CHAPTER FOUR
Human Rights Standards in Health: Indian Scenario

Human rights standards address the civil, political, economic, social and cultural sphere. Each human right, while formally belonging to one of those categories, in reality encompasses aspects of all of them. This is easily identifiable within the human right to health. Moreover, the right to health within the human rights framework is defined as the right to achieve the “highest attainable standard of health” not merely the absence of disease. Both of these aspects of human rights are consistent with a social determinant approach to health, as they take into account the wide array of factors that influence a person’s overall health status. Finally, a human rights and health care delivery approach both have in common an assumption that the primary purpose of a health care system is preserving health, rather than addressing economic interests. This chapter broadly focuses on health delivery system in India and helps in examining them as against the global standards. The background of health policy since independence and evaluation of government reports, commission’s recommendations and suggestions which we consider is of basic importance to know and explore the new dimensions of health rights. Second, it also presents the overview of health scenarios in India and standard setting norms in human rights and right to health which is a unit of analysis in this chapter. The argument flows from Alma Ata Declaration of 1978 and onwards.

The Alma Ata Declaration in 1978 gave an insight into the understanding of primary health care. It viewed health as an integral part of the socio-economic development of a country. It provided the most holistic understanding to health and the framework that States needed to pursue, to achieve the goals of development. The Declaration recommended that primary health care should include at least: education concerning prevailing health problems and methods of identifying, preventing and controlling them; promotion of food supply and proper nutrition, and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; promotion of mental health and provision of essential drugs. It emphasized the need for strong first-level care with strong
secondary- and tertiary-level care linked to it. It called for an integration of preventive, promotive, curative and rehabilitative health services that had to be made accessible and available to the people, and this was to be guided by the principles of universality, comprehensiveness and equity. In one sense, primary health care reasserted the role and responsibilities of the State, and recognized that health is influenced by a multitude of factors and not just the health services. It also recognized the need for a multi-sectoral approach to health and clearly stated that primary health care had to be linked to other sectors. At the same time, the Declaration emphasized on complete and organized community participation, and ultimate self-reliance with individuals, families and communities assuming more responsibility for their own health, facilitated by support from groups such as the local government, agencies, local leaders, voluntary groups, youth and women’s groups, consumer groups, other non-governmental organizations, etc. The Declaration affirmed the need for a balanced distribution of available resources (WHO 1978).

Keeping this definition in mind, we now discuss whether this holistic concept has been utilized as a framework by policy-makers to develop various health policy documents, health committee reports and the five-year plans since Independence so as to impact on the health system. After Independence, India adopted the welfare state approach, which was dominant worldwide at that time. As with most post-colonial nations, India too attempted to restructure its patterns of investment. During that time, India’s leaders envisaged a national health system in which the State would play a leading role in determining priorities and financing, and provide services to the population. ‘If it was possible to evaluate the loss, which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency through malnutrition and preventable morbidity, we feel that the result would be so startling that the whole country would be aroused and would not rest until a radical change had been brought about’ (Bhore Committee Report 1946).

The emphasis of the first health report, i.e. the Health Planning and Development Committee’s Report, 1946 (popularly known as the Committee Report) on the role of the
State was explicit. It was a plan equivalent to Britain’s National Health Service. Report was based on a countrywide survey in British India. It is the first organized set of health care data for India. The poor health status was attributed to the prevalence of insanitary conditions; malnutrition and under nutrition leading to high infant and maternal mortality rates; inadequacy of the existing medical and preventive health organizations; lack of general and health education; unemployment and poverty that produced adverse effects on health and resulted in inadequate nutrition; improper housing and lack of medical care. Inter-sectoral linkages were well discussed with nutrition, housing and employment as essential precursors for healthy living. It considered that the health programme in India should be developed on a foundation of preventive health work and proceeds in the closest association with the administration of medical relief. The Committee strongly recommended a health services system based on the needs of the people, the majority of whom were deprived and poor. It felt the need for developing a strong basic health services structure at the primary level with referral linkages. It also recommended the need to invest in the pharmaceutical sector to develop indigenous capabilities and reduce excessive reliance on multinational companies.

India was therefore one of the few developing countries which adopted a health policy that integrated the principles of universality and equity. Community participation and cooperative efforts to promote preventive and curative health work was important to achieve a vibrant health system. The Committee felt that large sections of the people were living below the normal subsistence level and they could not afford to pay for or contribute to the health services. It was decided that medical benefits would have to be supplied free to all at the point of delivery and those who could afford to pay should channel contributions through the mechanism of taxation. Though the report stated that ‘…it will be for the governments of the future to decide ultimately whether medical service should remain free to all classes of the people or whether an insurance scheme would be more in accordance with the economic, social and political requirements of the country at the time (Bhore Committee Report 1946), one point was apparent-that no individual should fail to secure adequate medical care, curative and preventive because of
the inability to pay for it. They recommended that State Governments should spend a minimum of 15 per cent of their revenues on health activities.’

The National Planning Committee (NPC) set up by the Indian National Congress in 1938 under the chairmanship of Colonel S. Sokhey stated that the maintenance of the health of the people was the responsibility of the State, and the integration of preventive and curative functions in a single state agency was emphasized. The Sokhey Committee Report was not as detailed as the Bhore Committee Report but endorsed the recommendations of the Bhore Committee Report and commented that it was ‘of the utmost significance’.

The objectives of the First (1951-56) and Second Five-Year (1956-61) Plans were to develop the basic infrastructure and manpower visualized by the Bhore Committee. Though health was seen as fundamental to national progress, less than 5 per cent of the total revenue was invested in health. The following priorities formed the basis of the First Five-Year Plan: provision of water supply and sanitation; control of malaria; preventive health care of the rural population through health units and mobile units; health services for mothers and children; education, training and health education; self-sufficiency in drugs and equipment; family planning and population control. Starting from the first plan, vertical programmes started, which became the centre of focus. The Malaria Control Programme, which was made one of the principal programmes, apart from other programmes for the control of TB, filariasis, leprosy and venereal diseases, was launched. Health personnel were to take part in vertical programmes. However, the first plan itself failed to create an integrated system by introducing verticality.

The concern of the Health Survey and Planning Committee (Mudaliar Committee 1962) was limited to the development of the health services infrastructure and the health care at the primary level. It felt the growth of infrastructure needed radical transformation and further investment. Another major shift came in the Third Five Year Plan (1961-66) when

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1 Health and Family Planning Services in India: An Epidemiological, Socio-Cultural and Political Analysis and a Perspective”, Lok Paksh, New Delhi, 1985
family planning received priority for the first time. Increase in the population became a major worry and was seen as a hurdle to the development process. Although the broad objective was to bring about progressive improvement in the health of the people by ensuring a certain minimum level of physical wellbeing and to create conditions favourable for greater efficiency, there was a shift in focus from preventive health services to family planning. During the Fourth Plan (1969-74), efforts were made to provide an effective base for health services in rural areas by strengthening the PHCs. The vertical campaigns against communicable diseases were further intensified.

During the Fifth Plan (1974-79), policy-makers suddenly realized that health had to be addressed alongside other development programmes. The Minimum Needs Programme (MNP) promised to address all this but became an instrument through which only health infrastructure in the rural areas was to be expanded and further strengthened. It called for integration of peripheral staff of vertical programmes but the population control programme got further impetus during the Emergency (1975-77) and most of the basic health workers got sucked into the family planning programme. Meanwhile the Chaddha Committee Report (1963), the Kartar Singh Committee Report on Multipurpose Workers (1974) and the Srivastava Committee Report on Medical Education and Support Manpower (1975) remained focused on giving recommendations on how the health cadres at the primary level should be distributed. With the widespread disillusionment with vertical programmes worldwide and the need to provide universal health services came the Primary Health Care Declaration at Alma Ata in 1978, which India was a signatory to. The Sixth Plan (1980-84) was influenced by two policy documents: the Alma Ata Declaration and the ICMR/ICSSR report on ‘Health for All by 2000’. The ICMR/ICSSR Report (1980) was in fact a move towards articulating a national health policy that was thought of as an important step to realize the Alma Ata Declaration. It was realized that one had to redefine and rearticulate and get back into track an integrated and comprehensive health system that policy-makers had wavered from. It reiterated the need to integrate the development of the health system with the overall plans of socio-economic and political change.
It recommended that the Government formulate a comprehensive national health policy dealing with all dimensions e.g., environmental, nutritional, educational, socio-economic, preventive and curative. The National Health Policy (1983) attempted to incorporate all these. Provision of universal, comprehensive primary health services was its goal. A large number of private and voluntary organizations who were active across the country in the health field were to support the Government in its efforts to integrate health services. Evolving a decentralized system of health care and nation wide chain of epidemiological stations were some of the main recommendations.

Once again, a selective approach to health care became the focus when a strong lobby questioning the financial repercussions of the primary health care approach came up. Verticality was reintroduced as an ‘interim’ arrangement and interventions of immunization, oral rehydration, breastfeeding and anti-malarial drugs were suggested\(^2\). This was seen as a technical solution even before comprehensive primary health care could be realized. UNICEF too came out with its report on the state of the world’s children health and suggested immunization as the spearhead in the selective GOBI-FF (growth monitoring, oral rehydration, breastfeeding, immunization, food supplements for pregnant women and children, and family planning) approach (Rifkin and Gill 1986).

Programme-driven health policies were once again the central focus. Hence, the plan documents emphasized on restructuring and developing the health infrastructure, especially at the primary level. The Seventh Plan (1985-90) restated that the rural health programme and the three-tier health services system need to be strengthened and that the government had to make up for the deficiencies in personnel, equipment and facilities. The Eighth Plan (1992-97) distinctly encouraged private initiatives, private hospitals, clinics and suitable returns from tax incentives. With the beginning of structural adjustment programmes and cuts in social sectors, excessive importance was given for vertical programmes such as those for the control of AIDS, tuberculosis, polio and malaria funded by multilateral agencies attached with specific objectives and conditions.

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Both the Ninth (1997-2002) and the Tenth Five-Year Plans (2002-2007) start with a dismal picture of the health services infrastructure and go on to say that it is important to invest more on building good primary-level care and referral services. Both the plans highlight the importance of the role of decentralization but do not state how this will be achieved.

The National Health Policy (2002) includes all that is wanted from a progressive document and yet it glosses over the objective of NHP 1983 to protect and provide primary health care to all. The Policy document suggests that the integration of vertical programmes, strengthening infrastructure, providing universal health services, decentralization of the health care delivery system through Panchayati Raj Institutions (PRIs) and other autonomous institutions, and regulation of private health care but fails to indicate how it achieves the goals. It encourages the private sector in the first referral and tertiary health services. However, to understand the health right within the framework of standard setting one has to know the delivery of health services in the public sector.

**Delivery of Health Services in the Public Sector**

Health Systems an end in themselves or a means to achieving certain ends? Worldwide, there seems to be a consensus on measuring health systems in terms of improving the health status, enhancing patient satisfaction and providing financial risk protection. In 2000, the World Health Organization (WHO) further expanded the definition of health. It includes a reduction in disparities for improving health status and sharing the financial burden in accordance with the ability to pay as being a fair form of health financing. There is, however, not withstanding the evolved standards, little consensus on what constitutes an ideal health system in universally acceptable terminology to enable better inter country comparisons. This is because, unlike any other sector, health systems are highly contextualized and influenced by various exogenous factors such as societal values, epidemiology and disease burden, availability of financial resources, technical capacity, individual preferences and the nature of demand. Technological innovation in

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the health sector has improved the quality of life but has also increased costs. In countries that have no social insurance and where the role of the state is limited, people spend a substantial proportion of their incomes on seeking medical treatment, and in the process, get impoverished, thus widening disparities in the health status. To contain spiraling prices and distortions created by market failures such as moral hazard, asymmetry in information, induced demand etc., countries resort to multiple policy instruments. Health systems have five aspects or knobs that interact with each other and influence its basic nature and direction: (i) financial (tax, user fees, out-of-pocket expenditure, insurance), (ii) payment systems (how providers are paid: salary, per service rendered, capitation), (iii) organizational (manner in which the delivery systems are organized/structured), (iv) legal (regulatory frameworks) and (v) social (access to health information, advertising). The effectiveness with which these instruments of state policy are designed and used determines the extent to which the health system is equitable, appropriate or fair. The health system in India consists of a public sector, a private sector and an informal network of providers of care operating within an unregulated environment, with no controls on what services can be provided by whom, in what manner, and at what cost, and no standardized protocols to help for measuring the quality of care. There are wide disparities in access, further worsened by the poor functioning of the public health system.

Evolution of the Health System in India: An Overview

The evolution of India’s health system can be categorized into three distinct phases:

- Phase I (1947-83)-when the health policy was based on two principles: (i) that none should be denied care for want of ability to pay, and (ii) that it was the state’s responsibility to provide health care to the people.

- Phase II (1983-2000)-when the first National Health Policy of 1983 articulated the need to encourage private initiative in health care service delivery, while at the

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same time expanding access to publicly funded comprehensive primary health care.

- Phase III (post-2000)-which is witnessing a further shift that has the potential to profoundly affect the health sector in three important ways: (i) the desire to utilize private sector resources for addressing public health goals; (ii) liberalization of the insurance sector to provide new avenues for health financing; and (iii) redefining the role of the state from being only a provider to a financier of health services as well.

