CHAPTER I

INTRODUCTION
CHAPTER-I

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1.1. Introduction

Health is wealth is the common basic principle that the man from time immemorial has been interested in trying to control disease. The meaning of health is wealth may be a simple sentence but its sense and meaning is so tremendous and deep. Through the years, in all societies around the world, health has become synonymous and equivalent to the value of wealth. Every human being is expected to lead a healthy life and a life with dignity and worth. Right to health is now a major priority on the international and national agenda. It is an imperative for the development. Right to health is considered as human right and the same cannot be deprived of or abridged, and it is being a human right is universal in its nature. According to Article 25 of the Universal Declaration of Human Rights 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 or other lack of livelihood in circumstances beyond his control. Right to health has been recognized in many countries. The right to better living conditions and the right to health and medical service are important among other rights. According to Dr Margaret Chan, the world needs a global health guardian, a custodian of values, a protector and defender of health, including the right to health. World Health Organization defines as health includes physical, mental, social, environmental and spiritual aspects of health. Any threat to health care must be considered as denial of the right to life. Every country in the world is now a party to at least one human rights treaty that addresses health-related rights. This includes the right to health as

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1 The Director-General, World Health Organisation
2 World Health Organisation
well as other rights that relate to conditions necessary for health. Consumer is sovereign and customer is the king has become a mere myth especially when the patient approaching a doctor is viewed as consumer. Patients who can be termed as consumers, whether a person is approaching a government or private hospitals have certain rights and these rights emanate from human rights, Constitutional rights, civil rights, consumer rights and codes of ethics of medical and nursing profession. The Indian Constitution bestows certain rights to the citizens. One of them is right to healthy life. A right to healthy life is an integral part of the right to life. Basic optimal health care is the right of every citizen and it is the responsibility of the State to provide it. The Government of India has passed certain laws relating to health and to protect the citizens. Some of these are, the Drugs and Cosmetics Act, the Medical Council Act, and the Consumer Protections Act, the Codes of ethics of medical and nursing councils.

All these enactments in one way or other bring out the responsibility of the doctors and nurses towards the patient. Thus these duties and responsibilities form the basis for patient's rights as a consumer. When a patient or Consumer avails service of a doctor for treatment, he has certain duties. Some of them are (a) he must disclose all information that may be necessary for proper diagnosis and treatment. (b) the doctors have to reveal all the complications relating to patients health and also the treatment which is going to be given to him. Thus patient as a consumer has right to health information. The information provided in the prescription shall be made known to the patient. This information therapy can help reduce medical errors. Information regarding healthcare costs helps to receive better health care. Therapy market is one of the sources of information people want. Information therapy is not a substitute but definitely supplement to doctor's counseling. A patient is the custodian of his own health and has right to know more about his diagnosis and treatment options. He has to be a partner in health education along with the health care providers. Information is considered to be the best prescription. Lack of regulatory compliance by the manufactures of alternative medicine like
ayurvedic and homeopathic are also required to follow law, which is designed to protect consumers. Consumer organizations are one of the most important stake-holders in the successful implementation of the Right to Information Act, 2005. Consumer education empowers consumers to exercise their consumer rights. It is perhaps the single most powerful tool that can take consumers from their present disadvantageous position to one of strength in the marketplace. Consumer education is dynamic, participatory and is mostly acquired by hands-on and practical experience. For instance, a woman who makes purchase decisions for the household and does the actual buying in the marketplace would be more educated about market conditions and ‘best buys’ than a person who educates himself about the market with the help of newspapers or television. Also, today, it is not just the market or products that a consumer needs to educate himself about but s/he also needs to know about company profile, government policies and introduction of new technology.

Market influences have grown so much that not just wholesale and retail sellers but even medical practitioners are falling prey to their pressures. The pharmaceutical industry is one such example. India, with its 1 billion population and largely uneducated consumers, is a very lucrative market for this industry. The pharmaceutical industry, to boost its sales, offers free samples of medicines, freebies, and even free luxury holidays to physicians to influence them to use their brands and give them preference over other brand names. There have been many instances when drugs banned in countries like US, have been prescribed to Indian consumers and are readily available as over-the-counter drugs. It is a sad example of gross violation of consumer trust by medical practitioners. This situation is rampant not just in rural areas but also among educated urban consumers. The reason why the market, in connivance with physicians, is able to exploit consumers is that Indian consumers are not aware of the prevailing situation and do not keep themselves abreast with latest developments taking place around them. Consumer education can play a crucial role in protecting consumers against such dangers. In the Indian context,
sustainability and traditional knowledge can play a vital role in empowering consumers but consumers are unable to connect to their knowledge base. Consumer education can rejoin the broken link and make traditional knowledge accessible to consumers again. Some sources of consumer education are past experiences of consumers, information dissemination by government agencies and NGOs, classroom teaching by teachers and informal lessons by parents.

The patients being the consumers do have the right to consumer education relating to their health rights. Both at national and international level the rights have their own significance and the patients have right to realize them because they have the recognized interests. Since independence, India has been striving to develop and strengthen the entrepreneur base. But in the process the consumer has been made to endure substandard products and services, adulterated foods, deceitful weights and measures, spurious and hazardous drugs and exorbitant prices. India has been observing 15th March, since 1989 as the World consumers' Day. This day has a historic importance as it was on this day in 1962 when the bill for Consumer's Rights was moved in the U.S. congress. President John Kennedy in his speech had remarked "If a consumer is offered inferior products, if prices are exorbitant, if drugs are unsafe or worthless, if the consumer is unable to choose on an informed basis, then his dollar is wasted, his health and safety may be threatened and national interest suffers". Without healthy population, no sustainable economic, scientific and technological development is possible. Moreover an individual's health is directly related to the enjoyment of all other human rights and is a precondition of full participation in social, political and economic life. Another issue relating to exploitation of patient as consumer is in the area of sale of drugs and medicine. Buying medicine and medical products over internet, general use of prescription for and over the counter medicine, safe use for seniors, misuse of prescription for pain relievers, buying of expired medicines and different compositions other than prescribed are very crucial health aspects where education and information are very much needed. Herbal medicines are not
always safe. Drugs and Magic Remedies Act seeks to restrain objectionable 
advertisements promising magical cures. Health cannot be treated as a 
commercial concern. Now-a-days the health care centers, health care providers 
and pharmaceuticals are advertising about their centers, providers, medicines 
and pharmaceuticals. In such cases it is very difficult for the consumer to have 
a standard providers or medicine or pharmaceuticals. Another problem is 
duplication and imitation of medicines, drugs, cosmetics, and skin care 
products. Its use would that be harmful or fatal to consumers. Fake and 
counterfeit drugs extend from ordinary medicines which help to cure and 
prevent common cold to highly advanced and complex life saving drugs. The 
next important issue is regarding Maximum Retail Prices (MRP). This does not 
serve as a bench mark at all for a fair price, when there is little correlation 
between the cost to the manufacturer and the price at which they are finally sold 
to the consumer passing through several hands in between. Unfortunate thing 
it that most of the day to day purchases such as medicines, cosmetics are sold at 
MRP with no reduction. The good intention of the MRP that the consumers 
should not be cheated. The consumer groups have not been able to get this 
matter resolved despite their long battle. Their demand to the Government to 
order the producers to indicate the wholesale price besides the MRP on the 
product was not materialized.

