effective referral hospital care at CHC level as per the Indian Public Health Standards in each block of the country.[200] While NRHM, launched in 2006, has had some success in improving access to certain services, such as maternal healthcare under the Janani Suraksha Yojana program[201], it is not clear what effects NRHM has had on most other services. Moreover, the lack of community ownership of public health programs inhibits levels of accountability.

From the above analysis of plans and policies, it can be inferred that during the post independence period significant effort was made in India for improving the health status of population. However, the current levels of effort and resource allocation are not sufficient to meet the future needs of the people. The higher incidence of chronic diseases like AIDS, Hepatitis B and diabetes, and the problems due to new drug resistance for diseases like tuberculosis and malaria adds a new dimension to current health problems. Although provision for healthcare services requires adequate government funding, the degree of government involvement is still relatively limited. Under the present system, India spends 6% of her GDP on health care annually.[202] While the private households pay 75% of this total health expenditure, the public sector (central and state governments) contributes 22%, which amounts to only 13% of GDP.[203] Out of this meager amount, the share of central government is only 10%.[204] Also one has to acknowledge that the neglect of public health sector is an issue larger than government policy making and planning. The latter is the function of the overall political economy. Given the backwardness in India the demand of public resources for the productive sectors of the economy which

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200 Prasanna Hota, "National Rural Health Mission", 73 *Indian Journal of Pediatrics* 193 (2006).

201 The Janani Suraksha Yojana launched in 2005 encourages women to deliver in government health facilities or accredited private facilities by providing financial incentives. This conditional cash transfer scheme has the largest number of beneficiaries for any such programme in the world, estimated to be 9·5 million women giving birth in 2010. This scheme is complemented by a public-partnership programme, initially started as the Chiranjeevi Yojana in Gujarat and now being tested in other states in which private obstetricians are paid to assist women who are poor with their deliveries. Another complementary programme is the Muthulakshmi Scheme in Tamil Nadu that provides financial support before and after the delivery period. Assessments of Janani Suraksha Yojana and Chiranjeevi Yojana have suggested beneficial outcomes and ideas for improvements.

202 Economic Survey 2013: India's healthcare spends among the lowest, *Health*, February 28, 2013, viewed 25th Dec 2013, http://health.india.com/news/economic-survery-2013-indias-healthcare-spends-among-the-lowest/.

203 Id.

204 Id.

directly benefit capital accumulation, is more important from the business perspective than the social sectors, hence the latter, get only a residual attention from the State. Thus, the solution for satisfying the health needs of the people does not lie in the health policies and plans alone but it is also a question of structural changes in the political economy that can facilitate implementation of progressive health policies.[205]

1.4.4. Right to Health and Healthcare: Judicial Perspective

When we look at right to health and healthcare in the legal and constitutional framework, it is clearly evident that the Constitution and laws of the land do not in any way accord health and healthcare the status of a right. Though right to health has not been expressly incorporated in the Constitution as a fundamental right, over the years it has acquired fundamental right status through innovative judicial interpretation of Art.21 of the Constitution[206] and also various Directive Principles of State Policy. Scope for such an interpretation has been created by the dictum in *Maneka Gandhi* v *Union of India*[207] wherein, while interpreting Article 21 the Supreme Court held that the right to live is not merely confined to physical existence but it includes within its ambit the right to live with human dignity. Accordingly, the State is mandated to provide to a person all rights essential for the enjoyment of the right to life in its various perspectives. Consequently, the right to health and access to medical treatment has been brought within the fold of Article 21. Similarly, in *Francis Coralie Mullin* v *Union Territory of Delhi*[208], the Court interpreted the right to life under Art.21 expansively. It held that the right to life 'includes the right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter... Every act which offends against or impairs human dignity would

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[205] Ravi Duggal, *Health Planning in India*, CEHAT (2001), p.24, Viewed 25th Dec 2013, www.cehat.org/go/uploads/Publications/a168.pdf.

[206] Article 21 provides that, 'no person shall be deprived of his life or personal liberty except according to procedure established by law'.

[207] AIR (1978) SC 597.