Phase I (1947-83)

At the time of Independence, malaria affected almost a quarter of India’s population; virulent diseases such as smallpox, plague and cholera were rampant, maternal mortality was over 2000 per 100,000 live-births and longevity of life was less than 32 years (Bhore 1946). While the public sector consisted of a few city hospitals, the private sector consisted largely of individual practitioners of Indian systems of medicine and licentiates practicing in villages, as family doctors. With meager resources, this period saw the effective containment of malaria, bringing down the incidence from an estimated 750 lakh to less than 20 lakh, eradication of smallpox and plague, halving of the maternal mortality rate (MMR), reduction of the infant mortality rate (IMR) from 160 per 1000 live-births to about 105, containing cholera and increasing longevity of life to almost 54 years. Institutes of excellence such as the All India Institute of Medical Sciences (AIIMS) were set up for research and quality training, making India an exporter of highly trained medical doctors. These gains were in no small measure due to the strong foundation of public health on which the health system was grounded and the highly professionalized cadre of public health specialists who provided leadership from the front, camping in villages in hostile environmental conditions, whether to eradicate smallpox or supervise the malaria worker. However, under the overarching influence of modernization that characterized the post-colonial phase of global development, the urge to be on par with the western norms of modern medicine proved to be too strong to resist. India, unlike China, missed the opportunity to launch public health campaigns to promote, at the
community and individual household levels, healthy lifestyles alongside expanding public investment to assure universal access to water, sanitation, nutrition and education. Instead, and more particularly during the 1960s and 1970s, public health campaigns were focused only on promotion of the small family norm and family planning. India also failed to utilize the strengths of the traditionally used and accepted modes of medical treatment and gave undue emphasis to allopathy, gradually laying the base for an expanded market for western style curative services, which are urban based as well as costly.


Despite the remarkable achievements in disease control, the failure to control the population, the lack of access to basic health facilities in rural areas, and the international commitment to focus on providing comprehensive primary care as envisioned by the Alma Ata Declaration in 1978, led to the formulation of the National Health Policy of 1983. Limited resources to meet the growing demand for health services led to the articulation for private sector to shoulder some part of the burden. An estimated Rs 6500 crore worth of subsidy in terms of exemptions in customs duty for import of equipment, subsidized inputs such as land, etc. were extended to stimulate private investment in health. Alongside, the focus of state policy shifted to primary health care to reduce the iniquitous urban-rural divide and expand access to the rural populations, particularly the poor. Lack of resources resulted in segmenting health into independent silos of disease control programmes rather than visualizing health care as a continuum of service. Such segmentation led to simplistic formulations of the role of state being confined to primary health care and a selected list of diseases and health interventions, rather than being responsible for the well-being and health of the people. This phase witnessed an expansion of health facilities for providing primary health care in rural areas and the implementation of national health programmes (NHPs) for disease control under vertically designed and centrally monitored structures.

The adoption of this twin strategy had its advantages. With less than Rs 200 per capita investment (2000), prioritization of interventions that benefit the poor and entail wide
externalities, provided a moral and technical justification. Besides the establishment of health facilities in accordance with a population norm, guinea worm was eradicated and the disease load due to infectious diseases reduced and deaths averted. During the 1990s, with assistance from the World Bank, NHPs were upscaled with impressive outcomes: the cure rate of tuberculosis (TB) under the Directly Observed Treatment, the (DOTS) programme doubled and averted an estimated 50 lakh deaths, leprosy was eliminated except in 70 districts, the incidence of cataract as a cause of blindness reduced from 80 per cent to less than 50 per cent and the number of polio cases decreased drastically from 29,709 to about 100 (Table 1).

Fiscal stress gave rise to innovation; various States attempted to improve the overall performance of public health facilities by a combination of policies-improved availability of inputs, greater flexibility in spending; defining responsibilities and rationalizing performance outputs; widening the scope for involvement of local bodies, non-governmental organizations (NGOs), etc. Table 2 gives a broad idea of the policy areas, the direction and nature of such innovation and names of the pioneer states. The initiatives taken and the outcomes are impressive when analysed in reference to wide disparities in income and socio-cultural behaviour, a fast-changing economic scenario, comparatively unstable political environment in several States and a near stagnant average per capita investment in primary health care of Rs 105. Despite the reduced health spending as a result of fiscal pressures that States faced during this period, most of them took advantage of available opportunities to achieve whatever they could, underscoring the fact that a limited level of investment can only give a commensurate level of outcome. Notwithstanding the above factors, five serious omissions occurred in the public health policy: (i) the private sector was encouraged without provisions for regulations, standards and accreditation processes; (ii) there was an absence of surveillance and epidemiological surveys to get a more accurate understanding of the changing profile of disease prevalence and incidence, which is necessary for measuring risk factors, designing interventions and launching information campaigns to reduce risky behaviour; (iii) advantage was not taken of the 73rd and 74th Constitutional Amendments for decentralizing programme implementation to the local bodies/community for
increasing accountability in the system; (iv) neglect of research and development to promote technological innovation; and (v) inadequate investment in developing the critical mass of required skills and human resources. In other words, the governments ran public health programmes that would have been more cost-effective for the communities and local bodies and in the process neglected their more fundamental responsibility of governance- of laying down a framework, defining the rules of the game and monitoring systems to see that no player takes undue advantage in the health sector.

<table>
<thead>
<tr>
<th>Programme</th>
<th>Indicators</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control of Leprosy (prevalence per 10,000)</td>
<td>24 (1992)</td>
<td>2.44 (2003)</td>
</tr>
<tr>
<td>Control of HIV - per 1,000,000</td>
<td>3.5 (1998)</td>
<td>5.1 (2005)</td>
</tr>
<tr>
<td>Control of malaria in 8 project districts API 13.8</td>
<td>(1999) 9.5 API</td>
<td>(2002) In 32 out of 100 districts API fell below 2.</td>
</tr>
<tr>
<td>Reduction in polio cases</td>
<td>29,709</td>
<td>&lt;100</td>
</tr>
</tbody>
</table>

Sources: Ministry of Health and Family Welfare (MoFM), Government of Orissa
## Table 2

### Innovation in the Health Sector by States 1995-2000

<table>
<thead>
<tr>
<th>Area of Innovation</th>
<th>Broad Direction of the innovation and innovators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public-private partnerships</strong></td>
<td>Handing over the management of public facilities to NGOs (Gujarat, Karnataka); Contracting private specialist services and outsourcing other services, such as diet, distribution of IEC materials, etc. (most States)</td>
</tr>
<tr>
<td><strong>Decentralization</strong></td>
<td>Transfer of budgets to and involvement of local bodies (Kerala, Karnataka, Himachal Pradesh, Orissa); Management Boards of Health Facilities (Rajasthan, Madhya Pradesh, Andhra Pradesh)</td>
</tr>
<tr>
<td><strong>Human resources</strong></td>
<td>Contracting professionals for service delivery-ANMs, doctors, surveillance, auditing, etc. (all States); Multiskilling, pre-internship training, Mandatory pre-post graduate rural service (Orissa)</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>User fees and financial autonomy to hospitals (Madhya Pradesh, Rajasthan, Andhra Pradesh, Karnataka, Punjab, West Bengal, Maharashtra); Health insurance (Andhra Pradesh, Karnataka, West Bengal); Direct transfer of funds from GOI to districts under NHPs; Financial delegation of powers to PHCs, CHCs and district CMO (Tamil Nadu, Gujarat)</td>
</tr>
<tr>
<td><strong>Accountability</strong></td>
<td>Delegation of powers to district-level officials (Gujarat, Tamil Nadu, rationalizing responsibilities for better accountability, performance-based monitoring (Andhra Pradesh, Gujarat)</td>
</tr>
<tr>
<td><strong>Community mobilization</strong></td>
<td>Link couple schemes (Gujarat, Rajasthan); Village Planning and Community Health Worker (Madhya Pradesh, Uttar Pradesh)</td>
</tr>
<tr>
<td><strong>Regulation/standard setting</strong></td>
<td>Quality control circles (Gujarat); Blood transfusion standards (NACO); ISO certification (Karnataka, Himachal Pradesh) Ensuring the availability of essential drugs at health facilities under the Panch Byadhi Chikitsa scheme (Orissa); Centralized drug procurement (Tamil Nadu, Orissa, Andhra Pradesh, Rajasthan)</td>
</tr>
</tbody>
</table>

IEC: Information, Education and Communication; GOI: Government of India; NHP: National Health Policy; PHC: Primary Health Centre; CHC: Community Health Centre; CMD: Chief Medical Officer; NACO: National AIDS Control Organization.

SOURCE: Initiatives from Nine States, MOHFW, GOI 2004

### Phase III (post 2000) National Health Policy II, 2002

By 2000, India had not achieved 13 out of the 17 goals laid down in the first National Health Policy of 1983. Analysis of the 52nd Round National Sample Survey (NSS) on the utilization of health services showed that during 1986-96, there was a decrease in the
utilization of public facilities for outpatient care from 26 per cent to 19 per cent; a
decrease in access to free care from 19 per cent to 10 per cent and an increase in the
number of persons not seeking care due to financial incapacity (Table 3).

State-wise comparisons show that the poorest in the poorer States of UP and Bihar had to
pay substantial amounts for outpatient treatment and a low utilization of public facilities,
which indicates a virtual breakdown of the public health system. On the other hand, in
Assam and Orissa, a large proportion of persons did not avail of treatment at all. Read
along with the number of untreated ailments due to financial reasons, the picture is
dismal, as it further emphasizes the failure of the public health system in providing risk
protection, since the average cost of outpatient treatment for every episode of illness is
equivalent to three to five days’ wage of one earning member of the family. To reduce
the disease burden affecting the poor and alarmed by the falling levels in the utilization of
public facilities, the government brought forth the National Population Policy (2000), the
National Health Policy (2002), and the AYUSH Policy (2000), reiterating its resolve and
commitment to achieve a set of goals by 2010. The goals envisaged are to increase public
investment in health from the current level of 0.9 per cent to 2 per cent 3 per cent; to
increase the utilization of primary care facilities from less than 19 per cent to over 75 per
cent; to reduce the MMR by three quarters from the current level of over 540 per 1000; to
reduce the IMR from 62 per 1000 live-births to less than 30, eradicate polio, eliminate
leprosy, reduce deaths on account of TB and malaria by over 50 per cent, etc. Many of
these objectives are in consonance with the Millennium Development Goals (MDGs) for
2015. The following section highlights the systemic issues that may constrain from
achieving these goals within the given time-frame unless addressed on priority. Some of
the relevant data presented below which has been already discussed above.
Table 3
Utilization of Primary and Community Health Centres for Outpatient Care in Rural Areas

<table>
<thead>
<tr>
<th>State</th>
<th>Utilization of PHC/CHC for OP care (Out of total OP) (%)</th>
<th>Utilization of PHC/CHC for OP by the poorest 2 quintiles (Out of total PHC/CHC OP) (%)</th>
<th>Untreated ailments out of total number of ailments (%)</th>
<th>Untreated ailments due to financial reasons (Out of total number of ailments) (%)</th>
<th>Average total household expenditure for treatment per ailment (OP) (in RS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well performing States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kerala</td>
<td>5.4</td>
<td>49</td>
<td>11.7</td>
<td>1.5</td>
<td>119</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>7.2</td>
<td>41.5</td>
<td>22.4</td>
<td>---</td>
<td>79</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>5.7</td>
<td>52.1</td>
<td>25.5</td>
<td>5.2</td>
<td>116</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>6.5</td>
<td>47.7</td>
<td>11.4</td>
<td>2.9</td>
<td>144</td>
</tr>
<tr>
<td>Karnataka</td>
<td>11.0</td>
<td>55.1</td>
<td>22.3</td>
<td>2.6</td>
<td>91</td>
</tr>
<tr>
<td>Moderate performing States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gujarat</td>
<td>9.9</td>
<td>29.3</td>
<td>8</td>
<td>----</td>
<td>144</td>
</tr>
<tr>
<td>West Bengal</td>
<td>4.3</td>
<td>49.1</td>
<td>19.9</td>
<td>4</td>
<td>105</td>
</tr>
<tr>
<td>Punjab</td>
<td>1.8</td>
<td>41.2</td>
<td>1</td>
<td>0.5</td>
<td>173</td>
</tr>
<tr>
<td>Haryana</td>
<td>5.1</td>
<td>23.5</td>
<td>3</td>
<td>----</td>
<td>183</td>
</tr>
<tr>
<td>Poor performing States</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rajasthan</td>
<td>10.2</td>
<td>44.1</td>
<td>10.2</td>
<td>6.2</td>
<td>172</td>
</tr>
<tr>
<td>Orissa</td>
<td>18.4</td>
<td>30.2</td>
<td>32.3</td>
<td>14.6</td>
<td>99</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>8.9</td>
<td>27.6</td>
<td>16.3</td>
<td>1.7</td>
<td>129</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>1.5</td>
<td>38.6</td>
<td>9.4</td>
<td>----</td>
<td>202</td>
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<tr>
<td>Assam and NEast</td>
<td>27.13</td>
<td>---</td>
<td>44</td>
<td>9.02</td>
<td>83</td>
</tr>
<tr>
<td>Bihar</td>
<td>2.0</td>
<td>19.6</td>
<td>21.9</td>
<td>5.5</td>
<td>220</td>
</tr>
<tr>
<td>All India</td>
<td>6.4</td>
<td>37.9</td>
<td>17.3</td>
<td>3.5</td>
<td>144</td>
</tr>
</tbody>
</table>

PHC: Primary Health Centre; CHC: Community Health Centre; OP: Outpatient

NOTE: The total OP for a reference period of 15 days is 375.3 lakh. The total number of ailments (rural) is 408 lakh yearly. The average total expenditure for OP care is for the reference period of 15 days. Total expenditure includes medical expenditure and all expenses other than medical expense incurred by the household for availing the treatment.