Thus, the consumers particularly as patients should be educated on this 
matter and under any circumstances they should not pay more than MRP. Some manufacture units are selling their goods 10% less than MRP. The 
consumers feel that they are getting the goods at cheaper rates. Hence they 
don’t have opportunity to question. This is another type of exploiting the 
consumers. In addition to Government Agencies, Non Governmental Agencies, 
Media, Educational Institutions, voluntary organizations and judiciary are 
playing a pivotal role in this regard. Still there is lot to do in order to make the 
health education and information reach all the people. The quote used as the 
Preamble is very relevant to the notion of right to healthcare. Sigerist said this
long ago and since then most of Europe and many other countries have made this a reality. And today when such demands are raised in third world countries, India being one of them, it is said that this is no longer possible the welfare state must wither away and make way for global capital Europe is also facing pressures to retract the socialist measures, which working class struggles had gained since 19th century. So we are in a hostile era of global capital which wants to make profit out of anything it can lay its hands on. But we are also in an era when social and economic rights, apart from the civil and political rights, are increasingly on the international agenda and an important cause for advocacy. Thus health and health care is now being viewed very much within the rights perspective and this is reflected in Article 12 “The right to the highest attainable standard of health” of the International Covenant on Economic, Social and Cultural Rights to which India has acceded. According to the General Comment 14 the Committee for Economic, Social and Cultural Rights states that the right to health requires availability, accessibility, acceptability, and quality with regard to both health care and underlying preconditions of health. The Committee interprets the right to health, as an inclusive right extending 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 on sexual and reproductive health. This understanding is detailed below:

The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular

State party: Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the
State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs. Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

**Non-discrimination:** health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

**Economic accessibility (affordability):** health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

**Information accessibility:** accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However,
accessibility of information should not impair the right to have personal health data treated with confidentiality.

Acceptability: All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

Quality: As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. (Committee on Economic, Social and Cultural Rights Twenty-second session 25 April-12 May 2000) Universal access to good quality healthcare equitably is the key element at the core of this understanding of right to health and healthcare. To make this possible the State parties are obligated to respect, protect and fulfill the above in a progressive manner: The right to health, like all human rights, imposes three types or levels of obligations on State parties: the obligations to respect, protect and fulfill. In turn, the obligation to fulfill contains obligations to facilitate, provide and promote. The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfill requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

State parties are referred to the Alma-Ata Declaration, which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is
politically, socially and economically unacceptable and is, therefore, of common concern to all countries. State parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from Article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

- To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- To ensure equitable distribution of all health facilities, goods and services;
- To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.
The Committee also confirms that the following are obligations of comparable priority:

- To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- To provide immunization against the major infectious diseases occurring in the community;
- To take measures to prevent, treat and control epidemic and endemic diseases;
- To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
- To provide appropriate training for health personnel, including education on health and human rights.

The above guidelines from General Comment 14 on Article 12 of ICESCR are critical to the development of the framework for right to health and healthcare. As a reminder it is important to emphasise that in the Bhore Committee report of 1946 we already had these guidelines, though they were not in the 'rights' language. Thus within the country's own policy framework all this has been available as guiding principles for now 56 years. Right to health is guaranteed by numerous provisions in international law, including Article 25 of the Universal Declaration of Human Rights, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 24 of the Convention on the Rights of the Child (CRC), and Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), among others. The World Health Organization (WHO) issues the International Health Regulations from time to time as a guiding framework for domestic policies. These regulations have further strengthened the link between human rights and health. For instance, that the new International Health Regulations shall be implemented with full respect for the dignity, human rights and fundamental freedoms of persons. But it is due to ignorance, illiteracy and lack
of awareness about the rights of the consumer, these laws are not being implemented properly. The Constitutional imperatives, legislative framework and the judicial activism are not fully realized in India in general and rural India in particular. Lack of primary health centers, lack of monitoring agencies, lack of funds, non-allocation of sufficient budget in the annual budget is becoming an obstacle to implement the right to health. Governmental and non-governmental organizations, clinical laboratories, doctors, nursing system, medical pharmacies, medical research laboratories, medical councils, medical education and their effective implementation of their respective roles will make the health consumers to realize their rights to the fullest possible extent.

The widely acceptable definition of health is that given by the WHO in the preamble of its Constitution is “Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease.” In recent years, this statement has been amplified to include the ability to lead a 'socially and economically productive life'. Through this definition, WHO has helped to move health thinking beyond a limited, biomedical and pathology-based perspective to the more positive domain of “well being” also, by explicitly including the mental and social dimensions of well being, WHO has radically expanded the scope of health and extended the role and responsibility of health professionals and their relationship to the larger society. In India there is very little perception about the rights of the patients even amongst the educated persons. Therefore blunt violation of patient’s right is a routine occurrence. Right to consumer education with reference to health is thus gained importance as health is a subject closer to everybody’s life. Improvement of one’s health and health of one’s family is a Universal aspiration. Everyone has the right to a standard of living adequate for health and well-being of himself and of his

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3 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1947 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100); and entered into force on 7 April 1948

4 Kumar Avanish, “Human Right to Health”, satyam law international 2007 at 21

5 Article 25 of the Universal Declaration of Human Rights, 1948.
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, lack of livelihood are beyond his control. The right to have good health is one of the economic, social and cultural human rights that require positive and affirmative State action so that better living conditions of the people can be created. A healthy life depends on many social, economic, political and cultural factors which the State should guarantee. These factors include providing people with adequate sanitation, clean air and water and an adequate livelihood prohibiting discrimination and providing people with a mechanism for social change. Thus both health and development are intimately interconnected.

