CHAPTER - I
INTRODUCTION

Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health to all, free of charge; medicine like education is then no longer a trade it becomes a public function of the state.....

Henry Sigerist

The question of right to health has emerged as one of the most vibrant issues for discussion in this new millennium. Health care involves ever-changing challenges. The national and local decisions regarding health are affected by the global forces and policies. The effect of globalization on health has resulted in substantial gains for some groups and severe marginalization of others.

India bears 21% of global disease burden on its shoulders. This is coupled with spiraling health costs, high financial burden on the poor and erosion in their incomes. Around 24% of all people hospitalized in India in a single year fall below the poverty line. An analysis of financing of hospitalization shows that large proportion of people, especially those in the bottom four income quintiles borrow money or sell assets to pay for hospitalization.

The Alma Ata conference of 1978 convened by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF), is considered as a historical turning point in health care provisioning for the developing world. The declaration adopted, with its rallying cry of "Health for All by 2000", captured

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3 Ibid.
the imagination of the public health community in no uncertain way. Though the promises made by the political leadership of the 134 member countries to the people of the world remain largely unrealized, yet it continues to resonate even 31 years after the event. WHO’s Report of the year 2008, entitled as "Primary Health Care: Now more than ever", hoped to affirm that the concept is still valid. While social justice, universal access to health care, self-reliance, self-determination, enshrined in the declaration are values to aspire to, the question today is why the goals were not achieved.4

The Alma-Ata declaration came when India, free from direct colonial rule, was three decades into health planning. In 1947, when the country gained independence, half the population was dying before the age of 10 years, the life expectancy was less than 30 years and the major cause of death was communicable diseases, with "fevers" accounting for more than half of the deaths.5

As part of its welfare policy, the Indian government adopted the central guiding principle of the Bhore committee that no individual should be denied medical care because of his/her inability to pay for it. In 1959, the government appointed a committee under Dr. A.L. Mudialiar to review the health services and make recommendations. The committee (1962) observed that rural services were not popular among the doctors. Doctors wanted their posting in a city hospital or in the health department. The Shrivastav Committee set up in 1974 to review

5 Ibid.
medical education and support man power. So our historical experience tells us that we should abandon the policy approach and adopt the human rights route to assuring universal access to all people for healthcare.

Health is a state subject and health of all human beings is precious asset of the nation. It is nation's moral, legal and constitutional responsibility to promote, restore and maintain the health status of its population through meticulously designed policy, plans and programs, effectively implementing monitoring and evaluating them to yield targeted result in respect of health care infrastructure, man power support, provision of clean drinking water, sanitation and hygiene, besides a host of other inter-related activities.

In India, there are at present 1,46,026 Sub-Health Centres (SHCs), 23,236 Primary Health Centres [PHCs] & 3,346 Community Health Centers (CHCs). To meet 2001 population norm, additional 19,269 SHCs, 4337 PHCs and 3,206 CHCs are needed. At the end of 2000, India alone accounted for nearly one fourth of the world’s poor, highest number of maternal deaths (364 million) and undernourished children and one third of the world’s underweight children. Currently India spends on health less than one percent of its GDP.

In September 2000, 189 member states of the United Nations adopted the UN Millennium Declaration incorporating eight millennium Development Goals of which three sharply focused on "health" viz.

- Reduce child mortality

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6 Id. at 33. See for details infra chapter IV
7 Dr. Amrit Patel, 'Rural Health Commitment to UN Millennium Development Goals'. Kurukshetra, at 3(October 2008)
8 Id at 4.
• Improve maternal health
• Combat HIV/AIDS, malaria and other diseases

The year 2007 marked the mid point of the period agreed by the UN member states for the achievement of the MDGs. Infant mortality rate was 57 in 2005-06, the MDG aims to reduce it to one by 2012. Child mortality rate (under five) declined to 87 per 1000 live births in 2004 from 94 in 2000. The MDG aims to reduce to 41 in 2015. Maternal Mortality Rate (MMR) was 301 per 100,000 live births during 2001-03. The MDG aims to reduce to 109 by 2015.\(^9\)

However, disparities between rural and urban areas to access health care services were alarming. The state invested only 0.52% of its GDP on health care in 2005-06.\(^10\) Rural health centers, particularly the anganwadis, could not provide the needed health care to rural women and children because of insufficient resources. Most rural health centers had inadequate specialists, medical equipment and drugs. More than half a century's experience of waiting for the policy route to assure respect, protection and fulfillment for health care is now behind us.