Source: Mahal A, Yazbeck AS, Peters DH, et al., the Poor and Health Service Use in India. HNP Discussion Paper, Washington, DC, the World Bank, 2001
Organizational Structure of the Public Health Sector Delivery System

There has been a clear absence of any deliberate strategy to use the organizational tool for achieving public health goals, except family planning, until the Sixth Five-Year Plan when, under the Minimum Needs Programme, concerted efforts were made to focus on expanding access to primary care in rural areas. Thus, built over the years, the public health delivery system consists of a large number of dispensaries, primary health care institutions, small hospitals providing some specialist services, large hospitals providing tertiary care, medical colleges, paramedical training institutions, laboratories, etc.

The failure to improve the health status, be accountable and responsive to people’s needs or protect them from financial risk has brought into focus the functioning of the public health system, underscoring its failure in fulfilling such legitimate expectations. The focus of this section is to understand the causal factors that have led to such a failure. These causal factors can be divided into three broad groups:

1. Poor goal setting and lack of formulation of strategic interventions;
2. Management Failures;
3. Limited role of the State.

Goal-setting and Strategic Interventions

The public health system is inaccessible, disconnected to public health goals and inadequately equipped to address people’s expectations. For the majority of citizens, the public health system is out of their reach due to distance, lack of money, lack of confidence in the system or the availability of a cheaper alternative. The organizational structure requires a villager to travel an average distance of 2.2 km to reach the first health post for getting a paracetamol; over 6 km for a blood test and nearly 20 km for hospital care. Given the poor road connectivity, the unreliability of finding the provider at the health centre, the indirect costs for transport and wages foregone, the marginal cost of availing a public service outweighs that of getting some treatment from the local quack. Further, even when accessed, there is no continuity of care guaranteed5. In other words,

5 Sen P. D., Community Control of Health Financing in India: A Review of Local Experiences, Bethesda, Maryland, Abt Associates, Partnerships for Health Reform, xvii, Technical Report No. 8 USAID Contract No. HRN-5974-C-00-5024-00) October 1997, P. 83
the segmentation of the health system into primary, secondary and tertiary, administered and monitored by different bodies, with none working in coordination, has resulted in the dilution of the concept of the integral nature of health where curative services are a continuum of the preventive and promotive health care.

Table 4
Public health infrastructure In India, 1951-2001

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Total</td>
<td>2694</td>
<td>3054</td>
<td>3862</td>
<td>6805</td>
<td>11174</td>
<td>NA</td>
<td>15888</td>
</tr>
<tr>
<td>Rural</td>
<td>39</td>
<td>34</td>
<td>32</td>
<td>27</td>
<td></td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>43</td>
<td>57</td>
<td>71.2</td>
</tr>
<tr>
<td>Hospital/dispensary beds</td>
<td>117000</td>
<td>229634</td>
<td>34865</td>
<td>50453</td>
<td>66413</td>
<td>NA</td>
<td>71986</td>
</tr>
<tr>
<td>Rural</td>
<td>23</td>
<td>22</td>
<td>21</td>
<td>17</td>
<td></td>
<td>11.06</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>28</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
<td>38.2</td>
<td></td>
</tr>
<tr>
<td>Dispensaries Total</td>
<td>6600</td>
<td>9406</td>
<td>12180</td>
<td>16745</td>
<td>27431</td>
<td>NA</td>
<td>23.06</td>
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<tr>
<td>Rural</td>
<td>79</td>
<td>80</td>
<td>78</td>
<td>69</td>
<td></td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>13</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>PHCs</td>
<td>725</td>
<td>2695</td>
<td>5131</td>
<td>9115</td>
<td>18671</td>
<td>22149</td>
<td>22842</td>
</tr>
<tr>
<td>Sub-centres</td>
<td>27929</td>
<td>84736</td>
<td>13016</td>
<td>13625</td>
<td>8</td>
<td>13731</td>
<td>1</td>
</tr>
<tr>
<td>CHCs</td>
<td>761</td>
<td>1910</td>
<td>2633</td>
<td>3043</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PHC: Primary Health Centre; CHC: Community Health Centre
SOURCE: Health Statistics/Information of India, CBHI, GOI, Various Years; Rural Health Bulletin, GOI 2002; National Health Policy, MOHFW, GOI, 2002

In eight States, substantial investments were mobilized from the World Bank to upgrade, strengthen and establish hospitals at the district, sub-district and block levels. The comprehensive definition of the primary health infrastructure (Health for All Report of 1980) got a further distortion with the community health centres (CHCs) rechristened as first referral centres (FRUs), divorcing them from their contextual framework. In Andhra Pradesh, Karnataka, Punjab, etc. the World Bank-funded CHCs were brought under the administrative control of autonomous Directorates dealing with secondary level hospitals while those CHCs not covered under the project are continued to be administered by the Director of Health Services. An evaluation report of West Bengal, AP, Karnataka and Punjab showed that while these states were successful in improving the quality of care in urban and semi-urban areas (Table 5), an expected outcome, such as, for example, an increase in institutional deliveries was not realized. Had the focus been on establishing
the referral system and linkages with the other World Bank-assisted disease control and Reproductive and Child Health (RCH), investments made for strengthening the health systems would have had a considerable impact on reducing maternal, neonatal and infant deaths, or deaths due to malaria, TB which require hospitalization? This experience clearly demonstrates that mere increase in investments in infrastructure does not automatically translate into better health outcomes.

It also underscores the urgent need for conceptual clarity on the expectations of the organizational structures that have been established and the urgent need for standardization of facilities across the country. Shortage of funds has been primarily responsible for the non-availability of facilities in accordance with the norms set by the government; and inadequate provisioning of critical inputs such as drugs, equipment, facilities such as operation theatre, etc. Due to lack of budgets and the pressure to achieve targets, several States upgraded the two-roomed sub-centres to PHCs, with no place for laboratory, examination, pharmacy, etc. Most of them are non-functional. There are PHCs with over 33 sub-centres and there are sub-centres which cover over 200 habitations. It is estimated that 25% of people in Madhya Pradesh and Orissa, and 11% in Uttar Pradesh could not access medical care due to hospital location reasons (NSS-India Health Report, 2003). The question that then arises is to what extent is infrastructure an important determinant in health outcomes? Is there any association? Box 1 reveals the mockery we have made of the health care service delivery system by having subcentres function in non-standardized places denying dignity and privacy to women who visit the ANM for treatment and care. Some of the evidence gives the levels of utilization of the PHC facilities. It links outcomes with the infrastructure to examine if there is any such association. What emerges from the data is that while in the poorer performing States, the ratio of facilities to 100,000 population are on par with the rest of the States, and even better than that in Andhra Pradesh and West Bengal, the health outcomes are poor. This shows that it is not mere establishment of a physical facility but a combination of factors such as distance, availability and quality of skills, adequacy of infrastructure and access to alternative sources of care that seem to influence health-seeking behaviour and determine outcomes which have been captured by a set of indicators such as complete
immunization, percentage of those severely malnourished, full antenatal coverage, safe and institutional deliveries and finally, the IMR and the under five mortality rate (U5MR). While it is clear that infrastructure development had little linkage to goal setting, it is also seen that policy interventions per se often lacked focus, were not based on hard evidence, and had weak institutional capacity to translate policy into action.

### Table 5
Evaluation of World Bank-Assisted for State Health Systems

<table>
<thead>
<tr>
<th>State/year of project</th>
<th>Increase in the utilization of outpatient care (%)</th>
<th>Increase in the utilization of inpatient care (%)</th>
<th>Increase in laboratory tests (%)</th>
<th>Additional beds (% increase)</th>
<th>Increase in bed occupancy (%)</th>
<th>Reduction in institutional deliveries 1999-2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karnataka (1996-2001)</td>
<td>72.2</td>
<td>83.3</td>
<td>29.0</td>
<td>29.3</td>
<td>10.8</td>
<td>From 55% to 33%</td>
</tr>
<tr>
<td>West Bengal (1996-2004)</td>
<td>44.6</td>
<td>29.3</td>
<td>54.4</td>
<td>12.9</td>
<td>71.6</td>
<td>From 77% to 74%</td>
</tr>
<tr>
<td>Punjab (1996-2003)</td>
<td>115.9</td>
<td>65</td>
<td>456.6</td>
<td>45.6</td>
<td>14.4</td>
<td>From 97% to 26%</td>
</tr>
<tr>
<td>Andhra Pradesh (1995-2002)</td>
<td>102.2</td>
<td>100</td>
<td>Not available</td>
<td>67.3</td>
<td>Not available</td>
<td>From 35% to 33%</td>
</tr>
</tbody>
</table>


Lack of Focus, Evidence and Capacity

Lack of focus: Vertical Versus Horizontal Programmes

Box 1
The State of India’s Health Delivery System

In one district, where the NCMH took up a facility survey, officials stated that 90% of the 369 ANMs did not reside in the area of their jurisdiction—a situation referred to in Rajasthan and Gujarat as ‘up-down’—and that with just Rs 75 per month as rental most subcentres were functioning in verandahs. Now the rent has increased to Rs. 250 but the ‘verandahs cannot be left as dues have to be paid’! Due to lack of any facility and privacy, the ANM does not provide any maternal services.
The NHP 1983 made a strong policy commitment to establish a comprehensive primary health care, based on the active involvement of the community and intersectorally linked to non-health determinants such as water, sanitation, etc. Such an approach if implemented would have helped avert an additional 15 lakh infant and 800,000 maternal deaths. Gains could have been impressive. However, the NHP was hardly implemented. Instead, largely due to resource constraints, strategies contrary to what was stated in the policy, were adopted (such as the selective primary health care approach). The adoption of the strategy of selective primary health care, running counter to the vision of a comprehensive primary health care laid down in the NHP of 1983 was on account of resource constraints. Compulsions to prioritize resulted in selecting interventions based on the criteria of the extent to which the disease/condition affected the poor disproportionately more, was technically feasible to implement and could be made available at comparatively low cost, and to be implemented vertically from the centre. Evidence from community-based experiments and surveys however tell another story. They conclusively show that people have other health needs and expectations from their health system which make integrated approaches more effective, efficient and, in the long run, more sustainable. The experiments also show that vertical programmes fail to integrate with the provisioning of general health services, weaken the health system as a whole and, over a period of time, get disconnected from local health problems, priorities and the community itself. These observations find resonance in the experience gained so far. A range of health needs such as treatment for debilitating fever that incur wage losses for the labourer, treatment for epilepsy, uterine prolapses, infertility or menstrual problems affecting women’s ability to work are concerns that are ignored as public health systems narrowly focus on achieving programme targets: sterilization, immunization, collection of blood smears in case of fever, providing drugs to sputum positive persons etc. In fact, even under a programme such as the RCH, which is expected to be gender-sensitive, due to its vertical, target-oriented nature, the number of women receiving postmortem care was very low (NFHS II). Given the large number of domiciliary deliveries, the health workers visited an average of 5.1 per cent mothers within one week of delivery and 16.5 per cent mothers within 2 months of delivery. In Madhya Pradesh, these figures were 1.8 per cent and 10 per cent and in Uttar Pradesh 2 per cent and 7.2 per
cent, respectively. This not only explains the reason for such high neonatal mortality but also the unattended morbidity which in these two States was reported to have affected nearly 17 per cent women, while 10 per cent 13 per cent suffered heavy women health problem (NFHS-2, 1998-99). Such postmortem morbidities go unmonitored, as they are not a part of the programme targets to be achieved. Apart from such distortions, vertical programming with line item-wise budgeting provides little flexibility for front-line workers responsible for delivering care, making integration difficult as seen in the case of HIV with Family Welfare or providing treatment for malaria or TB to pregnant women.

Another example of a narrow, programmatic approach is TB. While there is no doubt about the technical efficacy of Directly Observed Treatment (DOTS) for curing TB, there is some concern about the techno-managerial approach to a disease that is embedded in the biosocial determinants of poverty, poor housing, illiteracy, financial problems, migration, and low resilience to the initial side-effects of the drugs affecting the ability to work. The DOTS programme is a highly sophisticated one and very well designed, ensuring the availability of microscopes, trained manpower and drugs etc. but has little effort or budgetary resources for tackling the root cause of the disease, for spreading awareness about the programme, for social mobilization to see that people in need get the treatment. In an attention to the social causes or community involvement can result in dropouts or the very poor not being able to access or continue with the treatment, for example migratory labour. Besides, a legitimate concern expressed widely is the potential for increase in primary multi-drug resistant (MDR) TB, which is currently estimated to be 2.8 per cent in North Arcot near Chennai. This is largely on account of the existence of multidrug regimens being administered by doctors in the private sector and the tendency of shopping that patients resort to, on an average about six to nine providers, before finally reaching the DOTS center. Such frequent switching of doctors by the patients is not only draining their financial base but also, with the irrational prescriptions given, could well be contributing to drug resistance. MDR TB is not only far more expensive to treat but may also not be treatable. Yet, India barely has a surveillance network to closely
monitor this aspect. The story of TB reiterates the need for social/community control on the process and the need for adopting a public health approach to the disease⁶.