In J.P. Unnikrishnan Vs. State of Andhra pradesh⁶ a Constitution Bench held that right to health is a fundamental right and right to potable water has been held to be a fundamental right and meaningful right to life has also been held to be a fundamental right. Right to Consumer Education means the right to acquire the knowledge and skill to be an informed consumer throughout life. Ignorance of consumers, particularly of rural consumers, is mainly responsible for their exploitation. They should know their rights and must exercise them. Only then real consumer protection can be achieved with success. Consumer should insist on getting all the information about the product or service before making a choice or a decision. This will enable him to act wisely, responsibly and also enable him to realize the rights namely a) right to safety b) right to be informed c) right to choose d) right to be heard e) right to seek redressal f) right to consumer education. Soon after the adoption of the Constitution of India though the right to health is not expressed, but it was impliedly imbedded under the Directive Principles of State Policy. Later it was realized that the right to health should be made a fundamental right and thus the right to health is recognized as a fundamental right within the purview of Article 21 of the Constitution of India, by the judiciary. The Supreme Court in

⁶ (1993) 1 SCC642
State of Punjab and others Vs. Mohinder Singh Chawala⁷, held that for contending that the Government has constitutional obligation to provide health facilities and they should pay the cost even for the treatment taken in private hospitals. Part IV of our Constitution deals with the Directive Principles of State Policy. Among several provisions that touch on the subject of health are Articles 39(e), (f), 42 and 47 of the Constitution⁸.

Health is a fundamental right of every human being irrespective of age, region, status, country and continent. It is a state of complete physical, social and mental well being and complete alienation of freedom from disease. A country should have a good policy of health law, information, education and medicine to ensure healthiness. In addition to this people should be aware of their rights as consumers of health care system. Unless this is recognized, the people cannot know about their rights and cannot fight for their rights. Hence consumer education in general and consumer health education in particular are essential for every individual in a country. Education is an important instrument of development of the individual, society and nation. Right to consumer education or information and right to health are directly or indirectly, explicitly or implicitly recognised by the law of the land. The Constitution of India implicitly included in the right to life because protection of human life is of paramount importance.

⁷ (1997) 2 SCC 83
⁸ 39 (e) 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 a vocations unsuited to their age or strength; (f) 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. 42. Provision for just and humane conditions of work and maternity relief. The state shall make provision for securing just and humane condition of work and for maternity relief. 47. 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 endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.
In order to promote and protect the rights of consumers such as protection against marketing of goods which are hazardous to life and property; the right to be informed about the quality, quantity, potency, purity, standard and price of goods to protect the consumer against unfair trade practices; the right to be assured, wherever possible, access to an authority of goods at competitive prices; the right to be heard and to be assured that the interest of consumers will receive due consideration at appropriate forums; the right to seek redressal against unfair trade practices or unscrupulous exploitation of consumers and right to consumer education. The object is also to provide speedy and simple redressal to consumer disputes, quasi judicial machinery is sought to be set up at the district, State and Central levels. These Quasi Judicial bodies will observe principles of natural justice and have been empowered to give relief of specific nature and to award, wherever appropriate, compensation to consumers. Penalties for non-compliance of orders given by Quasi Judicial bodies have also been provided. In a historic Judgment in Consumer Education and Research Centre Vs. Union of India, the Supreme Court held that the right to health and medical care is a fundamental right under Article 21 of the Constitution as it is essential for making the life of the worker a meaningful and purposeful with dignity of person.

The consumer education has got certain aspects namely information choice, value system, recognition of rights and responsibilities and catalyst for action. Everybody at one time or the other is a consumer to the goods or services. Referring to consumer, Mahatma Gandhi had rightly stated as “A Consumer is the most important visitor in our premises. He is not dependent on us, we are dependent on him. He is not an interruption in our work, he is the purpose of it. He is not an outsider to our business, he is part of it. We are not doing any favour by serving him, he is doing us a favour by giving an opportunity to do so”. A consumer is a person who hires, buys, possess goods,
services, rights for his own sake or for his family. In case of failure he can express his rights and claim relief. In modern State, satisfaction of consumer is one of the main functions of State. In a mixed economy State has a function as provider, as regulator, as entrepreneur etc. During 1990s, patients become increasingly better informed, developed higher expectations regarding the convenience and quality of care, and became more active in trying to have these expectations met. As a result, they increasingly demanded more of a voice in decisions that affected their health care. The health care consumerism has gained momentum in many parts of the world in the recent past. As it continues to gain momentum, consumerism has become one of the most important factors shaping the health care system. The growing interdependence of the world economy and international character of many business practices have contributed to the development of universal emphasis on consumer right, protection and promotion. Consumers, clients and customers in the world over are demanding value for money in the form of quality goods and better services.

Modern technological developments have no doubt made a great impact on the quality, availability and safety of goods and services. But the fact is consumers are still victims of unscrupulous and exploitative practices. In addition, with revolution in information technology newer kinds of challenges are thrown on the consumer like cyber crimes, exploitation by doctors of corporate hospitals, deficiency of services by government doctors because of lack of technology which is affecting the consumer in a very bigger way. A country should have a good policy of health, law and medicine to ensure healthiness. Right to health education or health information is nothing but right to health or health care which in lieu is a right to life. In addition, the people should be aware of their rights as consumers of health care system. Unless this is recognized, the people cannot know about their rights and cannot fight for their rights. Hence consumer education, especially consumer health education is essential for every individual in a country. The consumers are highly respected
in developed countries. In developed countries the industries form committees by involving consumers, take their advices regarding the quality, standards and prices, then only they produce the commodities and release in the market. But the position in India is different. Here the producers/Industrialists/Marketers control and boss over the consumer. There is hardly any role played by the consumers in production and supply of quality goods, fixation of price, maintaining standards so on and so forth. Due to non involvement, lack of proper health education and ignorance the consumers are forced to buy whatever is available in the market.