Infact, 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 governments are primarily responsible for ensuring the health of their people, people have the right and duty to

\(^9\) Ibid.
\(^10\) Ibid.
participate individually and collectively in the planning and implementation of their healthcare.11

Research Hypothesis

Globalization of medical care has resulted in increase in cost. The emergence of big corporate hospitals as ‘ivory towers’ has brought world class medical standards to a few cities. But they are focused on curative medicine, and show the least commitment to preventive or promotive system of medicine.12 The large health infrastructure seems to be non-functional and unresponsive. Feedback monitoring and evaluation for planning and implementation of health initiatives have been found to be wanting in the country. This resulted in decline in accessibility and affordability of goods and services for common consumers. The present hypothesis rest on the presumption that if this situation remained unchecked the repercussions of this problem shall be annihilating to the biological and social structure of the society. For that matter, a comprehensive medico-legal study is required in order to strengthen the present legal control mechanism and plug the loopholes and also to modify the legal norms and practices.

Objective of Study

Enacting of legislation and establishment of infrastructure for their enforcement is not sufficient to achieve the desired goal. Experience is the biggest educator. It is all the more essential to have a continuous monitoring and, evaluation of existing laws. It is with this view that the present research work has been undertaken. The objective of study is to have comprehensive

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11 Binayak Sen, ‘Thoughts on Alma Ata and Beyond’ Economic and Political Weekly at 36 (November 22, 2008).
analysis of existing laws and government policies and evaluation of effectiveness of both laws and policies.

**Research Methodology**

The present research work requires both theoretical and empirical study. The theoretical work will deal with the literature relating to “right to health” in its historical perspectives various traditions and customs, various support systems like examination of constitutional, legislative provisions relating to health, government programmes and polices and also the international conventions and conferences, etc. affecting the national scenario.

A purely theoretical study of right to health cannot prove very beneficial unless an empirical study is performed in order to identify the grass root deficiencies. Thus, the empirical study has been conducted to ascertain the awareness amongst people as well as drawbacks existing in the implementation of the laws related to health rights. An important step in any research process is to select the method of data collection. The techniques which have been used in this research work to collect the data for analysis are the subjects from various strata of society, which are involved in any way with this problem. Following enlists the categories of subjects which are included:

- Data is collected from health professionals working in various health centres. To solicit the view of doctors, discussion and interviews were arranged with them.
- Views of general public have also been collected to know the grass root problem in this field.
- Views of students from legal and non-legal background have also been collected to know their opinion about the existing laws relating to right to health.
Questionnaire contained few questions which are known as class question. These questions were meant for special classes i.e. doctors, educated working people etc.

However, where the subjects were illiterate or not well versed with english language, the researcher filled it by asking the questions orally. It was a self-administered questionnaire, which reduces the chances of biasness to minimal. After the data was collected, it was arranged in spreadsheets and was analysed using MS-Excel. In most of instances it is expressed in form of percentage which is easy to understand and compare. Further to facilitate the comparison between various categories of subjects graphic representation is done.