**Weak Evidence Base for Interventions**

Neither the Ministry at the Centre nor at the State level has adequate in-house capability to design research studies, collect data and analyze research findings of the various health interventions to enable evidence-based policy-making. Substantial resources are being spent on programmes and interventions that have a poor evidence base. For example, there is no evidence to indicate the current burden of malaria, or maternal mortality. Similarly, hardly any studies are available to assess the efficacy of the use of a drug or of a treatment protocol in different settings and conditions for formulating differential strategies to suit the diverse conditions prevailing in India.

Such non-availability of good quality research for evidence based policy formulation is one instance of the health delivery system missing the woods for the trees. For example, the principal goal of the National Reproductive Health Programme is to reduce maternal mortality. Over 100,000 women die every year due to pregnancy-related reasons that necessitate skilled attendance and some surgical interventions. The international definitions of skilled attendants disqualify either the traditional birth attendants (TBAs) or the 18 months’ trained ANMs. Surgical interventions on the other hand require a minimum infrastructure such as access to blood, an operation theatre, access to personnel skilled in surgery and administration of anesthesia, etc. Public policy should in all these years have to focus on making investments on development of infrastructure and building-up a professional and skilled cadre of attendants for facilitating safe and institutional deliveries. The failure to link intervention with evidence has resulted in poor outcomes.

The organizational strategy consisted of three concepts: (i) Village-level clinics conducted by a professional health team consisting of a medical doctor, a trained nurse,

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laboratory assistant, etc. to provide antenatal care (ANC) and examine other ailments, with the auxiliary nurse attending to mandatory registration of all pregnant women, other public health duties and promoting institutional deliveries, etc; (ii) Investment in establishing well-equipped maternal and child health (MCH) clinics/hospitals for delivery; and (iii) a strong health management information system (HMIS) and monitoring system including a regular medical audit of every maternal death for taking corrective action. Compared to the above factors, India for several years promoted training of village-based TBAs, consistently lowered the quality of training and competencies of the ANMs and neglected supervision and monitoring. Resorting to such low-cost solutions helped avoid committing resources required for the establishment of the requisite infrastructure and human resource development. The example of MMR is useful as it is a good proxy for demonstrating the effectiveness of the health system. A similar mismatch between goal and strategic intervention is evident in the case of reducing the IMR. While 40 per cent of deaths take place within one week of birth, and nearly 23 per cent on account of upper respiratory tract injections and diarrhoeal diseases, strategies required to address these causal factors have been overshadowed by the immunization programmes, particularly the one for polio. The single-point pursuit of polio eradication has resulted in adversely affecting the routine immunization programme, which was initiated in 1986 as a Technology Mission for achieving full protection against all vaccine-preventable diseases by 2000. As per a household survey conducted in 1998 and again in 2003 (Indian Institute of Population Sciences 2004), the data for 220 districts showed that in the majority of the districts, there was either a declining performance or no improvement at all under the Universal Immunization Programme (UIP). Second, the high percentages of drop-outs for oral poliomyelitis virus (OPV3) indicated the wrong perception among mothers of the need to adhering to the immunization protocol (Table 6). Discussions with field staff seemed to suggest that this decline was largely on account of the emphasis given to polio, which not only commanded better resources and visibility in the media but also consumed nearly one-third of the time, 30 times the cost and exhausted the staff in 2003, the Government of India (GOI) had to dispatch half the departmental officers to oversee the Pulse Polio Initiative (PPI) Round due to resistance from the local staff which had got tired of
participating in one campaign after another- 4 rounds of PPI with each round requiring one whole month of preparation, two family health awareness programmes camps of the National AIDS Control Organisation (NACO), health melas of the GOI, leprosy household rounds for identification of left-out cases, registration of patients with guinea worm infection, RCH camps, family planning targets, and so on. Such isolated programmatic approaches have made it impossible to allow the health system to develop. Therefore, even as we get set to achieving zero polio prevalence in India, the question remains as to whether vertically driven strategies implemented in a campaign mode, which are also resource intensive and neglect equally important public health functions, are worthwhile.

**Table 6**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Positive decline</th>
<th>Stagnant</th>
<th>Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td>13.2</td>
<td>72.3</td>
<td>14.5</td>
</tr>
<tr>
<td>DTP</td>
<td>40.4</td>
<td>53.8</td>
<td>5.8</td>
</tr>
<tr>
<td>OPV3</td>
<td>54.1</td>
<td>43.6</td>
<td>2.3</td>
</tr>
<tr>
<td>Measles</td>
<td>30.0</td>
<td>57.7</td>
<td>12.3</td>
</tr>
<tr>
<td>Full immunization</td>
<td>48.2</td>
<td>43.2</td>
<td>8.6</td>
</tr>
</tbody>
</table>

BCG: Bacille Calmette-Guérin; DTP: Diphtheria, Tetanus, Pertussis; OPV: Oral Poliomyelitis Vaccine
SOURCE: IIPS, GOI

**Inadequate Capacity to Plan and Implement at the Centre, State and District levels**

Failure to develop a public health cadre and widening the eligibility criteria to include clinicians, without making public health training a mandatory requirement for working in posts that need public health skills, have adversely affected the implementation of public health programmes. Non-reservation of posts or the absence of a dedicated public health cadre have also reduced the employability of persons trained in public health resulting in an accumulated shortage of the critical mass of epidemiologists, biostatisticians and other personnel. With radiographers, orthopaedicians, surgeons working as an Additional Chief Medical Officers (ADMO) in charge of the RCH programme or programmes for malaria or TB, or IAS officers as project officers of HIV/AIDS, etc., the lack of technical capacity in providing the required level and quality of leadership at the State/district-level has been a serious handicap. Mavlankar (Mavlankar 1999), persuasively argues that one reason for the successful implementation of the maternal health strategies is that the
availability of technical capacity to design and monitor at all levels, from the village to
the Central Government. In India with a billion populations has one Director-level
officer for MH in the Ministry of Health at the Centre. Besides the gross inadequacy of
the number, technical posts in the Central Government are manned by personnel drawn
from the Central Health Service with no fixed tenure or any pre-qualifications. For
example, a Director of MH should have knowledge of public health, obstetrics and
midwifery and related fields. While so the personnel of the Central Health Service have a
distinct handicap of not only not having these technical qualifications but also no
experience of working in a PHC or a CHC, made worse with no field training upon
recruitment as is the case with Indian Administrative Service (IAS) officers.

Lack of technical expertise and non-availability of the critical mass or a minimal number
at the Central and State levels are reasons for public health programmes lacking in
focused designing, development of national treatment protocols and standards, the non-
integration with other related sectors/programme such as TB with HIV, HIV with MH,
MH with malaria, health with nutrition or water, etc.; or absence of technical leadership
in States and districts on the operationalization of interventions based on technical norms;
or assessing and building up of technical skills and human resources required by the
programme. Most importantly, this absence of adequate technical skills have also been
responsible for the near absence of operational research for obtaining the evidence base
for designing better targeted programmes in keeping with the wide social and
geographical disparities that characterize India. Instead, at the Central and State levels,
almost 40% of the time of these ill-equipped officers in charge of complex programmes is
spent in attending to administrative duties.

The situation in the States is no better. A survey conducted in six States to assess the
technical capacity of these States for maternal health (MH) programmes, (or for that
matter malaria) showed that except one Deputy Director-level officer in Kerala, in none
of the other five States of Tamil Nadu, Maharashtra, Rajasthan, Gujarat and Chhattisgarh
was there even one officer exclusively earmarked for monitoring the maternal health
programme (Mavlankar 1999). The situation in the districts is worse. The void in the
unavailability of such capacity for surveillance and monitoring at district levels has temporarily been addressed under the TB control and Polio Pulse programmes by taking persons on a contract basis—many from the government itself, thus further weakening the already fragile technical capacity required for implementing the large number of government programmes. In addition, there is also the question of the State Governments’ ability to sustain these programme-based consultants after withdrawal of external support.

The collection and review of data is hardly given any importance, leave alone analyzing it for future planning. Monitoring is essentially confined to the bare minimum of NHP targets and now, polio pulse immunization targets. In the absence of any system of surveillance or epidemiological data gathering, planning interventions lack an evidence base and also make it impossible for the system to be responsive to felt needs. A study conducted in Zenana Hospital in Udaipur, Rajasthan found that during 1983-93 nothing had changed despite the improved road network and awareness levels.7

The researcher further observes that the failure of the system to provide ambulance services, which resulted in incurring expenditures on transport ranging between Rs.150 and 300, borrowed from moneylenders ‘leaving the people poorer both materially and emotionally when despite their desperate efforts the woman’s life could not be saved’. The study also showed that during this period while there was a drop in eclampsia, there was a six-fold increase of deaths on account of malaria induced anaemia and abortions induced by unqualified practitioners ‘Abortion and emergency obstetric services remain almost unavailable to the vast majority of the rural women.

Inconsistent Procedures

Rules and procedures do not synchronize with objectives of a programme or foster any accountability among the functionaries. For example, unsafe abortion is said to cause at

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least 8 per cent of all maternal deaths. Yet field surveys showed that untrained and unqualified providers in the informal sector routinely conduct illegal abortions. This flourishing clandestine business is because of government procedures that take over 15 months for getting a centre certified the conflicting provisions such as the requirements for a person trained in medical termination of pregnancy to be working at the centre, but then having no facilities to train such private providers, etc. It is for such reasons that a large State like Rajasthan has only 338 certified private facilities with 78 per cent of them in nine districts, five districts having no private facility and 6 having one. With no effective intervention to ensure government facilities having all the required skills, equipment and drugs, the number of deaths due to unsafe abortions remains high.

Management Failures

Management failure due to a combination of reasons such as low budgets, untimely and irregular supplies, corrupt practices and poor governance has adversely affected the functioning of the health system. The dispersed and disaggregated nature of responsibilities and conflicting job profiles make accountability a difficult proposition. While the Secretary of the Department of Health has no control on when and how much money will be made available to implement programmes, the medical officer (MO) in the peripheral centre has no administrative powers over the front-line workers and other functionaries working under him. With most supplies such as vaccines and drugs being provided by the Centre for the NHPs, the States have little control to ensure outcomes, as in several instances procurement delays by the Centre can take as long as over one financial year, affecting the credibility of the system. All these factors have serious implications for the quality of management and efficiency. We now discuss the most frequently cited and widely accepted reasons for management failure.

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9 Mavalankar D V. ‘Study of Technical top Management Capacity for Safe Motherhood Programme in India’, Study Commissioned by the World Bank, New Delhi (Unpublished Monograph)
Performance-Based Monitoring

There is absence of accountability in the system. To this end, Andhra Pradesh introduced performance-based monitoring in 1998-99. Primary health facilities, where the maximum absenteeism among doctors and health workers was observed and were graded into four categories based on programme targets/achievement indicators, scores/grades were given. This was then the basis for review at the highest level. It enabled identification of the problems and corrective action to be taken. Under various programmes and in some States, such performance-based monitoring is done but is neither timely nor systematic, except under the donor-funded programmes of blindness, TB Control Programmes and the Pulse Polio Initiative. It is however pertinent to note that an estimated 1500 consultants were appointed by WHO at the field level to monitor the TB and polio control programmes. In addition, common to these three programmes is the extensive computerization of monitoring and review systems that provided access to information at the district level. Such systems need to be adopted by other programmes and also for other aspects of implementation.

Absenteeism from Place of Work

A majority of doctors opt for specialization and/or urban practice. The reluctance to serve in rural areas has become a major impediment in the government’s ability to provide health services to the rural population. Not surprisingly, absenteeism among doctors and front-line workers from their place of work is high. A study conducted by the World Bank (2004) and other studies (Mohan et al. 2003; Rao 2003) show absenteeism ranging from 40 per cent to 45 per cent among doctors working in primary health centres. The World Bank Study based on a simple regression analysis showed the relationship between income and absenteeism, which suggested that higher income States have lower rate of absenteeism with point value at 0.001, meaning that every increase of Rs 1000 State per capita income is associated with a reduction in absence of 1 per cent point, with p values on the co-efficient on income at 0.13. However, this is a crude analysis as, at another level, absenteeism is high in these rich States where doctors are also engaged in
private practice. Punjab has the lowest utilization of public facilities only because of large-scale absenteeism of doctors\textsuperscript{10}.

**Quality of Service Delivery - An Imbalanced Mix of Inputs**

Vehicles without POL budgets, beds without washing allowances, X-ray machines lying idle for the want of consumables or maintenance budgets, empty shelves in pharmacy counters, etc. also contribute to management failure. In addition, quality is also perceived to be low due to the often unfriendly, rude, corrupt behaviour of the personnel working in these facilities, distance, inconvenient timings and lack of reliability in the availability or the skill of the provider, etc. reflecting management failure. The subcentres are never open as the single ANM is required to undertake village visits, attend to fixed day immunization schedules, domiciliary deliveries, disseminate health information, oversee the work of the TBA, coordinate with the anganwadi worker (AWW), conduct household survey, attend review meetings in PHCs maintain records, etc. With better rearrangement of these factors utilisation can be drastically improved.