Right to health is not included directly as a fundamental right in the Indian Constitution. The Constitutional makers imposed this duty on State to ensure social and economic justice. Part IV of Indian Constitution which enumerates Directive Principles of State Policy imposes duty on States. Article 38 of Indian Constitution imposes liability on State enshrining that States will secure a social order for the promotion of welfare of the people but without public health. The State cannot achieve it. It means without public health welfare of people is impossible. Article 39(e) relates with workers to protect their health. Article 41 imposes duty on State to public assistance basically for those who are sick and disable. Article 42 makes provision to protect the health of infant and mother by maternity benefit. Under Article 47 it is the primary duty of the State to improve public health, securing of justice, human condition of works, extension of sickness, old age, disablement and maternity benefits. Further, State’s duty includes prohibition of consumption of intoxicating drinking and drugs are injurious to health. Article 48A ensures that State shall endeavour to protect and impose the pollution free environment for good health. Article 47 makes improvement of public health a primary duty of State. Hence, the court should enforce this duty against a defaulting authority on pain of penalty prescribe by law, regardless of the financial resources of such authority.\footnote{Rajastan Municipal Council Vs. Vardichand, AIR 1980 SC 1622} Under Article 47, the State shall regard the raising of the level of
nutrition and standard of living of its people and improvement of public health as among its primary duties. None of these lofty ideals can be achieved without controlling pollution in as much as our materialistic resources are limited and the claimants are many.\textsuperscript{12} It is to be noted that the UN Committee on Economic, Social and Cultural Rights in 2000 states that the notion of the "highest attainable standard of health" in Article 12(1) of ICESCR takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."

The State under Article 47 has to protect poverty stricken people who are consumers of sub-standard food from injurious effects.\textsuperscript{13} Public Interest Petition for maintenance of approved standards for drugs in general and for the banning of import, manufacturing, sale and distribution of injurious drugs is maintainable. A healthy body is the very foundation of all human activities. In a welfare State, it is the obligation of the State to ensure the creation and sustaining of conditions congenial to good health.\textsuperscript{14} Some other provisions relating to health fall in Directive Principles of State Policy. The State shall in particular, direct its policy towards securing health of workers.\textsuperscript{15} On the State organized village panchayats were given such powers and authority for to

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\item \textsuperscript{12} Javed Vs. State of Haryana, AIR 2003 SC 3057
\item \textsuperscript{13} Tapan Kumar Vs. FCI, (1996) 6 SSC 101
\item \textsuperscript{14} Vicent Vs. UOI, AIR 1987, SC 990
\item \textsuperscript{15} Article 39(e) of the Constitution of India
\end{itemize}
function as units of self-Government. This Directive Principle has now been translated into action through the 73rd Amendment Act 1992 whereby part IX of the Constitution titled “The Panchayats” was inserted. The Panchayat system has significant implications for the health sector. Which are engrafted in Articles 243, 243A to 243O contained in Part IX of the Constitution of India.

The Directive Principles of State Policy are mere directive and are non justiciable and a person cannot claim for non fulfilling of these directives. But it is the judiciary which has brought right to health which is implied in these directives to come under the purview of Article 21 of the Constitution. The scope of this provision is very wide. It prescribes for the right of life and personal liberty. The concept of personal liberty comprehended many rights, related to indirectly to life or liberty of a person. And so a person can claim his right of health. Thus, the right to health, along with numerous other civil, political and economic rights, has afforded protection under the Indian Constitution. The debate surrounding the implementation of the human right to health is fresh and full of possibility for the developing world. In fact, India has been able to create a legal mechanism whereby right to health can be protected and enforced. The early 1970s, witnessed a watershed in human rights litigation with the *Keshwanand bharti Vs. State of Kerla* ushering in a unprecedented period of progressive jurisprudence following the recognition fundamental rights. At the same time standing rules were relaxed in order to promote Public Interest Litigation and access to justice. So there were two developments in 1980s, which led to a marked increase in health related litigation. First was the

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16 Article 40 of the Constitution of India
17 Article 41 provides right to assistance in case of sickness and disablement. It deals with “The state shall within the limits of its economic capacity and development, make effective provisions for securing the right to work, to education and to public assistance in case of unemployment, old age, sickness and disablement and in other cases of undeserved want”. Their implications in relation to health are obvious. Article 42 give the power to State for make provision for securing just and humane conditions of work and for maternity relief and for the protection of environment same as given by Article 48A and same obligation impose to Indian citizen by Article 51A.(g).
19 (1973) 4 SCC 225.
establishment of Consumer Courts that made it cheaper and speedier to sue doctors for medical negligence. Second, the growth of PIL and one of this offshoots being recognition of health care as a fundamental right. Through PIL the Supreme Court has allowed individual citizen to approach the Court directly for the protection of their Constitutional Human Rights.

In many cases the Supreme Court held that right to health and medical care is a fundamental right covered by Article 21 since health is essential for making the life of workmen meaningful and purposeful and compatible with personal dignity. The State has an obligation under Article 21 to safeguard the right to life of every person, preservation of human life being of paramount importance. The Supreme Court has in the case of Parmanand Katra Vs. Union of India, held that whether the patient be an innocent person or be a criminal liable to punishment under the law, it is the obligation of those who are in charge of the health of the community to preserve life so that innocent may be protected and the guilty may be punished. Article 23 is indirectly related to health. Article 23(1) prohibits traffic in human beings. It is well known that traffic in women leads to prostitution, which in turn is to major factor in spread of AIDS. Article 24 is relating to child labor it deal with “No child below the age of 14 years shall be employed to work in any factory or mine or engaged in any other hazardous employment.” Thus this article is of direct relevance to child health. In addition to Constitutional remedies sensitizing of the relevant ordering law towards later health for all adds to the content of right to health. Legal prohibition of commercialized transplantation of human organ and effective application of the Consumer Protection Act, 1986 to deal with deficient medical services have animated right to health.