[208] (1981) 2 S.C.R. 516. The issue presented in the case was whether detainees in police custody had the constitutional right to consult with a lawyer under Article 21. The Court found that the right to life does indeed include furnishing legal counsel for detainees.

constitute deprivation *pro tanto* of this right to live....'[209] While dealing with the substantive content of the right to life, the Court found that the right to live with human dignity includes the right to good health. [210] In *Consumer Education and Research Centre* v *Union of India*[211], the Court explicitly held that 'the right to health ... is an integral part of a meaningful right to life'. In *Akhila Bharatiya Soshit Karamchari Sangh* v *Union of India*[212], the Supreme Court pointed out that fundamental rights are intended to foster the ideal of a political democracy and to prevent the establishment of authoritarian rule, but they are of no value unless they can be enforced by resort to courts. The directive principles cannot, in the very nature of things be enforced in a court of law, but it does not mean that directive principles are less important than fundamental rights or that they are not binding on the various organs of the State. In a series of subsequent cases, the Court held that it is the obligation of the State to ensure the creation of conditions necessary for good health, including provisions for basic curative and preventive health services and the assurance of healthy living and working conditions. Some of the important decisions of the court have been examined below.

1.4.4.1. *Right to Emergency Medical Care*

In *Parmanand Katara* v *Union of India*[213], the Court addressed the availability of access to curative health services. The issue presented to the Court was whether injured citizens have a constitutional right to instantaneous medical treatment for emergencies under Article 21. The Court held that Article

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209 Id. p.529.

210 *Bandhua Mukti Morcha* v *Union of India,* A.I.R. 1984 S.C. 802, 812. The Court found that protection of health and opportunities for healthy development are among the minimum requirements which must exist in order to enable a person to live with human dignity.

211 *Consumer Education and Research Centre* v *Union of India,* India (1995)3 SCC 42. The case dealt with workers' rights to health and medical aid in the asbestos industries, and the necessity of caring for the health of workers in hazardous occupations.

212 AIR 1989 SC 2039.

213 *Parmanand Katara* v *Union of India,* A.I.R. 1989 S.C. 2039. The case concerned the availability of emergency medical treatment for a seriously injured man at a local hospital. The hospital doctors refused to provide the man with emergency aid and sent him to another hospital twenty kilometers away. The injured man died en route to the other hospital. The Court found that it was essential to the preservation of life that doctors provide medical services to individuals in need. The Court required the state to remove legal impediments imposed on doctors and hospitals for providing emergency medical aid.

21 of the Constitution casts an obligation on the state to take every measure to preserve life.

1.4.4.2. *Right to Life includes Right to Health*

In *Paschim Banga Khet Mazdoor Samity* v *State of West Bengal*[214], the Court addressed the adequacy and availability of medical treatment for individuals in need of medical assistance. The issue presented to the Court was whether the lack of adequate medical facilities for emergency treatment constituted a denial of the fundamental right to life. The Court found that it is the primary duty of a welfare State to ensure that medical facilities are adequate and available to provide treatment. The Government hospitals run by the State are duty bound to extend medical assistance for preserving human life. Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21.

1.4.4.3. *Right to Quality care*

In *State of Punjab* v *Ram Lubhaya Bagga*[215], the Supreme Court observed that Government hospitals and health centers should be easily accessible to all

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[214] 1996 4 SCC 37. In this case, a man fell from a train and suffered serious head trauma. He was brought to a number of state hospitals, including both primary health centers and specialist clinics, for treatment of his injuries. Seven state hospitals were unable to provide emergency treatment for his injuries because of a lack of bed space and trauma and neurological services. The Court required the state to ensure that primary health centers are equipped to provide immediate stabilizing treatment for serious injuries and emergencies. The court has also addressed the importance of providing preventive health services to the Indian population.
See also, *Mahendra Pratap Singh* v *State of Orissa*, A.I.R. 1997 Ori. 37, 37. This case concerned the failure of a local government to take steps to immediately open a village primary health care center. Individuals in the community petitioned the High Court of Orissa for a writ commanding the state government to take appropriate measures to open the health center. The High Court began its judgement by re-emphasizing the central importance of health to a meaningful existence. The court ordered the government to open a primary health center in the village within three months of the ruling.
In *Prayag Vyapar Mandal* v *State of Uttar Pradesh* A.I.R. 1997 All. 1. The case concerned an individual petition to prohibit the construction of a pharmacy inside the hospital for the provision of medicine for in-patients; the Allahabad High Court also recognized the importance of providing pharmaceutical services to hospital patients. In this case, the court held that providing patients with access to medicine at night and at reasonable prices was worthy of protection.