**BOX-3**

Management Issues in the Rural Health Care

\begin{center}
\begin{tabular}{|l|}
\hline
Doctors do not stay at PHCs and absenteeism among PHC staff is high. \\
Training during MBBS is not geared to impart skills for providing service in rural areas. \\
Doctors need to be provided financial and non-financial incentives for staying in rural areas. \\
There is a need for increasing para-medicalization of primary health care services. \\
\hline
\end{tabular}
\end{center}

**Lack of Policies for Human Resource Development**

The recruitment policy is a contributory factor for the lack of motivation among doctors to provide services in rural areas. Quite often, postgraduate students are recruited by the governments and placed at PHCs where the skills acquired by them during post graduation are of little relevance. This is made worse by the lack of equipment, drugs and

adequate caseload. Similarly, there is almost always a mismatch of skills gynecologist is posted at a CHC where there is no anesthetist resulting in the underutilization of skills. Likewise, transfers are often arbitrary and without adherence to any norms, resulting in the low morale of doctors. Even the States that do have a transfer policy rarely adhere to it. Recently, there was an instance in a State where at a CHC all the seven doctors were transferred out in one go, leaving behind a hapless lot of patients. Often, the skills needed or acquired in a training programme are not taken into consideration. Therefore, under the NHP, money may be spent in training a doctor in anesthesia, intraocular lens (IOL) implantation surgery, or a manual vacuum aspiration (MVA), but fail to impact on the programme as, more often than not, on return from training, he or she is posted to a place where the acquired skills are not required or the required equipment is not available. The absence of transparent transfer policies, norms for deployment of personnel, and reward for merit, are some of the factors contributing to the deviant behaviour among providers. Therefore, the professional commitment is getting diluted in health sector.

**Limited Promotional Avenues**

In many States (such as Orissa, Bihar, Uttar Pradesh, Rajasthan) an MO often gets the first promotion after 15-20 years of service. There are many doctors who continue to remain MOs without promotion while their counterparts in civil services might have been promoted from the post of an SDM to Special Secretary or even Secretary and from Accounts Officer to Financial Advisor. Career stagnation affects the morale. In Madhya Pradesh, the Departmental Promotion Committee (DPC) meeting has not been conducted in the past 20 years. In Chhattisgarh, all chief medical officers have been posted on an ad hoc basis.

**Poor Payment Systems and Dual Practice**

To compensate for the relatively low salaries, doctors are permitted private practice after office hours or are given a non-practising allowance, often 25 per cent of the basic pay. Lack of monitoring and effective supervision at times, collusive relationships which are causes for the abuse of this facility affecting patient care in public facilities. Due to financial constraints, most States have now stopped recruiting MOs in the regular pay
scales and instead are now offering contractual services for as small a remuneration as Rs 8000 per month, a strategy which has a high turnover with doctors joining services only for getting rural service experience for admission to Postgraduate Entrance Examination, or as a makeshift service for preparing for the PG entrance exams, or joining service and just lingering on to it in the hope that some day their services might get regularized. Time has come to review such arrangements keeping a long-term perspective in view. Doctors, particularly, specialists need to be paid better and there is a need to sanction posts of specialists and public health managers in hospitals at district and State levels. Low cost solutions or decisions based on present day contingencies cannot sustain the system which will develop fissures, and cost more to repair

11 Rifkin SB, Gill W., Why Health Improves: Defining the Issues Concerning Comprehensive Primary Health Care And Selective Primary Health Care, Social Science and Medicine, Volume 23, Issue 6, 1986, Pp. 559-566

Poor Facilities at Work

The most de-motivating factor is the lack of appropriate facilities and required inputs to enable a qualified doctor to do his best for his patient and derive job satisfaction. In addition, lack of decent housing facilities and educational facilities for their children are further contributory factors to the reluctance to work in rural and underserved areas. The working conditions of nurses/midwives are worse, ranging from the lack of basic amenities such as toilets to physical safety. Inadequate and unreliable supply of inputs, absence of supervision and technical guidance, limited opportunities for career advancement, absence of accommodation with over 60 per cent of the subcentres functioning in rented places hired for about Rs 100-300 per month, and often doubling up as a part of her residential accommodation are other factors that contribute to sub-optimal outcomes. Initially, subcentres were envisaged to consist of a multipurpose worker (male) (MPWM) and one multipurpose worker (female) (MPW-F). However, 60 per cent of the posts of MPW-M are lying vacant, thereby increasing the workload of the ANM and affecting the ANM’s quality of services. In the community setting, female health functionaries face many problems with regard to transportation, accommodation, gender-based harassment and lack of security, in addition to lack of incentives, stagnation of
career due to inadequate development opportunities and inadequate provision for living with the family and education of their children.\textsuperscript{12}

**Corruption**

This then brings us to the key issue of corruption. As per Transparency in India, health has the maximum public interaction and is the second most corrupt sector. The Karnataka Lok Ayukta has estimated that at least 25 per cent of the budget is siphoned off through corruption practices. An analysis of the Lok Ayukta shows that all categories of government health functionaries—ayahs and ward boys to nurse, doctors and specialists—are involved. Corrupt is in many areas ranging from indulging in unauthorized private practice to issuing medical certificates, transfers, postings, recruitment, in ‘tolerating’ absenteeism, etc. The most sensitive areas are in the procurement of drugs and licensing of blood banks, where unlicensed manufacturers have been recipients of orders and action on spurious drug suppliers tardy.

**BOX-4**

The ANM – First Interface with the Community

| The ANM still continues to be the only worker for delivery of primary health care in rural areas in the public sector. She is presently working in isolation without a team and with no support or supervision from either the lady health visitor (LHV) or the Medical Officer. She is overloaded with too many functions and activities to be delivered at too many places to too many groups of clienteles. She is required to deliver health services, travel, educate communities, counsel clients and mobilize communities. She has to fill in several registers and submit several reports. The mean number of years of gap between her obtaining qualification and joining service is 4.2 years. Few sub-centres operate from government-owned buildings which are poorly maintained and many are in rented buildings. The sub-centre is a small area and cannot accommodate an examination or labour table, and the supplies are inadequate, irregular and erratic. About 40 per cent to 62 per cent ANMs do not live at headquarters, the most common reason for their non-availability being security concerns. In about half the cases, the sub-centre, are located far from the village. |


The pervasive spread of corruption is not limited to the public sector. The private sector is also working under low thresholds of integrity. Patients are exploited by being made to undergo unnecessary tests only for making money. Providers in private practice are seen

\textsuperscript{12} Ibid
to own pharmacies and diagnostic centres. They get ‘cuts’ and commissions for referrals and such fee splitting is the mainstay of many doctors’ monthly earnings. There are adequate studies that have shown the disproportionately large number of caesarean sections 66 per cent of all deliveries in private hospitals in Kerala\(^\text{13}\). The rate of hysterectomies being performed among young women is one example of the absence of ethical standards that need to be effectively countered by fostering transparency, widening participation, strictly enforcing inspections and, above all providing leadership, in technical, administrative and political organizations in reiterating and reasserting value systems.

Enforcing good management and governance is then absolutely essential since the implication of bad practices in the health sector hurts persons who are poor and suffer the double tragedy of being sick. No market can function or sustain itself unless there is a minimal level of integrity, fair play and rule of law. Therefore, if insurance and contracting the private sector are to be the new ways of expanding access and financing health, then it is essential that values of probity, nurturing of informed consumers and wider participation through good governance be ensured. Consumer forums, patient management committees, village health committees, patients /citizens’ charter, Transparency Act, right to information, imparting of value systems and training in management practices, e-governance, redressal systems, etc. are some of the instruments that need to be employed by the government for counter-checking malpractice and to realize the patients rights at the grass-root levels.

**Lack of Discipline and Work Ethic**

In India, government employees often explain the omissions or commissions on ‘lack of political will’. It is however, a fact that more often than not, there is large-scale abdication of responsibility at the field levels, say for example when a head of the department or a CMO does not undertake field visits, conduct review meetings, monitor the implementation of various activities, attend office on time and check attendance

\(^{13}\) Kutty Raman, Panikar, ‘Impact of Fiscal Crisis on the Public Sector Health Care System in Kerala’ A Research Project, Achutha Menon, Centre for Health Science Studies, Thiruvananthapuram, 1995
registers, listen to grievances, fill vacancies, promote people, punish the wrong, reward the good, then there is abdication of duty. When the CMO ‘allows’ doctors and other functionaries to absent themselves from duty, then it is collusion. No amount of funding or administrative reforms can help till there is an overall institutional discipline enforced at all levels and pride for good work instilled. Creating such an environment again carries the implication of having systems and tools that facilitate its emergence. Therefore, it needs effective institutional arrangement not only to supervise the overall administrative service of the top but also to carry out the detail functionaries of the organization as well as grass-root problems. The critical factor may be personal commitment of head of the department is require at all levels to maintain harmony among the staff and health problems of the society.\textsuperscript{14}

Use of IT for Better Decision-Making

Effective leadership rests on access to organized information which is increasingly becoming possible due to e-governance. Information about health inputs and outcomes, achievement of targets and goals are necessary for formulating policies and monitoring activities, they are related to technology, human resources or infrastructure. Since quality monitoring based on performance indicators on a concurrent basis is fundamental to curbing errant behaviour, the need for the use of IT cannot be overstated. IT should be used for record maintenance, monitoring supply and inventory control, tracking events and disseminating information to consumers. This would place a great amount of power in the hands of the government to guide, monitor and correct. Such data analysis also reduces subjectivism in transfer policies and personnel development, and ensures transparency in all transactions, the only check to abuse of discretionary power. Besides, even for patient care through the use of telemedicine, or establishing call centres for giving instant advice on coping with a small emergency or advising which hospital to check into etc. technology has the solution. Such a system development will become even more important with the government shifting its role as a financier of services rather than

\textsuperscript{14} Ranga Rao AP. Report on Role and Efficiency of ANM and Male Worker In Primary Health Care, Andhra Pradesh: A Qualitative Study Funded by DFID, Unpublished - Paper Commissioned by DFID, New Delhi, India, 2003
a provider; as a regulator of providers; and as the final protector of patient and consumer rights to medical practices that are safe and appropriate.

**Urgent Need for Infusion of New Skills**
What emerges from the recounting of the several areas of management failure particularly at the point of service is the need to institute a class I All India cadre of Public Health Managers—directly recruited and trained in public health and posted at district levels, like the IAS officers. Over a period of time these young recruits will become the backbone for providing leadership in the public health area. Such persons need not necessarily be doctors—they could be from a wide variety of related disciplines such as a PG in microbiology etc but possess a Masters in Public Health. In such a system, those keen to specialize can gradually be veered to work in the hospitals and be provided career opportunities to work in teaching hospitals and super specialize etc. Such options for human resource management will be critical for steering the country from out of the veritable mess we are in presently

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**Dysfunctional Structure—the Role of the State**

Though health is a State subject, the Central Government has certain powers and responsibilities related to the control of infectious diseases, family planning, education, drugs and research. Therefore, the departments dealing with health and family welfare, at the Central and State levels are large in terms of the human resources employed and the wide span of work covered. At both levels, there are several directorates headed by doctors and technical units dealing with the myriad issues in the health sector. For discharging their multiple functions of provider, regulator, facilitator, educator and promoter, the departments employ a large number of technical people—doctors, nurses, paramedical staff, etc. for running hospitals, dispensaries, health centres, medical colleges, nursing schools, and public health laboratories, for inspecting the quality of food and pharmaceutical products, for providing information on public health issues, production of vaccines, etc.

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15 Ibid
Structurally, the administrative units do not take into their purview the functioning of the private sector, which is seen as an independent, autonomous entity. This disassociation is in part due to the fact that various ministries administer matters that directly affect health outcomes and have no mechanism to ensure coordination among them. For example, in the Central Government, the pharmaceutical industry is under the Ministry of Chemicals, policies related to import or export of drugs and technology are the responsibility of the Ministry of Commerce, drug regulation is under the Ministry of Health, programmes related to nutrition are part of the Department of Women & Child Welfare, while water and sanitation is looked after by the Ministry of Rural Development, research in medical diagnostics or vaccines by the Department of Biotechnology, health insurance by the Ministry of Finance, etc. Such intense fragmentation across departments and States is the single most important factor that confines the Ministry of Health to narrowly focus on the implementation of budgeted programmes and activities. The second structural mismatch is the fragmentation of the Ministry itself: into the Departments of Health, Family Welfare and AYUSH. Such fragmentation that took place in the 1990s had negative downstream effects down to the implementation level, making inter programme integration problematic, diluting the technical capacity to think holistically and duplicating resource use. For example, the Reproductive and Child Health (RCH) programme rarely addresses HIV/AIDS, malaria or tuberculosis (TB). Likewise, the programme for malaria control has no indicator focusing on pregnant women; or nutritional deficiencies in the child health programmes.