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20 Kumar Awanish “Human Right to Health” satyam law pub. 2007 at 171
21 A.I.R.1989 SC 2039
22 Ibid.
23 Constitution of India
24 Spring Meadow Hospital Vs. Harijol Ahluwaliya, A.I.R. 1998 SC180
With the recognition that both the Indian Constitution and the fundamental right of life emphasize human dignity, began to address the importance of health to Indian citizen. In the Directive Principles of State Policy, Art.47 declares that the State shall regard the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties. Since Directive Principles of State Policy are not enforceable by the Court, implementation of the guarantee has remained illusory.\(^{25}\) However, in a series of cases dealing with the substantive content of the right to life, the Court has found that the right to live with human dignity includes right to good health.\(^{26}\) In *Consumer Education and Research Center Vs. UOI\(^2\)*, the Court explicitly held that the right to health was an integral factor for a meaningful right to life. The Court held that the right to health and medical care are a fundamental right under Article 21. The Supreme Court, while examining the issue of the Constitutional right to health care under article 21, 41 and 47 of the Constitution of India in *State of Punjab Vs. Ram Lubhaya Bagga,\(^2\)* observed that the right of one person correlates to a duty upon another, individual, employer, Government or authority. Hence, the right of a citizen to live under Article 21 casts and obligation on the State. This obligation is further reinforced under Article 47; it is for the State to secure health to its citizens as its primary duty. No doubt the Government is rendering this obligation by opening Government hospitals and health centers, but to be meaningful, they must be within the reach of its people, and of sufficient liquid quality. Since it is one of the most sacrosanct and valuable rights of a citizen, and an equally sacrosanct and sacred obligation of the State, every citizen of this welfare State looks towards the State to perform this obligation with top priority, including by way of allocation of sufficient funds. This in turn will not only secure the rights of its citizens to their satisfaction, but will benefit the State in achieving its social, political and economic goals.

\(^{25}\) Bandhua Mukti Morcha A.I.R. 1984 SC 812
\(^{26}\) Ibid, at-811
\(^{27}\) A.I.R. 1995 SC 636
The Supreme Court, in *Paschim Banga Khet mazdoor Samity and ors* Vs. *State of West Bengal and ors*, while widening the scope of Article 21 and the Government’s responsibility to provide medical aid to every person in the country, held that in a welfare State, the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an obligation undertaken by the Government in a welfare State. The Government discharges this obligation by providing medical care to the persons seeking to avail of those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. 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. The Court made certain additional directions in respect of serious medical cases:

- Adequate facilities be provided at the public health centers where the patient can be given basic treatment and his condition stabilized.
- Hospitals at the district and sub divisional level should be upgraded so that serious cases are treated there.
- Facilities for given specialist treatment should be increased and having regard to the growing needs, it must be made available at the district and sub divisional level hospitals.
- In order to ensure availability of bed in any emergency at State level hospitals, there should be a centralized communication system so that the patient can be sent immediately to the hospital where bed is available in respect of the treatment, which is required.

Proper arrangement of ambulance should be made for transport of a patient from the public health center to the State hospital.

Ambulance should be adequately provided with necessary equipment.

In the Indian Penal Code many provisions have been made for the protection of health of every citizen of our country. As per Section 304-A of the Indian Penal Code, 1860, "whoever causes the death of a person by rash or negligent act not amounting to culpable homicide shall be punished with imprisonment for a term of two years or with a fine, or both". It is not necessary that only death lead to criminal negligent lawsuits. If a patient is alive and has serious injury due to rash and negligent treatment by doctor, then doctor can be charged under Section 337 and 338 of IPC. When a doctor is charged under Section 304-A, only then he or she can be arrested but can also obtain bail at the same time. Doctors can also take defense of Section 80 of IPC where nothing is an offence that is done by accident or misfortune, and Section 88 where a person cannot be accused of an offence as long as act is unintentional and done in good faith.

Indian Courts do not held doctors liable for patient's death that are caused as mistake of judgment in selection and application of remedies or from error of judgment. Section 304A of the Indian Penal Code of 1860 states that whoever causes the death of a person by a rash or negligent act not amounting to culpable homicide shall be punished with imprisonment for a term of two years, or with a fine, or with both. In the Santra case, the Supreme Court has pointed out that liability in civil law is based upon the amount of damages incurred; in criminal law, the amount and degree of negligence is a factor in determining liability. However, certain elements must be established to determine criminal liability in any particular case, the motive of the offence, the magnitude of the offence, and the character of the offender.

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30 Indian Penal Code, 1860
In *Poonam Verma Vs. Ashwin Patel* 31 the Supreme Court distinguished between negligence, rashness, and recklessness. A negligent person is one who inadvertently commits an act of omission and violates a positive duty. A person who is rash knows the consequences but foolishly thinks that they will not occur as a result of her/his act. A reckless person knows the consequences but does not care whether or not they result from her/his act. Any conduct falling short of recklessness and deliberate wrongdoing should not be the subject of criminal liability. Thus a doctor cannot be held criminally responsible for a patient’s death unless it is shown that she/he was negligent or incompetent, with such disregard for the life and safety of his patient that it amounted to a crime against the State32. *Sections* 80 and 88 of the Indian Penal Code contain defenses for doctors accused of criminal liability. Under *Section* 80 (accident in doing a lawful act) nothing is an offence that is done by accident or misfortune and without any criminal intention or knowledge in the doing of a lawful act in a lawful manner by lawful means and with proper care and caution. According to *Section* 88, a person cannot be accused of an offence if she/ he performs an act in good faith for the other’s benefit, does not intend to cause harm even if there is a risk, and the patient has explicitly or implicitly given consent.