[215] 1996 (2) SCC 336. An employee of the Punjab government, received emergency treatment from the Escorts Heart Institute and Research Center after suffering a heart attack. He sought reimbursement for medical costs from the State of Punjab. The Respondent sought full reimbursement of medical expenses The Policy stipulated that medical cost reimbursement would occur at a rate determined by the Director, Health and Family Welfare, Punjab, on the advice of an expert committee. The issue concerned whether the Policy was fair and reasonable, and whether only reimbursing a portion of medical expenses constituted a breach of Articles 21and 47. The Court held that as states did not have unlimited financial resources it was permissible for the state to put in place scales and rates

sections of the people and they should be of good quality. The State should allocate sufficient funds for this purpose. The State can never disown its responsibility to provide medical facilities, as it would be a violation of Article 21.

1.4.4.4. *Right of Workers to Health and Healthcare*

In *Bandhua Mukti Morcha* v *Union of India*[216], the Court began to address the types of social conditions or living conditions necessary for enjoyment of health. The issue presented in the case was whether the workers at stone quarries were deprived of their right to life because of inhumane living and working conditions. It was held that state actors must provide the basic conditions necessary for the enjoyment of health in order to guarantee the right to live with human dignity. Therefore, the State was required to provide workers with clean drinking water, sanitation facilities, and medical facilities to protect their health. In *CESE Ltd* v *Subash Chandra Bose*,[217] the Court held that the health and strength of a worker is an integral facet of the right to life. Similarly in *CERC* v *Union of India*[218], the Court ruled that the right to health and medical care, to protect health and vigour, while in service or after retirement, is the fundamental right of a worker. The State, be it the Union or the State Government or an industry, public or private, is enjoined to take all such action that will promote health, strength and vigour of the workman during the period of employment and leisure, and health even after retirement, as basic essentials to live life with health and happiness. Denial thereof denudes the workman the finer facets of life violating Article 21.

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[216] A.I.R. 1984 S.C. 802. See also, *Citizen & Inhabitants of Municipal Ward No. 15, Gwalior* v *Municipal Corporation, Gwalior*,A.I.R. 1997 Mad. Pra. 33, 37. Lack of sanitation and drainage facilities in the district was posing health and safety risk to district occupants. The High Court of Madhya Pradesh held that a fundamental obligation of municipalities was to ensure proper living conditions. Hence, the court held that the municipality must take steps to provide for the development of adequate drainage and sewer systems.
See also, *Puttappa Honnaypa Talavar* v *Deputy Commissioner*, A.I.R. 1998 Karn. 10, 11. The case concerned the right of individuals to dig underground borewells for water. The High Court of Karnataka has also held that the right to life includes access to clean drinking water.
In *Sanjay Phophaliya* v *State of Rajasthan*, AIR 1998 Raj 96, the Court discussed the problem posed by stray animals living on the streets who were a nuisance to the public. The Court found that these animals interfered with public transportation, presented a health hazard to the public, and polluted the city. The Court held that the uncontrolled presence of these stray animals on the streets of the city deprived Indian residents of their right to life under Article 21.

[217] (1992) 1 SCC 46.

[218] (1995) 3 SCC 42.

1.4.4.5. *Right to Healthcare for Convicts and Under Trials*

The Supreme Court, while recognizing the custodial rights of individuals in Supreme Court *Legal Aid Committee through Honorary Secretary* v *State of Bihar and Others*[219] ruled that it is the obligation of the police to ensure appropriate protection of the person taken into custody, including medical care if such a person needs it.

The above discussion of case-laws demonstrates that right to health and health care has been recognized by the Supreme Court. Though, this is a major leap there are number of limitations. Firstly, fundamental rights are available only against the State and not against private individuals or organizations. Secondly, the State is required to enforce this right which is, however, subject to financial availability. But the positive outcome is that by giving 'right to life' a wider interpretation, the Court rulings would prove to be a useful tool for achieving the goal of 'Health for All'.

1.5. RIGHT TO HEALTH OR HEALTHCARE?

In the international documents on rights and health issues, the term 'right to health', 'right to healthcare' and 'right to health protection' is used interchangeably. The 'right to health protection' is the term favored by Pan-American Health Organization, and is also a term used in national constitutions and legislations. While these terms more or less convey a similar meaning, yet each term implies a specific meaning.

In the light of international statements such as that provided by the WHO and UNICEF Declaration of Alma Ata, 1978[220]: 'health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector'.[221] Thereby, health depends on a number of

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219 1991 3 SCC 482.