In addition to the inadequate technical oversight, the departments also function more like ‘casualty wards’ where managing themselves rather than the system has taken centre stage. The Department of Health, for example, spends over three-quarters of the time addressing VIP claims under the Central Government Health Scheme (CGHS); sanctioning medical colleges; procuring medical drugs and supplies, and transferring doctors and court cases. Lastly, the problem of governance, whether at the Centre or States, has also been compounded with the frequent shifting and transfers of ministers

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and officers. During 1998-2003, there were five ministers in the Central Government and as many Secretaries.

**Restructuring of the Administrative Departments**

The issues raised above have been felt for a long time. The Ministry of Health itself commissioned studies to restructure its organization to face the emerging challenges. The three reports: Administrative Staff College of India (1986); the Bajaj Committee (1996) and the Center for Policy Research (2000) made some important recommendations which are waiting to be implemented:

- Constitute Hospital Committees and delegate administration to them;
- Outsource and decentralize promotional and publicity functions;
- Convert the CGHS to an autonomous board;
- Constitute an Advisory Body to advise the ministry on policy issues;
- Decentralize planning and programme formulation to States, confining the Centre to monitoring adherence to national policy goals and providing technical support;
- Outsource procurement to an independent body;
- Establish a Federal Drug Authority and a Commission for medical education;
- Transfer all Delhi-based hospitals to the Delhi Government and make the Central hospitals autonomous;
- Merge all the three departments;
- Create an Indian Medical Service such as the Indian Administrative Service (IAS);
- Establish an institutional mechanism for interdepartmental coordination;
- Establish a manpower planning cell in the ministry.

Implementation of the above recommendations would ‘free’ the Ministry of Health at the Central and State levels to address more important issues of governing the health system as a whole. In other words, the Ministry of Health is not only expected to be concerned with the implementation of its programmes but the functioning of the health system comprising both the public and private sector, by diligent oversight safeguarding the interests of the public in general and patients in particular. Such a change in understanding of the functional responsibilities would not only require space in terms of
time but also capabilities and skills to address such a role. Organizational structures reflect the objectives and aims of a policy. For example, since RCH objectives emerged as a consequence of the failure of a family planning strategy, it was added on to the Family Planning Programme and renamed as Family Welfare (FW), explaining the anomalous position of the DGHS who does not have any role in the technical aspects of the RCH programme. In the districts, such disassociation of FW from the technical head, namely the Director of Health Services, has had a negative impact on the technical quality of the program. In States where the Health Department is divided into Health and FW, implementation of the FW programmes has been problematic due to nonalignment between authority and responsibility. Due to these factors, recently, the two departments have been merged at the Centre. While this is a positive step, there is still need to restructure the set-up on a functional basis all through the chain.

**Case for systemic reforms: Restructuring Institutional Frameworks**

The process for systemic reform will need to start from the Central Ministry of Health, looking at the big picture which has been setting standards and laying down rules and regulations to be followed by all stakeholders; mobilizing resources; providing leadership based on its knowledge and technical superiority; facilitating and steering the health system to ensure that the goals of equity, efficiency and quality are met. Such a role would require the Central Ministry to restructure its work allocation based on functional homogeneity.

The Ministry should also shift from micromanagement by divesting and delegating powers and authority to functional units. There is also an urgent need to establish new institutions, such as an autonomous institute for health information and disease surveillance, a food and drugs authority; a social health insurance corporation to take care of government employees and the labour in the organized sector by merging the CGHS and the Employees State Insurance Scheme (ESIS); enable the Indian Council of Medical Research (ICMR) to have more autonomy (such as the National Institutes of Health, USA) by generating its own resources; and outsourcing all procurement work to professional bodies. The manpower and time that would be available with the removal of
this historical burden of functions would enable the Ministry to discharge its stewardship functions which require laying down standards on health infrastructure and quality, classification of diseases, costs and norms for monitoring utilization levels, carrying out research to evaluate the cost-effectiveness of the various interventions being implemented, training, etc.

The functions listed under the stewardship role are not simple, and entail mobilizing multidisciplinary groups and collecting and collating evidence for revising existing policy or formulating a new one. Standard setting is a tedious process and has cost implications. For example, setting a standard to include five ultrasound tests for an antenatal protocol would have substantial financial implications, besides driving investment to expand availability of this technology, though there is no evidence to establish its efficacy in assuring better outcomes of pregnancy. Likewise, it is through research that long term consequences of policies need to be studied before taking decisions. For example, India’s hasty decision to relax vigil in the 1970s and disbanding the malaria programme resulted in its resurgence in a form more serious and also more expensive.

Such decisions therefore need inputs from public health specialists as well as economists to state which interventions work and which do not, and what policies should be adopted and why. If public policies fall short it is because such expertise is sadly lacking and in short supply in the country. Thus, good governance is not only dependent on political commitment but also having the appropriate tools, instruments and information. Bad policies need not only be the result of careless oversight or narrow sectional interests, but also due to lack of evidence and information. In addition to the above, the administrative departments of health, including those at State levels, need to achieve greater efficiency in reference to some aspects described below.

**Regulation in the Health Sector: Accreditation of Facilities**

The role of the government in the health sector is to look after patients’ welfare. Drawing up legislation in a sector like health is complex and requires an understanding of the incentives or disincentives such legislation may have on human behaviour and a balanced
approach. For example, if the legislation is too inflexible and specific, putting all risks on
the provider, then it may result in mindless litigation, increasing defensive medicine and
higher costs for the patient, endanger the patient-doctor relationship which should be
based on trust and entail harassment and outright corruption at the hands of the
bureaucracy. If, on the other hand, it is too considerate to provider concerns, the patient
may end up getting shortchanged. Besides, it is the enforcement of the laws that is more
important. In other countries, inspectors and assessors sent to evaluate provider facilities
for accreditation or licensing are trained, so that at all times the focus is on achieving the
objective of increasing awareness and creating a sense of accountability among providers
regarding the quality of patient care, and not the blind and mindless application of a
standard or a rule. Thus, supervision requires being supportive, not prescriptive or fault-
finding, as the objective is not to drive away the providers but to persuade and convince
them of the need to adhere to quality and patient safety. This calls for a different mindset
to be cultivated through intensive training programmes and performance monitoring
systems. Supportive supervision is a new skill that needs to be nurtured in the
government sector.

The key challenge to governance is the enforcement of regulations related to the ‘quack’
or the unqualified practitioner in the villages. In a setting where the public health system
does not function and the private sector is too expensive, it is the quack who meets the
social need. Rational arguments of quality or harmful practices, lack of qualification, etc.
do not matter as, for the people; the quack is able to provide instant relief to a need at
affordable cost. How then does the Government achieve its norms for quality and
standards of patient care while allowing this clearly illegal and perhaps harmful practice
to continue? Good governance would require a political will to resolutely enforce
discipline and make the public health system work, besides educating the people on the
rational use of medical practices or drug use.
Devolution of Authority- The District Societies: A Mechanism for Better Utilization of Funds

A major problem being faced by the Department of Health was untimely the release of funds. Routinely, Central assistance meant for specific programmes would be diverted by the State finance departments for tiding over their ways and means position, resulting in delayed release of funds, stalling the implementation of health programme activities. Therefore, under the National Programme for the Control of Blindness, district societies for blindness control programmes were first constituted during the early 1990s. Under this arrangement funds were directly released to the district societies.

This mechanism was subsequently used by all programmes resulting in the constitution of over four to five societies, one each for TB, Blindness, Malaria, RCH, and Leprosy. The experience has been a positive one as it has enabled better absorption of funds and quicker implementation. The experience of district societies is now being used to integrate them into District Health Societies so as to facilitate district-level health planning and monitoring activities to achieve health goals.

A pilot study conducted on the functioning of these different societies in the district of Orissa brought forth some interesting suggestions in following points:17

- Develop capacity for better management through training;
- Establish more rigorous monitoring and programme review systems to improve outcomes and ensure cost-effective utilization of funds;
- Standardize reporting and auditing formats; and
- Sensitize officers on programme goals and objectives, and increase the involvement of civil society to reduce the temptation to misuse or misallocate funds.

Based on the above, training in data analysis and planning processes, developing indicators for performance review and monitoring for corrective action will need to be accorded priority focus. The societies also need better expertise, persons trained in health

economics, financial planning, statistics and data analysis, epidemiology etc. In the absence of such expertise and evidence-based planning, the tendency is to merely repeat what was being done earlier, nullifying the benefits of a bottom-up planning concept. Resources are not only financial. It is the government’s responsibility to monitor the availability of human resources as well. What skills are needed, what are being produced, where and by whom are they being utilized, where are they concentrated, etc. are the sort of issues that should attract priority attention, as 5-8 years are needed before the required human resources are available? Past neglect of human resources is the cause for today’s imbalance in skills mix, acute shortage of trained nurses. This function will gain even greater importance in future years as with the General Agreement on Trade in Services (GATS), more professionals from India will be able to find employment abroad. The government needs to establish mechanisms to know the migration flows of skill and identify areas of shortage so that corrective action can be taken in advance.

**Local Bodies**

In the health sector in India, decentralization has to be viewed, not only in the context of devolving authority and power to States by the Centre, to districts and States but to the multilayered local bodies as well. Such devolution of authority has taken place only in Kerala. Kerala has invested both time and resources in systematically focusing on building capacity for governance among elected leaders. Leadership and governance means having the ability to plan, budget, implement, manage, monitor, review and accept responsibility for the decisions taken. The strategy of the ‘big bang’ approach adopted in Kerala where, in one sweep, functions, powers and responsibilities were transferred rather than the usual cautious approach, of training and building capacity before delegating responsibility, has proved to be successful compared to the experience of other States where devolution has been incremental, halting and sporadic.

Devolution of powers has, however, not been easy. The Kerala experience shows that despite the transfer of some proportion of the budgets and bringing all-district level institutions under the control of the local bodies, the benefits in terms of health indicators
have not really been visible\textsuperscript{18}. This is largely because of the lack of technical guidance at the panchayat level, lack of standardization of facilities laying down clearly the functions, duties, responsibilities and outcomes of health personnel working in facilities located at different levels, lack of clarity and clear delineation of what services ought to be available where, making it difficult for the local bodies to understand what exactly should be their priorities and areas of focus. Lack of integration between different systems of medicine, ego problems between the highly educated doctor, senior in rank, to functionaries of the local government, dual control, multiplicity of bodies handling health budgets such as the chief medical officer (CMO), hospital superintendent, zilla parishad, district societies for each national programme, hospital development committees, etc. are other reasons that were found to have complicated matters. Kerala is therefore now working towards evolving minimum standards of care and conduct, a citizen’s charter and community-based monitoring of health programmes. Decentralization to local bodies has been under consideration for several years but was never implemented in true spirit due to various reasons. The attitude towards the involvement of local bodies has nearly always been to sensitize the representatives and use them in an advisory capacity or for execution of government works under the Rural Development Programme. In the health sector, utilization of the local bodies as agents of change or in social mobilization has been minimal and perfunctory. Experience shows that unless the local bodies are provided funds, specific responsibilities and powers, the benefits of decentralized systems cannot be fully realized.

In this context, it would be useful to keep in mind the international experience in fiscal decentralization as they provide a few lessons to be learnt based on certain principles\textsuperscript{19}. For fiscal decentralization, all aspects and components need to be addressed such as:

- Assignment of expenditure responsibility to local governments to be followed by revenue responsibilities;

\textsuperscript{18} Vijayanand S, Decentralization of Health Planning and Implementation - the Kerala Experience on the Role of Local Government Institutions in Population, Presented at NIHFW Workshop 17-23rd. February, 2003

• Availability of a strong state ability to monitor and evaluate the intergovernmental fiscal system;
• Devolution of powers and responsibilities in keeping with capabilities;
• Linking of revenue-raising and expenditure decisions;
• The intergovernmental system should be designed to match a set of clearly specified objectives, kept simple and flexible, while at the same time be subject to the discipline of budget constraints.

Applying these principles will mean having a clear-cut delineation of duties and functions to be carried out by the local bodies at different levels vis-à-vis the government departmental hierarchies; the financial implications of those functions and systems for utilization and reporting; and finally the kind of authority, powers, or control they have on the functionaries responsible for discharging those duties.

Such delineation needs to be based on clear government orders or legislation as the case may be and backed by intensive training and guidelines provided in simple, easy-to-understand formats. Without such a systems approach merely ‘orienting’ locally elected representatives to be ‘involved’ in health activities is as valuable as the paper on which it is written. Given the vastness and diversity, India will find it difficult to reverse the trend on communicable diseases such as malaria and TB unless the local bodies and the wider community are also fully involved. However, such involvement needs to be formalized. For example, the local bodies should be made responsible and accountable for certain health actions, registering births and deaths, carrying out all anti-malarial activities such as plugging the breeding grounds of mosquitoes, etc. In fact, later when social health insurance picks up, it will be necessary to have such a capability available at the local level for making the health insurance scheme function at minimal cost. Wider participation of the communities through village health committees working in coordination with management committees at higher-level facilities is the only way the health system can be made more accountable to the people they are meant to serve. More inclusive approaches and greater democratization is essential if health gains are to be achieved. The initiatives would remain platitudes unless there is close monitoring by the
State and provisioning of technical advice. This would require having a team at primary health centres (PHCs) and community health centres (CHCs) to work exclusively on the development of the community-based strategies—the village health workers, village health teams, local bodies, etc. In the absence of such administrative restructuring to guide, facilitate and supervise the development of the demand side of the health system, decentralization may not really go beyond tokenism.