Negligence in legal words means the breach of a legal duty. In other words, it is carelessness revealed in matters in which carefulness is compulsory by the law. Negligence gives right to patients to initiate action against such act. ‘*Implied Undertaking*’ is the duty of every person who offers medical advice and treatment, which consists of decision to take a case, its treatment and to administrate the same33. But doctors are not liable for their treatment, if they do not charge fees as per the term Services defined in *Section* 2(1) of Consumer Protection Act, 198634. A doctor can be held liable for negligence only if the plaintiff can give enough evidence that defendant is guilty of a failure that no

32 House of Lords decision in *R Vs. Adomako* (1994) 3 All ER 79
33 *Laxman Balkrishna Joshi Vs. Trimbak Bapu Godbole* (MANU/SC/0362/1068)
34 Constitutional Law of India –J.N.Pandey
other doctor with ordinary skills would have done with reasonable care. Certain conditions must be satisfied before liability can be considered. Expert opinion and evidence from medical science can be used best to prove the allegation. There are certain merits and drawbacks also in the cases where doctor’s liability is to be fixed under the Consumer Protection Act, 1986 for negligence. Under Consumer Protection Act, 1986, the definition of terms such as service, consumer etc., are unclear and have very thin relevance to medical negligence. It lacks terminology too, hence can lead to confusion during trials in consumer forums\textsuperscript{35}. It also lacks the provision for a general physician to be as a member of commission, as it is nowhere mentioned in the composition of district, State and national dispute redressal commissions. This can lead to unfair judgment, as the commission has no primary knowledge of medicine.

The right to refuse to attend a patient granted to doctors can be detrimental in the cases of emergency. Generally no medical professional or physician will claim such rights but there can be an exceptional cases where doctors do refuse and its contrary to article 21, right to life and personal liberty which implies right to healthcare\textsuperscript{36}. Fake complaint or lawsuit can be filed under Consumer Protection Act, 1986, causing serious harm to the reputation of doctors. The personal influence of doctors, if released on bail can affect the proceeding in Court under criminal negligence and can lead to tampering of evidences and further conclude to injustice. The investigating officer and the private complainant cannot always be supposed to have knowledge of medical science so as to determine whether the act of the accused medical professional amounts to rash or negligent act within the domain areas of criminal law under \textit{Section 304-A} of IPC. After the Consumer Protection Act, 1986, came into effect, a number of patients have filed cases against doctors. Public awareness of medical negligence in India is growing. Hospital managements are increasingly facing complaints regarding the facilities, standards of professional

\textsuperscript{35} Consumer Protection Act, 1986
\textsuperscript{36} Parmananda Katara Vs. Union of India (AIR 1989 SC 2039)
competence, and the appropriateness of their therapeutic and diagnostic methods. After the Consumer Protection Act, 1986 came into force some patients are filing legal cases against doctors establishing that the doctors are negligent in their medical service, and claim and receive compensation. As a result, a number of legal decisions have been made on what constitutes negligence and what is required to prove it. Negligence is the breach of a legal duty to care. It means carelessness in a matter in which the law mandates carefulness. A breach of this duty gives a patient the right to initiate action against negligence. Persons who offer medical advice and treatment implicitly state that they have the skill and knowledge to do so, that they have the skill to decide whether to take a case, to decide the treatment, and to administer that treatment. This is known as an "implied undertaking" on the part of a medical professional. In the case of the State of Haryana Vs. Smt Santra, the Supreme Court held that every doctor "has a duty to act with a reasonable degree of care and skill."37

Doctors in India may be held liable for their services individually or vicariously unless they come within the exceptions specified in the case of Indian Medical Association Vs. V P Santha.38 Doctors are not liable for their services individually or vicariously if they do not charge fees. Thus free treatment at a Non-Government hospital, Governmental hospital, health centre, dispensary or nursing home would not be considered as a "service" as defined in Section 2 (1) (0) of the Consumer Protection Act, 1986. However, no human being is perfect and even the most renowned specialist could make a mistake in detecting or diagnosing the true nature of a disease. A doctor can be held liable for negligence only if one can prove that one is guilty of a failure that no doctor with ordinary skills would be guilty of it acting with reasonable care.39 An error of judgment constitutes negligence only if a reasonably competent professional

with the standard skills that the defendant professes to have, and acting with ordinary care, would not have made the same error. In a key decision on this matter in the case of *Dr Laxman Balkrishna Joshi Vs. Dr Trimbak Bapu Godbole*, the Supreme Court held that if a doctor has adopted a practice that is considered "proper" by a reasonable body of medical professionals who are skilled in that particular field, he or she will not be held negligent only because something went wrong. Doctors must exercise an ordinary degree of skill. However, they cannot give a warranty of the perfection of their skill or a guarantee of cure. If the doctor has adopted the right course of treatment, if she/he is skilled and has worked with a method and manner best suited to the patient, she/he cannot be blamed for negligence if the patient is not totally cured. Certain conditions must be satisfied before liability can be considered. The person who is accused must have committed an act of omission or commission; this act must have been in breach of the person’s duty; and this must have caused harm to the injured person. The complainant must prove the allegation against the doctor by citing the best evidence available in medical science and by presenting expert opinion.

In some situations the complainant can invoke the principle of *res ipsa loquitur* or "the thing speaks for itself". In certain circumstances no proof of negligence is required beyond the accident itself. The National Consumer Disputes Redressal Commission applied this principle in *Dr Janak Kantimathi Nathan Vs. Murlidhar Eknath Masane*. The principle of *res ipsa loquitur* comes into operation only when there is proof that the occurrence was unexpected, that the accident could not have happened without negligence and

40 Whitehouse Vs. Jordan (1981) 1 All ER 267 the House of Lords.
43 Dr Laxman Balkrishna Joshi Vs. Dr Trimbak Bapu Godbole AIR 1969 (SC)128
44 Dr Janak Kantimathi Nathan Vs. Murlidhar Eknath Masane 2002 (2) CPR 138.
lapses on the part of the doctor, and that the circumstances conclusively show that the doctor and not any other person was negligent.

The burden of proof of negligence, carelessness, or insufficiency generally lies with the complainant. The law requires a higher standard of evidence than otherwise, to support an allegation of negligence against a doctor. In cases of medical negligence the patient must establish her/his claim against the doctor. In Calcutta Medical Research Institute Vs. Bimalesh Chatterjee it was held that the onus of proving negligence and the resultant deficiency in service was clearly on the complainant45. In Kanhaiya Kumar Singh Vs. Park Medicare and Research Centre, it was held that negligence has to be established and cannot be presumed 46. Even after adopting all medical procedures as prescribed, a qualified doctor may commit an error. The National Consumer Disputes Redressal Commission and the Supreme Court have held, in several decisions, that a doctor is not liable for negligence or medical deficiency if some wrong is caused in her/ his treatment or in her/ his diagnosis if she/he has acted in accordance with the practice accepted as proper by a reasonable body of medical professionals skilled in that particular article, though the result may be wrong. In various kinds of medical and surgical treatment, the likelihood of an accident leading to death cannot be ruled out. It is implied that a patient willingly takes such a risk as part of the doctor-patient relationship and the attendant mutual trust.

