

# POLICY BRIEF

## MOVING TOWARDS RIGHT TO HEALTH CARE

### Why Right to Health Care ?

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

Even after 57 years of Independence the Indian State has failed to provide its citizens the basic requirements like food security, health care, housing and education, which are the basis for reasonable human existence. Due to rampant poverty and lack of social equity large sections of population have been denied adequate nutrition, clean drinking water and sanitation, basic education, good quality housing and a healthy environment, which are all prerequisites for health. A highly inequitable health system has denied

quality health care to all those who cannot afford it. The first National Health Policy (NHP) of 1983 made its motto 'Health Care for All by 2000' which has not happened, while the subsequent National Health Policy 2002 welcomes the participation of the private sector in all areas of health activities thus in a sense endorsing inequity. The failure of National Health Policies to introduce social justice and equity has brought to the forefront the issue of need for a comprehensive legislative framework to empower the vast impoverished masses with rights for a healthy life.

While Universal Access to Health Care will be the ultimate aim, the promulgation of a comprehensive legislative framework on Right to Health Care could be a prelude to the 'Right to Health Care' as an enforceable fundamental right.

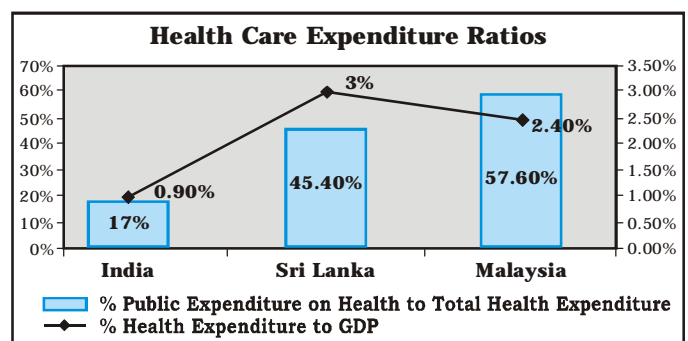
### What are the Characteristics of the Current Health Scenario?

- **A collapsing public health system**

The National Health Policy 2002 clearly acknowledges that the public health care system is grossly short of defined requirements, functioning is far from satisfactory, that morbidity and mortality due to easily curable diseases continues to be unacceptably high, and resource allocations generally insufficient - *"It would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and para-medical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services."*(para 2.4.1 NHP 2002).

- **Public spending on health care in India is as low as 0.9% of the Gross Domestic Product (GDP) in contrast to a total health expenditure of 5% of GDP making public health**

expenditure a mere 17% of total health spending in the country<sup>1</sup>. Decreasing public health expenditure has adversely affected the health outcomes. In India, under 5 mortality is 95 per 1000 whereas in comparison Sri Lanka with only 3% of GDP as total health expenditure has under 5 mortality of only 19 per 1000, and this difference is due to the fact that in Sri Lanka public health expenditure accounts for as much as 45.4% of total health expenditure. Malaysia spends only 2.4% of GDP on health care but 57.6% of it is from public resources and as a result the under 5 mortality is only 14 per 1000<sup>2</sup>. *The NHP 2002<sup>3</sup> acknowledges that the public health investment in the country has been comparatively low and plans to raise it to 2 percent of GDP by 2010, however this is much lower than the 5% GDP recommended by the World Health Organisation (WHO).*



- **Increasing private health sector expenditure vs. shrinking public health expenditure**

India has one of the most privatised health systems in the world, denying the poor access to even basic health care. The trend of unrestrained growth of private health sector during the last decade is clearly visible. In 1993-94 the private health expenditure was 1.5 times more than the total public expenditure. In 2002-03 the private health expenditure was nearly 5.4 times the public health expenditure.<sup>4</sup> The crushing burden of bearing expenses on health care is put on the people of this country resulting in out-of-pocket expenditure on private health care services which is as high as 82 per cent<sup>5</sup>. NHP 2002 in principle, 'welcomes the participation of the private sector in all areas of health activities' – primary, secondary or tertiary. This is in contrast to the basic goal of NHP-1983 of providing 'universal, comprehensive primary health care services, relevant to actual needs and priorities of the community'.