One has to analyse the fact that without support of legal instruments or documents, it would not be possible to claim health as a human right. Both international legal instruments and national laws are important in examining the rights standards and how it is realised at the ground level. This is done with support of cases. It brings a couple of Orissa health cases which are relevant to the present study. Hence, a series of argument gathered to prove health as human right. Both favourable and unfavourable cases are presented here to substantiate the above argument and to see that how the standards are set through the constitutional and judicial process in India. This helps in understanding how the scope of the standards got enlarged.

**Constitutional mandate to the State**

The obligation of the State to ensure the creation and the sustaining of conditions congenial to good health is cast by the Constitutional directives contained in Articles 39(e) (f), 42 and 47 in part IV of the Constitution of India.\(^\text{20}\) State has to direct its policy towards securing that health and strength of workers, men and women, and the children are not put to health hazards and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength (Article 39(e)) and 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 moral and material abandonment (Article 39(f)). The State is required to make provision for just and humane conditions of work and for maternity benefit (Article 42). It is the primary duty of the State to endeavour for raising of the level of nutrition and standard of

living of its people and improvement of public health and to bring about prohibition of the consumption, except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health (Article 47). Protection and improvement of environment is also made one of the cardinal duties of the State (Article 48 A). The State legislature is (under entry 6 of the State List) contained in the Seventh Schedule to the Constitution, empowered to make laws with respect to public health and sanitation, hospitals and dispensaries. 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 infections or contagious diseases or pests affecting man, animals or plants, by entries 23, 26 and 29 respectively contained in the concurrent list of the Seventh Schedule.

**Health as right to life**

Article 21 of the Constitution guarantees protection of life and personal liberty by providing that no person shall be deprived of his life or personal liberty except according to the procedure established by law. As a result of liberal interpretation of the words ‘life’ and ‘liberty’, Article 21 has now come to be invoked almost as a residuary right. Public interest petitions have been founded on this provision for providing special treatment to children in jail; against health hazards due to pollution; from harmful drugs; for redress against failure to provide immediate medical aid to injured persons; against starvation deaths; inhuman conditions in after-care home and on scores of other aspects which make life meaningful and not a mere vegetative existence. A positive thrust is given to the nature and content of this right by the Apex Court imposing a positive obligation upon the State to take effective steps for ensuring to the individual a better enjoyment of his life. The Supreme Court has held that the right to live with human dignity enshrined in Article 21 derives its life and breath from the directive principles of State policy particularly Article 39(e) & (f), 41 and 42 and would therefore include protection of health as envisaged in the directives.

The expanded meaning of right to life is wholly justified, for, without health of a person being protected and his well-being being looked after, it would be impossible for him to
enjoy other fundamental rights such as rights to freedom of speech and expression, to move freely throughout the territory of India, to practice any profession or carrying on any trade, occupation or business, to form associations guaranteed by Article 19 in a positive manner. Without a guarantee of health and well being most of these freedoms cannot be exercised fully. To make other rights meaningful and effective right to a healthy life is the basis underlying the constitutional guarantees. All that the courts have done is to provide redressal by a meaningful and just interpretation to the right to life and commanding enforcement of the duties of a welfare State. The Court itself being an authority and therefore ‘State’ within the meaning of Article 12 which definition is made applicable by Article 36 to part IV containing the Directive Principles of State Policy, has to bear in mind these directives in its decision making process.

**State’s Obligation to Preserve Life**

Article 21 casts an obligation on the State to safeguard the right to life of every person, preservation of human life being of paramount importance. The Apex court has held that whether the patient be 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 be punished. A doctor at the government hospital positioned to meet this State obligation is, therefore, duty bound to extend medical assistance for preserving life. Every doctor, whether at government Hospital or otherwise, has a professional obligation to extend his services with due expertise and care for protecting life. It has been held that this obligation is total, absolute and paramount, and laws of procedure, whether in Statutes or otherwise, which would interfere with the discharge of this obligation cannot be sustained and must therefore give way to higher standards. A doctor does not contravene the law of the land by proceeding to treat the injured victim on his appearance before him either by himself or being carried by others.

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 essential part of the obligations undertaken by the government in a welfare state. The government discharges
this obligation by running hospitals and health centres which provide medical care to the person seeking to avail of those facilities. The government hospitals run by the State and Medical Officers engaged therein 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 the injured victim’s right to life guaranteed by Article 21.

Responsibilities of Municipalities and Panchayats

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’. Similar provision is made for the panchayats under Article 243-G read with the Eleventh Schedule (item 23), of the Constitution. 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 a supply of water proper and sufficient for preventing danger to the health of the inhabitants from the insufficiency or unwholesomeness of the existing supply, public 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. Therefore, 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. This continues to be one of the areas of tension between these two levels of the authority.

**Right to Health: Judicial Activism**

Health as stated earlier is a state of complete physical, mental and social well being. The term ‘health’ implies more than mere absence of sickness as held by the Supreme Court. The Apex Court in India has played a significant role in realization of the right to health by recognising the right as a part of the fundamental right to life and issuing suitable directions to the State authorities for the discharge of their duties. The Court has recognised that maintenance of health is a most imperative constitutional goal whose realisation requires interaction of many social and economic factors.

In this context the theory of the inter-relatedness between rights was famously articulated in the Maneka Gandhi decision. This became the basis for the subsequent expansion of the understanding of the ‘protection of life and liberty’ under Article 21 of the Constitution of India. The Supreme Court of India further went on to adopt an approach of harmonization between fundamental rights and directive principles in several cases. With regard to health, a prominent decision was delivered in Parmanand Katara v. Union of India. In that case, the court was confronted with a situation where hospitals were refusing to admit accident victims and were directing them to specific hospitals designated to admit ‘medico-legal cases’. The court ruled that while the medical authorities were free to draw up administrative rules to tackle cases based on practical considerations, no medical authority could refuse immediate medical attention to a patient in need. The court relied on various medical sources to conclude that such a refusal amounted to a violation of universally accepted notions of medical ethics. It observed that such measures violated the ‘protection of life and liberty’ guaranteed under Article 21 and hence created a right to emergency medical treatment.

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22 AIR 1978 SC 597
23 AIR 1989 SC 2039
Another significant decision which strengthened the recognition of the ‘right to health’ was that in Indian Medical Association v. V.P. Shantha\textsuperscript{25}. In that case, it was ruled that the provision of a medical service (whether diagnosis or treatment) in return for monetary consideration amounted to a ‘service’ for the purpose of the Consumer Protection Act, 1986. The consequence of the same was that medical practitioners could be held liable under the act for deficiency in service in addition to negligence. This ruling has gone a long way towards protecting the interests of patients. However, medical services offered free of cost were considered to be beyond the purview of the said Act.

With regard to the access and availability of medical facilities, the leading decision of the Supreme Court was given in Paschim Banga Khet Mazdoor Samiti v. State of West Bengal\textsuperscript{26}. The facts that led to the case were that a train accident victim was turned away from a number of government-run hospitals in Calcutta, on the ground that they did not have adequate facilities to treat him. The said accident victim was ultimately treated in a private hospital but the delay in treatment had aggravated his injuries. The Court realized that such situations routinely occurred all over the country on account of inadequate primary health facilities. The Court issued notices to all State governments and directed them to undertake measures to ensure the provision of minimal primary health facilities. When confronted with the argument that the same was not possible on account of financial constraints and limited personnel, the Court declared that lack of resources could not be cited as an excuse for non-performance of a constitutionally mandated obligation. The Court set up an expert committee to investigate the matter and endorsed the final report of the said committee. This report contained a seven-point agenda addressing several issues such as the upgrading of facilities all over the country and the establishment of a centralized communications system amongst hospitals to ensure the adequacy and prompt availability of ambulance equipment and personnel. Some commentators have argued that by recognizing a governmental obligation to provide medical facilities, the Court has created a justiciable ‘right to health’.

\textsuperscript{25} AIR 1996 SC 550
\textsuperscript{26} AIR 1996 SC 2426
The judgment of the Supreme Court in Nilbati Behra State of Orissa\textsuperscript{27} case holds that in view of the fundamental right to life (Article 21 of the Constitution)\textsuperscript{28} the Government cannot claim ‘sovereign immunity’ for liability for the negligence of its employees.

The right to health and health care is protected under Article 21 of the Constitution of India, as a right to life and reach of which can move the Supreme Court on High Court through writ petition. Practice of medicine is capable of rendering great service to the society provided due care, sincerity, efficiency and skill are observed by doctors. When doctors performed their duties towards the patient negligently in a Government hospital, the servants of the state violated the fundamental right of the patient, guaranteed under Article 21 of the Constitution.

Medical profession has its own ethical parameters and code of conduct. ‘Services’ of medical establishments are more of purchasable commodities and the ‘business’ altitude has given an impetus to more and more malpractices and instances of neglect. But the question is, whether, on the whole, branding the entire medical community as a delinquent community would serve any purpose or will it cause damage to the patients. The answer is, no doubt, the later. It is not that measures to check such dereliction are absent. Victims of medical negligence, considering action against an erring doctor, have three options.

a. Compensatory mode - Seek financial compensation before the Consumer Disputes Redressal Forum or before Civil Courts,
b. Punitive/Deterrent mode - Lodge a criminal complaint against the doctor,
c. Corrective/Deterrent mode - Complaint to the State Medical Council demanding that the doctor’s license be revoked.

Jurisdiction of Civil Court was never disputed but its scope was limited for damages only. In the recent times, professions are developing a tenancy to forget that the self-

\textsuperscript{27} AIR 1993 SC 1960
regulation which is at the heart of their profession is a privilege and not a right and a profession obtains this privilege in return for an implicit contract with society to provide good competent and accountable service to the public. The self-regulator standards in the profession have shown a decline and this can be attributed to the overwhelming impact of commercialization of the sector. There are reports against doctors of exploitative medical practices, misuse of diagnostic procedures, brokering deals for sale of human organs, etc. It cannot be denied that black sheep have entered the profession and that the profession has been unable to isolate them effectively. Two basic propositions laid down in law regarding liability for negligence are: firstly, ‘Breach of Duty’ to care and secondly, standard of care, i.e. the practitioner must bring to his task a reasonable degree of skill, knowledge and exercise a reasonable degree of care with caution. Supreme Court has made necessary guidelines for protection in order to secure life and health of individuals which are elaborated in the case presented in this study.

**Health Right of Workmen:**

The importance of health promotion at the work place is increasingly recognized particularly in larger organisations. Health promotion at workplace reduces absenteeism and can lead to gain in productivity. The Supreme Court surveyed in CESC case various functions of the State to protect safety and health of the workmen and emphasized the need to provide medical care to the workmen to prevent disease and to improve general standards of health consistent with human dignity and right to personality. It was held that medical care and health facilities not only protect against sickness but also ensure stable manpower for economic development. Facilities of health and medical care generate devotion and dedication among the workers to give their best physically as well as mentally, to productivity. It was held that the medical facilities are, therefore, part of social security and like gilt-edged security; it would yield immediate returns to the employer in the form of increased production and would reduce absenteeism. Just and favourable conditions of work imply ensuring safe and healthy working conditions to the workmen. The periodic medical treatment invigorates the health of workmen and harnesses their energy resources. Prevention of occupational disabilities enthuses them to render efficient service which is a valuable asset for greater productivity to the employer.
and national production to the State. Medical facilities, therefore, is a fundamental human right to protect his health. It was held that health insurance, while in service or after retirement was a fundamental right and even private industries are enjoined to provide health insurance to workmen.

The expression ‘life’ as held by the Supreme Court does not connote mere animal existence or continued drudgery through life but has a much wider meaning which includes right to livelihood, better standard of life, hygienic conditions in work place and leisure. Continued treatment, while in service or after retirement is considered to be a moral, legal and constitutional concomitant duty of the employer and the State. Right to health and medical care is a fundamental right under Article 21 read with Articles 39 (c), 41 and 43 of the Constitution to make the life of workman meaningful, held the Supreme Court in C E & R C V. Union of India. The Court directed that the workers who suffered from asbestosis - an occupational health hazard, should be paid compensation by the concerned establishments. All the asbestos industries were directed to maintain and keep maintaining healthy record of every worker up to a minimum period of 40 years from the beginning of the employment or 15 years after retirement or cessation of employment whichever is later, to adopt the Membrane Filter test to detect asbestos fibre, and to compulsorily insure health coverage to every worker. The Union and the State governments were directed to review the standards of permissible exposure limit value of fibre /cc in tune with the international standards reducing the permissible content.

Health Right of Mentally ill:
Ranchi Mansik Arogyashala a mental hospital located at Kanke near Ranchi once upon a time enjoyed international reputation and patients from outside India used to come for treatment there. But the complaints that the Supreme Court received about the institution were of a serious nature. During the pendency of the matter the Supreme Court therefore gave interim directions for -

1. increased daily allocation for diet to patients,
2. supply of pure drinking water to the hospital,
3. restoration of proper sanitary conditions in the bathrooms and toilets of the hospital,
4. supply of mattresses and blankets to the patients,
5. immediate removal of ceiling limit which was in vogue in respect of costs of medicines allowable for each patient and for providing them medicines as prescribed by the doctors irrespective of the costs, and
6. appointing a qualified psychiatrist and a medical superintendent for the hospital.