**Analysis of Literature**

The literature resource for analysis is available in the form of number of books, newspaper, magazines, journals, articles, conventions, WHO reports, and internet sites. The literature relating to the right to health, various tradition and custom, various support systems like constitutional, legislative, government programmes and policies and also the international conventions and conferences affecting the national scenario has been studied in detail. The internet had a substantial effect to research work without which the research would have been much more difficult. All sources of information, digital or otherwise, have been cited in footnotes to the main text and these may serve as useful tools to guide those desiring to undertake in depth research in any of the areas that the work contains. One word of caution though websites and URLs being rather transient in nature, sometimes links might have lapsed, the footnotes only tell of those sites that existed at the time of writing along with the date when they accessed.
Universe of Study

A lot has been said about the right to health as a fundamental right, most of it emotional, some even poetic but little of much practical significance. There is almost concentrated lack of national will to deal with the health rights of children and women. Commissions are appointed,\textsuperscript{13} suggestions and recommendations made, discussed heatedly and subsequently ignored. In this era of universal human rights, health of citizens is still ignored.

Though the problem is not localized and knows no geographical limit, the study has been carried out in universal context due to the very nature of the subject yet with special focus on Chandigarh. Chandigarh being a capital of two states and a Union Territory, there is a significant growth in population which includes migrants also from other states. Due to these reasons and also due to the easy availability of the resources and to ensure a close look at the problem at grass-root level, the area of empirical study has been purposely confined to Chandigarh.

Plan of Study

The research has been presented schematically by dividing into nine chapters detailed as under:

Chapter - I: gives the introduction of the topic, its problem profile, object of study, research hypothesis, literature analysis and universe of study.

Chapter - II: deals with the historical perspective of 'health' and how the 'health' is defined under various alternative systems of health like Naturopathy, Ayurveda, Homeopathy, Unani, Siddha etc. The 'right to health' has been accorded the status of an

\textsuperscript{13} Bohra Committee Primary Health care approach recommended has not been paid attention. Legal News and Views, December 1998 at 36.
aspirational right in various international instruments. It is recognised as a basic human right worldwide under Universal Declaration of Human Rights 1948. Therefore, the discussion on right to health in the international scenario has been made part of Chapter-III of this study. In this chapter various international and regional conventions, declarations along with the role of WHO, UNICEF, WHA etc has been deliberated.

After examining international perspective of the health rights, the Constitutional and Legislative Provisions and Policies regarding health have been examined in Chapter-IV of this research. Since there are total approximately 71 legislation dealing with various health issues, only about 30 relevant have been discussed.14

Chapter-V deals with women’s and children’s right to health in India. This chapter is divided into two parts. In the first part focus is made on women and various issues affecting their health such as anaemia, malnourishment, HIV AIDS and other sexually transmitted diseases, menopausal health problems, prostitution, domestic violence etc have been analysed with the help of study of existing relevant laws in this regard. The second part of this chapter examines the children’s right to health. Here also, various factors affecting their health such as anaemia, malnourishment, female foeticide, child labour, illiteracy, child abuse etc have been discussed with the help of relevant laws in this direction.

No study regarding ‘right to health’ can be completed without examining the role of medical profession. Therefore,

14 The National Health Bill, 2009, Schedule III has given the list of 71 statutes which have to be reviewed under draft section 37 with the objective to effectuate its general purpose to facilitate uniformity of the law’s with respect to the subject matters of this Act among all the states. Visit http://www.mohfw.nic.in/nrhm/Draft Bill.htm. (accessed on April 15, 2009).
Chapter-VI analyse their role particularly in relation to medical negligence with the help of the judicial response. The doctor-patient relationship is also examined in the light of medical ethics as well as National Rural Health Mission programme.

Today science and technology has made tremendous progress in every field including medical. The affect of various new scientific developments on human health such as cloning both reproductive and therapeutic, organ transplantation, in-vitro fertilization, use of mobile phones, microwave ovens, GM foods, botox in the area of cosmetology etc have been deliberated both in the international and national context in Chapter-VII of this work.

Chapter-VIII is an empirical study confined to the UT Chandigarh in relation to public awareness as well as government's attitude on the 'right to health'.

Finally, based upon the research, in Chapter-IX the conclusion has been drawn and few suggestions have been given for effective implementation of the 'right to health' in the background of the draft of National Health Draft Bill 2009 which is yet to be debated in the Parliament.