220 Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12, September 1978, viewed 14th Dec 2013, http://www.who.int/publications/almaata_declaration_en.pdf

221 Id. see, Declaration. I

determinants: nutrition, education, social and economic development, the absence of environmental contaminants, public health services, access to medical care, genetic predisposition, and individual choices.[222] Health therefore, emerges from an interaction of genetic inheritance, the physical circumstances in which people grow up and live[223], the social environment, personal behaviour[224], and crucially, access to resources which give control over life. Thus, in order for government to guarantee 'health' to its citizens it would have to be empowered to prohibit unhealthy behaviors like smoking or eating junk food, require healthy activities like getting enough exercise, and eliminate economic inequality since personal income is positively associated with overall health.[225] Hence, it is impossible for the government to assure perfect health to its citizens as the health of individuals is dependent on the health of the society that nurtures them. Though perfect health may be achievable at some point in the future, it is not a realistic benchmark against which to adjudicate a right. An important task of modern government is to secure means by which people can preserve or restore their health.[226] Hence, majority of the international conventions and declarations use the term 'right to healthcare'. Moreover, the 'right to health care' is distinct from the 'right to health', which is broader and includes social predictors of health such as level of education and income, and is influenced by a variety of factors, including lifestyle choices and behaviors.

A right to health care, by contrast, entitles right-holders to the 'goods and services' that aid in the achievement of health and, consequently, obligates the government to ensure access to these goods and services. Thus, by guaranteeing health care rather than health, the government binds itself to providing services rather than guaranteeing good health. Kristen Hessler and Allen Buchanan recently reiterated this view, stating that a '*right to health care* implies, on its face, a right

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222 Puneet K. Sandhu, "A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence"?, 95 *Calif. L. Rev.* 1151 (2007), p.1160.

223 For example, housing, air, quality, working environment etc.

224 Personal behavior constitutes smoking, diet, exercise etc.

225 S.L. Isaacs and S.A. Schroeder,"Class-the Ignored Determinant of the Nation's Health", 351 *NEJM* 1137 (2004), p.1139.

226 Derek Morgan, *Issues in Medical Law & Ethics*, Cavendish Publishing Ltd., London (2001), p.47.

to certain services; by contrast, a *right to health* seems to imply a right to be healthy, which is an impossible standard'.[227]

1.6. CONCLUSION

The above discussion makes it clear that the scope of health is vast and is not just restricted to absence of disease or illness. The term is broad enough to include preventive, promotive and rehabilitative services. Thus, the concept has an intersection between healthcare at individual as well as at the societal level and it also has an inter-relationship with aspects such as the provision of a clean living environment, protections against hazardous working conditions, social security measures in respect of disability, unemployment, sickness and injury. Keeping in mind the broadness of the concept of health, the researcher has restricted this study with respect to the protection and recognition of specific 'rights of patients'.

Since 1970s, there has been a growing concern for protecting the 'patient', extending beyond individual protection to encompass the recognition of specific rights. One manifestation of this has been the social and cultural reassertion of the values of individual freedom and self-determination which in turn encourages individual choice and the opportunity to exercise it freely, and is what promotes the concept of patients' rights. It also includes, *inter alia*, commitment to build appropriate mechanisms to ensure necessary quality care. Human rights law no doubt provides a useful framework in which to consider the dilemmas and the one most fitting in a democratic society. Hence, the brief overview of human rights in healthcare should serve us to remind the legal issues arising in the context of providing healthcare to patients which may invariably involve potential rights violations of patients. Also, the approach of this thesis is to study the rights of patients in a broader framework encompassing both individual and social rights.

Currently, there is an increase in the quest for wellbeing and physical fitness. This is combined with better information and education of the public about health, which have heightened awareness of the possible choices and stimulated greater sharing of knowledge in the field of health. Rapid advances in medical and

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[227] Kristen Hessler & Allen Buchanan, "Specifying the Content of the Human Right to Health Care", in Rosamond Rhodes, Margaret P. Battin, and Anita Silvers, eds *et al.*, *Medicine and Social Justice: Essays On The Distribution Of Health Care* , Oxford University Press , New York (2002), p.85.

health science and technology have hastened the change in patients' expectations raising serious ethical concerns and legal questions. This is evident from the fact that almost all the constitutions of the countries round the world now focus on medical issues, such as abortion, the right to die, and free speech in the physician-patient relationship. Also, changes in medicine directly affect what humans can do and how humans think about humanity itself and therefore what rights and obligations humans should have. Mention must also be made here of the shortcomings of social and health administrations. Hence, there is a need to advocate new and more positive concepts of patients' rights.

Before delving deep into the ethical and moral issues in conferring rights to patients it is essential to find out who is a patient? Medicine is an ethical profession and in the earlier period it was ethics which largely governed medicine. Hence, it is also essential to discuss whether medical ethics recognized rights of patients. The following chapter discusses these two issues in detail.