The Supreme Court held that running of the mental hospital was in the discharge of the State’s obligation to the citizens and the fact that a huge amount was required to be spent by the public exchequer was not of any consequence. The State has to realise its obligation and the government of the day has got to perform its duties by running the hospital in a perfect standard and serving the patients in an appropriate way. When the directions given by the Court not complied in an effective way by the governmental authorities, the Supreme Court found that the institution cannot be run as a mental hospital of that magnitude unless there was a change in the administrative set up and a new service to patient oriented thrust was to be given to the institution. A Committee was therefore constituted for the management of the mental hospital and directions were given to the State of Bihar to provide for a basic fund of Rs. 50 lakhs to be spent for the improvement of the hospital in a manner approved by the Committee. It was directed that the quality of the hospital should improve and the patients should have the benefit of modern scientific treatment having regard to the fact that the method of care and attention for the mentally ill had undergone a sea change.

Noticing that even patients who had cured were kept as inmates for prolonged periods it was held that hospital is not a place where cured people should be allowed to stay. It was found necessary that there should be a rehabilitation centre for those who after getting cured are not in a position to return to their families or on their own seek useful employment. Thus, a rehabilitation programme was also treated as a part of health care. Sometimes patients also take advantages to use hospital for long time after they get
proper treatment from the hospital. The following points would provide a base for clear understanding of the court direction and medico legal cases.

**Court Directives in Medico Legal Cases Requiring Emergent Treatment:**
There was reluctance on the part of the doctors to treat medico-legal cases until clearance was given by the police authorities. There was also an instinct to avoid attending legal proceedings due to the inconvenience involved. The following case explains the points.

A scooterist was knocked down by a speeding car. Seeing that the profusely bleeding scooterist a person who was on the road picked him up and took him to the nearest hospital. The doctors refused to attend on the injured and asked the man to take the patient to different hospital located 20 kms away, which was authorized to handle medico legal cases. The Samaritan, without losing time, carried the victim to the other hospital, but before he could reach there, the victim succumbed to his injuries. The Court held that every doctor has a professional obligation to treat the injured victim and extend his services with due expertise for protecting life and the doctor does not contravene the law by proceeding to treat the injured victim. The court directed wide publicity to its decision to ensure that every doctor wherever he would be in the territory of India should forthwith be aware of this position.31

**Rights of Patients Undergoing Ophthalmic Treatment at Eye Camps:**
The problems of the ophthalmic health status of the Indian citizen are of a complex dimension causing an understandable concern. The very large number of cases of impairment of visual perception in the country needs the purposeful involvement of voluntary social organisations so as to provide an augmented, broad-based, participatory medicare for the general improvement of the tone of ophthalmic health in the country. The government of India has evolved a comprehensive policy and programme for control of blindness which amongst other things, envisaged a programme for the promotion of eye care through ‘eye camps’ organised by social and voluntary organisations and to provide financial assistance.

31 The Samaj, Daily Oriya Newspaper, Bhubaneswar, 25th June 2007
In A. S. Mittal V. State of UP, the Supreme Court was confronted with a case where the eyes of 84 out of 108 patients who were operated (88 for cataract), in an ‘eye camp’ were irreversibly damaged owing to a post-operative E-coli infection of the intra-ocular cavities of the operated eyes, which mishap was undisputedly due to a common contaminating source being the ‘normal saline’ used in the eyes at the time of surgery. The Court examined whether the existing guidelines prescribing norms and conditions for conducting ‘eye camps’ laid down by the government were sufficiently comprehensive to ensure the protection of patients, who were generally drawn in such eye camps from the poorer and the less effluent section of the society and issued directions to the government to incorporate the following suggestions made by a sub-committee of the Indian Medical Council in the revised guidelines:-

1. The operations should only be performed by qualified experienced ophthalmic surgeons and an ‘eye camp’ should not be used as a training ground for post-graduate medical students.
2. There should be a pathologist available to examine urine, blood etc.
3. Preferably, a dentist should also be present to check teeth for sepsis.
4. A physician for general medical check up of the patients should also be there.
5. All medicines to be used must be of standard quality duly verified by the doctor in charge of the camp.

On Medical Negligence:
The patient has a right to be treated with a reasonable degree of care, skill and knowledge. A mistake by a medical practitioner which no reasonably competent and careful practitioner would have committed is nothing short of negligence. But the law recognizes the dangers which are inherent in surgical operations, where the operations is a race against time, the court makes greater allowance taking into account the ‘risk-benefit’ test.

In Dr. L.B.Joshi V. Dr. T.B. Godbole, the Supreme Court held that a person who holds himself out ready to give medical advice and treatment impliedly undertakes that he
possesses skill and knowledge for the purpose. He owes a duty of care to the patient in deciding whether to undertake the case and what treatment to be given. A breach of such duty gives a right of action to the patient for negligence of the doctor.

Medical practitioners do not enjoy any immunity from an action in tort, and they can be used on the ground that they have failed to exercise reasonable skill and care. The Supreme Court has held that the fact that they are governed by the Indian Medical Council Act and are subject to the disciplinary control of the Medical Councils is no solace to a person who has suffered due to their negligence and the right of such person to seek redress is not affected. Service rendered to a patient by a medical practitioner (except where the doctor renders service free of charge to every patient or under a contract of personal service), by way of consultation, diagnosis and treatment, both medical and surgical, was held to fall within the ambit of 'service' as defined in Section 2(1)(O) of the Consumer Protection Act, 1986.

**On Quality of Blood for Transfusion:**
While transfusion of blood can save life of a needy patient, it can take away life if contaminated. In part XII-B of the Drugs and Cosmetics Rules, 1945 provisions are made to regulate blood collection and storage by prescribing the equipment and supplies required for a blood bank.

In a Public Interest Litigation serious deficiencies and shortcomings in the matter of collection, storage and supply of blood through various blood centres were highlighted before the Supreme Court and directions were sought to the Union of India and State to take steps for obviating the malpractices, malfunctioning and inadequacies of the blood banks. The Supreme Court constituted a Committee to examine the draft schemes suggested by the Petitioner and the Union of India. The Committee made a report proposing an action plan. Keeping in view the report of the Court Committee, the report of the Experts Committee set up by the Indian Red Cross Society and the programme that was being implemented by the National Aids Control Organisation, the Court held that the government should take suitable action as per the immediate implementation and long
term implementation plans suggested by the court committee and gave the following directions:

1. The Union of India should take steps to establish a representative body to be known as National Council of Blood Transfusion as a registered society to be funded by the government of India with empowerment to raise its own funds from trade, industry and individuals.

2. The State governments should establish State Councils in consultation with the National Council and they should be funded by the Government of India and the State Government, with empowerment to raise its own funds.

3. The programmes and activities of the National and State Councils shall cover the entire range of services related to the operation and requirements of blood banks including:
   (a) launching of effective motivating campaigns for stimulating voluntary blood donations.
   (b) launching programmes of blood donations in educational institutions, among the labour, industry and trade establishment and organisations of various services including civic bodies.
   (c) training of personnel in relation to all operations of blood collection-storage and utilization, separation of blood groups, proper labeling, proper transport, quality control and cross-matching of blood, separation and storage of blood components and all the basic essentials of the operations of blood banking.

4. The National Council should undertake training programmes, establish institution for research in collection, processing, storage, distribution and transfusion of human blood and its components.

5. The National Council should take steps for starting Special Post graduate courses in medical colleges in blood collection, storage, transfusion etc.

6. Donations to the National and State Councils may be made tax free by the Government of India.

7. The government should ensure that the blood banks operating in the country are duly licenced in a year.

8. Professional donor system should be eliminated in two years by the governments.
Protection against Injurious Drugs:

With the onward march of science and complexities of living processes, hitherto unknown diseases are notified. New and emerging diseases, combined with the rapid spread of pathogens resistant to antibiotics and of disease carrying insects resistant to insecticides, are daunting challenges to human health. The gap between the ability of microbes to mutate into drug-resistant strains and man’s ability to counter them is widening fast. To meet the new challenges new drugs have to be found. The Central Government is by Section 26A of the Drugs and Cosmetics Act, 1940 empowered to prohibit in public interest, manufacture, sale or distribution of any drug which is likely to involve any risk to human beings or animals or if does not have the therapeutic value claimed.

In Vincent Panikurlangara V. Union of India, directions were sought from the Supreme Court for banning import, manufacture, sale and distribution of the drugs which were recommended for banning by the Drugs Consultative Committee and for cancellation of all the licences authorising such drugs. Taking note of the fact that the WHO on the basis of expert advice, was of the view that human ailments can be treated effectively with 285 basic drugs, the Supreme Court observed that the Central Government on the basis of expert advice can indeed adopt an approved national policy and prescribe an adequate number of formulations which would on the whole meet the requirement of the people at large. While laying down guidelines, injurious drugs must be totally eliminated from the market, and great care in this regard has to be taken. Drugs as are found necessary should be manufactured in abundance and their availability to satisfy every demand should be ensured. The State’s obligations to enforce production of qualitative drugs and elimination of injurious ones from the market must take within its sweep an obligation to make useful drugs available at a reasonable price so as to be within the reach of a common man, which would involve regulating the price. It may be that on account of the cost of a particular medicine of improved quality it will have to sell at a higher price, but, for every illness which can be cured by treatment, the patient must be in a position to get its medicine. It was held that this is an obligation on the State in view of the fundamental directives of State policy enshrined in Part IV of the Constitution. The Supreme Court
gave a direction to the Central Government to examine the objections raised in the petition against the drugs or refer them to the consultative Committee for examination and take a decision within six months.

One disturbing trend noticed by the Court was that there was no adequate response from the bodies like Medical Council of India, the Indian Medical Association and the Drugs Medical Council of India despite notices by the Court.

It was held that these bodies are not litigants and do not have a choice of keeping away from the Court like private parties in ordinary litigations opting to go ex-parte. It was observed that, when the Court invited them to come forward and place their views on the relevant aspects, an attitude of callous indifference could not be appreciated.

**Welfare of Children:**
In Sheela Barse (II) V. Union of India, the Supreme Court held that the nation’s children are a supremely important asset. Their nurture and Solicitude are our responsibility. Children’s programmes should find a prominent part in our national plans for the development of human resources, so that our children grow up to become robust citizens, physically fit, mentally alert and morally healthy, endowed with skill and motivations needed by the society. By definition health encompasses with physical, mental and social well-being, therefore, this section is coming under the health and human rights purview. The state has to provide basic nutrition and health facilities to all its citizens including children.

**Conclusion**
Human rights standards address the civil, political, economic, social and cultural sphere. Each human right, while formally belonging to one of those categories, in reality encompasses aspects of all of them. This is easily identifiable within the human right to health. Moreover, the right to health within the human rights framework is defined as the right to achieve the “highest attainable standard of health” not merely the absence of disease. Both of these aspects of human rights are consistent with a social determinant approach to health, as they take into account the wide array of factors that influence a
person’s overall health status. Finally, a human rights and public health approach both have in common an assumption that the primary purpose of a health care system is preserving health, rather than addressing economic interests.

But a human rights approach is not merely consistent with a social determinant/public health model. It can also be employed as a tool to strengthen and promote, through policy and education, such a model. In the context of reproductive health, it brings greater definition and clarity to the parameters of what should be considered reproductive health concerns, and what are acceptable policy measures to influence or coerce reproductive health outcomes. This study addressed how that tool can be employed and the components and principles within the human rights framework of particular relevance to right to health matters.

The overview of the plans and policy reports not only throws light on the gap between the rhetoric and reality but also the framework within which the policies have been formulated. There has been an excessive preoccupation with single purpose driven programmes. Above all, the spirit of primary health care has been reduced to just primary level care. The health reports and plans mostly concentrated on building the health services infrastructure and even this lacked a sense of integration. Most of the policy reports miss out on the importance of a strong referral system. Instead, there has been more emphasis on building the primary level care and even that has lacked proper implementation. The Bhore committee report and later, the Primary Health Care Declaration discussed the operational aspects of integrating the other sectors of development related to health. The multi-sectoral approach that is much needed and the inter-sectoral linkages that are essential for a vibrant health system have not been well thought out, and there has been no plan drawn out for it later. The outline of plan documents and their implementation have been incremental rather than being holistic. It is important to question whether it is only the low investment in health that is the main reason for the present status of the health system or is it also to do with the framework, design and approach within which the policies have been planned.
Technological advances, investment and good policies can be turned to naught in the presence of a system lacking in leadership, direction and a core sense of integrity pervading all levels of health care. Unless all stakeholders are motivated by a set of values—of compassion and human concern for the sick and ill, of not accepting a system which allows people to be denied care only because of circumstances beyond their control, of a minimal sense of equality and dignity among all the health system will continue to reflect the cement and mortar issues of the expanding medical and drug industry, which can, in the absence of the guiding hand of the state, degrade human suffering into an opportunity for making profits. It then becomes critical to define the role of the State as the current utilitarian liberal approach of the health sector offers no acceptable solution. The issue is broader and needs to be examined within the context of the principles that underlie the concept of social contract of Rousseau or sense of justice of Rawls. If these principles enshrined in our Constitution are adhered to, then the State will need to intervene both intelligently and firmly.