Before the case of Jacob Mathew Vs. State of Punjab, the Supreme Court of India delivered two different opinions on doctors' liability. In Mohanan Vs. Prabha G Nair and another47, it ruled that a doctor's negligence could be ascertained only by scanning the material and expert evidence that might be presented during a trial. In Suresh Gupta's case in August 2004 the standard of negligence that had to be proved to fix a doctor's or surgeon's

45 Calcutta Medical Research Institute Vs. Bimalesh Chatterjee I (1999) CPJ 13 (NC)
46 Kanhaiya Kumar Singh Vs. Park Medicare & Research Centre III (1999) CPJ 9 (NC)
criminal liability was set at "gross negligence" or "recklessness." In Suresh Gupta's case the Supreme Court distinguished between an error of judgment and culpable negligence. It held that criminal prosecution of doctors without adequate medical opinion pointing to their guilt would do great disservice to the community. A doctor cannot be tried for culpable or criminal negligence in all cases of medical mishaps or misfortunes. A doctor may be liable in a civil case for negligence but mere carelessness or want of due attention and skill cannot be described as so reckless or grossly negligent as to make her/him criminally liable. The Courts held that this distinction was necessary so that the hazards of medical professionals being exposed to civil liability may not unreasonably extend to criminal liability and expose them to the risk of imprisonment for alleged criminal negligence. Hence the complaint against the doctor must show negligence or rashness of such a degree as to indicate a mental state that can be described as totally apathetic towards the patient. Such gross negligence alone is punishable.

On September 9, 2004, Justices Arijit Pasayat and CK Thakker referred the question of medical negligence to a larger Bench of the Supreme Court. They observed that words such as "gross", "reckless", "competence", and "indifference" did not occur anywhere in the definition of "negligence" under Section 304A of the Indian Penal Code and hence they could not agree with the judgment delivered in the case of Dr Suresh Gupta. The issue was decided in the Supreme Court in the case of Jacob Mathew Vs. State of Punjab. The Court directed the Central Government to frame guidelines to save doctors from unnecessary harassment and undue pressure in performing their duties. It ruled that until the Government framed such guidelines, the following guidelines would prevail. A private complaint of rashness or negligence against a doctor may not be entertained without prima facie evidence in the form of a credible opinion of another competent doctor supporting the charge. In addition, the investigating officer should give an independent opinion, preferably of a

48 Criminal Appeal Nos. 144-145 of 2004
Government doctor. Finally, a doctor may be arrested only if the investigating officer believes that she/he would not be available for prosecution unless arrested. The specific provisions which deal with health in India are also mentioned under Criminal Procedure Code. The procedural Sections are mentioned under CRPC and they are enumerated from Sec-133 to 136 and Sec-357 the judiciary also has specifically mentioned. In *Hari Krishna of Haryana Vs. Sukhbir singti* observed that in addition to conviction may order the accused to pay some amount by way of compensation which has suffered by action of the accused. So health care today is at cross roads. The doctors in order to promote health care in India have a very dynamic role in the sense they have the duty to inform the patient about the disease, treatment and further course of action. The Government should also bring under common frame of regulation the public and private sectors of health care. Except the laws related to the registration and training of health care professionals, the rest are not applied uniformly and for that there is no Justification. While the Government sector is required to implement policies, good or bad, the private sector has no obligation. Thus the majority of the Indian population is unable to access quality of health care from both Government and private players. The Government in unable to provide and private are reluctant to provide at free cost.

1.2. Significance of the Problem

Health is considered to be a major priority on the international as well as the national agenda, and even extended to the rural agenda. Problems faced by the people in getting health care, lack of consumer education and awareness about health either precautionary, preventive or curative, deficiencies in health care provided by the Government and Non-Government Organizations and other related activities which ultimately result in more serious affects to health and life of the people, prompted the researcher is selected the present problem for research. During 90s, patients became increasingly better informed, developed higher expectations regarding the convenience and quality of care,
and became more active in trying to have these expectations met. As a result, they increasingly demanded more of a voice in decisions that affected their health care. Health care consumerism has recently gained momentum as it continues to gain momentum; consumerism could become one of the most important factors shaping the health care system. Consumer education helps the consumer in many ways in protecting himself from the malpractices of the seller and in making judicious purchases. Consumers are being exploited because of illiteracy rate is more in our country and because of rural population. Appropriate forum for consumer education, enlightenment and protection of their rights is therefore mandatory to prevent such unhealthy practices in the service delivery system. Consumers must demand information and details on their rights, ongoing service activities for their own benefit or for benefit of their wards on a continual basis through group meetings, discussions, symposia, seminars, debates and declamations. There must be transparency in the practice or procedures of therapeutic planning, programming, implementation or execution of health service delivery systems. Consumer law in India recognizes two types of patients, such as paying and non-paying patients. Most of the Government hospitals in India have separate paying wards. The paying wards are mainly designed for affluent patients. However, the general wards are developed for the poor patients, who cannot afford the treatment cost.

The glaring contrasts in the state of health between the developed and developing countries, between the urban and rural areas and between the rich and the poor have attracted worldwide criticism as 'social injustice', has prompted the researcher to go in depth into the issues of health care system in a holistic way and so selected the present problem. Now-a-days the consumer education is an important aspect of development of the individual, society, nation and globe. Right to consumer education or information and right to health care are directly or indirectly, explicitly or implicitly recognized by the law of the land. The Consumer Protection Act, 1986 and various other laws exist to ensure free flow of true information from the providers of goods and
services. But the success of any law would depend upon the vigilance of consumers about their rights as well as their responsibilities. In fact the level of consumer protection is considered as the correct indicator. The 11th Five Year Plan has given an increased thrust on consumer awareness activities. Further by keeping the significance and contemporary relevance in mind, the researcher has selected this problem with great interest and enthusiasm.

1.3. Objectives of the Study

The following are the main objectives for taking up this research work.

- To evaluate the awareness about the right to consumer education relating to health.
- To study the historical development of consumer law relating to health and evaluate national and international scenario of consumer health education.
- To study and evaluate consumer laws relating to health in India and examine the role of judiciary in protection of health in India.
- To examine the principles relating to consumer health laws in the Constitution of India, Torts, Indian Penal Code and Code of Criminal Procedure
- To analyze the health system available to general public in India, and disclose a holistic approach regarding the role of Doctor, Patient, Media and N.G.O. in this system
- To suggest appropriate remedial measures for the realization of the health consumers rights

1.4. Scope and Limitation of the Study

Law plays a very important role in regulating the health care. In India there are provisions in the Constitution of India for right to health. The Indian parliament has enacted number of laws in protection of consumers. However there is no particular enactment or a Constitutional provision relating to right to
consumer education and health. Hence the researcher selected the topic for research. The subject right to consumer education and health is remained unexplored. The researcher tried to collect information as it is found difficult to obtain data to serve as source reference material. The scope of the subject is wide and extensive. The researcher mainly concentrated on the socio-legal aspects of the problem. The researcher left no stone unturned in his effort to gather facts and information necessary for the study.

1.5. Hypotheses

The following are the important hypotheses formulated to carry out the research

- Lack of awareness about consumer health rights, consumer education, and poverty are responsible for the consumer health exploitation.
- The laws enacted for protection consumers have not been properly implemented which affects adversely the consumer's rights.
- The quality of life that each Individual ultimately is to have is determined in part by the health decisions the person makes.
- Health has many complicated, interrelated components that must be balanced if high level wellness is to be achieved.
- Consumer education in relation to health is an integral part of development of the individual as well as the nation as health is a fundamental and inalienable right.
- Health consumer education involves joint efforts of the whole social fabric i.e., individual society and the State to protect and promote health.
1.6. Methodology

The study is conducted by doctrinaire method. The collected data is analyzed and placed in appropriate order. Relevant data from various sources like Law books, Journals, Periodicals, Medical texts, Reports, Commentaries, Articles has been collected. The data is also collected from E-books, E-documents, Electronic Journals, Internet and Intranet. The collected data is analyzed and placed in appropriate order. The Researcher has gained valuable insights into the problem through participation, interaction with fellow colleagues and gathered valuable information which has add quality to the present research.

1.7. Review of Literature

Literature in connection with the present problem is reviewed from various studies both vertically and horizontally. There are:-

ANIL KUMAR.,\textsuperscript{49} in his thought provoking book entitled, "Health Education", drew attention to the pioneering role of the need of health care in India, health education and private health care and public policy. He has also presented a comparative picture of the health services in developing countries.

ANNA BURGER,\textsuperscript{50} in his Book entitled, “Economic Problems of Consumers’ services” has discussed about the concept of services and their groups, services and commodity production and price of services. Further, he presented a detailed account of concept of survey services.

BAKSHI .P.M.,\textsuperscript{51} in his book entitled, “Consumer Protection Law” has presented detailed account of the consumer rights and consumer disputes redressal agencies.

\textsuperscript{49} International Scientific Publishing Academy, New Delhi, 2005.
\textsuperscript{50} Akademiai kiadq, Budapest, 1970.
\textsuperscript{51} Ashoka Law House, New Delhi, 2005.

DAVID L. LOUDON and ALBERT J. DELLA BITTA, in his Book entitled "Consumer Behavior" has made an endeavor to present a detailed account of consumer behavior and its groups.

ELIZABETH SMITH, RUAIRI BRUGHA and ANTHONY ZWI, in his Article entitled "Working With Private Sector Providers for Better Health Care: An Introductory Guide", observed the healthcare of private sector works, consumer awareness and roll of NGO's in health sector.

GURBAX SINGH, in his thought provoking Article entitled, "An overhaul of the law of consumer protection by the Consumer Protection (Amendment) Act, 1986" made an attempt to study the powers, functions and jurisdictional aspects of consumer forums.

JAIN M.P., in his book entitled "Indian Constitutional Law" observed Constitutional provisions relating to right to life and healthcare. Further it highlights related case laws.

JAMES F. ENGEL, ROGER D. BLACKWELL and DAVID T. KOLLAT, in his book entitled "Consumer Behavior" observed the consumer decision process and consumer education.

MUNIDHA R.C., in his Article entitled "can the Consumer Protection Act, 1986, Encompass medical services ", suggested medical discipline —

52 Kamal publishers, New Delhi, 2008.
doctors, hospitals under the umbrella of the Consumer Protection Act, 1986 and also defend doctors, patients services with important case laws.

RAVI SHINDE. in his Book titled, “Law and medicine” discussed different laws relating to medical healthcare and rules regulations relating to medicine.


Though there are certain studies but the earlier studies did not cover all the aspects on this problem in a comprehensive way, hence, the researcher has selected this topic with a view to provide a comprehensive and detailed account on socio-legal dimensions involved in this problem.

1.8. Scheme of the Study

The present study is divided into five chapters. First Chapter contains the introduction, significance of the problem, nature and scope of the study, review of literature, Hypotheses on which the present study proceeds, the objectives with which the study is undertaken and Methodology adopted to carryout the study.

The second chapter deals with the historical development of consumer law relating to health both at national and international level. It also covers the Consumer Protection regarding health in Ancient, Medieval and Modern Periods.

The third chapter lays emphasis on health laws in general and consumer education relating to health in India. This chapter covers medical ethics, medical administration, medical councils and the relationship between doctors
and patients, the confidentiality to be maintained by the doctors regarding patients health and at the same time creating and educating him about his own health.

Chapter four focuses the role of judiciary and right to health under the consumer protection law in Indian perspective. It also covers the analysis of the consumer health laws in torts, IPC and Cr.P.C. It is a comprehensive chapter which highlights the inter-relation between various laws dealing with the consumer problems and remedies and also regarding protection of consumer in the context of the patient.

The last chapter deals with conclusion and suggestions. This chapter has brought out certain concrete measures to be taken by the Government to create consumer education regarding health as wealth is the essence of productive life and not the result of ever increasingly expenditure on medical care.