- **India has a very large and unregulated private health sector**

In 2001 of all registered hospitals 72.52% were in the private sector and 27.47% in the public sector<sup>6</sup>. While public hospitals follow some norms and standards in provision of health care as defined in hospital manuals and government regulations the private sector has no such binding and operates completely unregulated. The professional associations have never shown any concern for ethics and self-regulation to ensure a standard level of health care provisions. The private sector is governed completely by the whims of the market. The private health sector's focus is on curative care. *Various studies show that private health sector accounts for over 70% of all primary care, which is sought, and over 50% of all hospital care<sup>7</sup>. This is not a very healthy sign for a country in which three-fourth of the population lives at or below subsistence.*

- **Wasteful expenditures due to lack of regulations and standard protocols for treatment**

Private hospitals in the country function without any regulation or adhering to any standards. Standards are not prescribed nor are being enforced either through legislation, bye-laws or professional organisations/associations.

In a study conducted in Satara district in Maharashtra in 1991-92 it was found that due to irrational prescriptions, a whopping 63.6% of money spent on drugs is a waste. The proportion is much higher in the private sector (69.2%) as compared to that in the public sector (55.4%)<sup>8</sup>, wastage amounts to an estimated Rs.17.70 crores out of total supply of Rs.22 crores. Similarly in the private sector a lot of household resources are wasted due to unnecessary surgeries, like Caesareans and hysterectomies, or diagnostic

procedures like CT Scans and Sonography etc. being done when rational therapeutics and practice do not demand it.

- **Very large numbers of unqualified and untrained practitioners**

There are over 1.2 million qualified doctors in India. Sixty percent are qualified and registered non-allopathic doctors. There are an additional quarter-to-half-a-million 'doctors' not having any recognised qualification<sup>9</sup>.

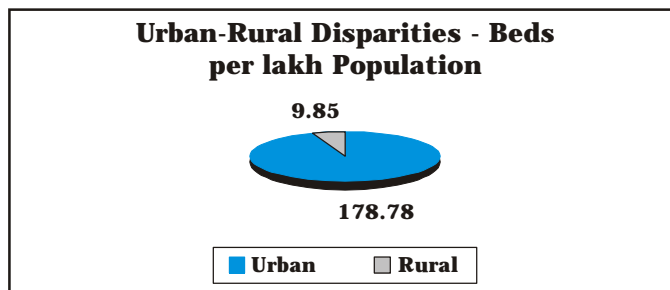
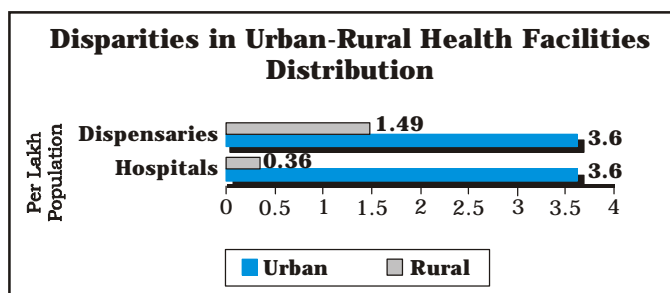
A survey on health care in Udaipur, Rajasthan, found that 41% of those in the private sector had no medical degree, 18% had no medical or paramedical training at all and 17% had not even graduated from high school<sup>10</sup>.

Mumbai alone has around 10,000 quacks, according to a 2001 survey conducted by the city chapter of the Indian Medical Association<sup>11</sup>.

*The NHP 2002 envisages enactment of suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/ medical institutions by 2003. However this recommendation has not been transformed into a reality till today!*

- **A lopsided health policy resulting in urban-rural disparities**

There are 17,000 hospitals (34 per cent rural), 25,670 dispensaries (40 per cent rural) and about one million beds (23 per cent rural) at present in the country.<sup>12</sup> In addition the rural areas have 24,000 PHCs and 140,000 sub-centres. However, the comparison between urban and rural areas show that urban areas have 4.48 hospitals, 6.16 dispensaries and 308 beds per 100,000 urban population in sharp contrast to rural areas which have 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and 44 beds per 100,000 rural population.



Source : Review of Health Care In India, 2005, CEHAT, Pg-S-15 to S-18, S-21

Thus the urban-rural disparity is striking in spite of the fact that 70% of the population comprises rural areas and only 30% comprises urban areas<sup>13</sup>. The shortfalls of the system are mentioned in the NHP 2002 'Applying current norms to the population projected for the year 2000, it is estimated that the shortfall in the number of SCs/PHCs/CHCs is of the order of 16 percent. However, this shortage is as high as 58 percent when disaggregated for CHCs only'.

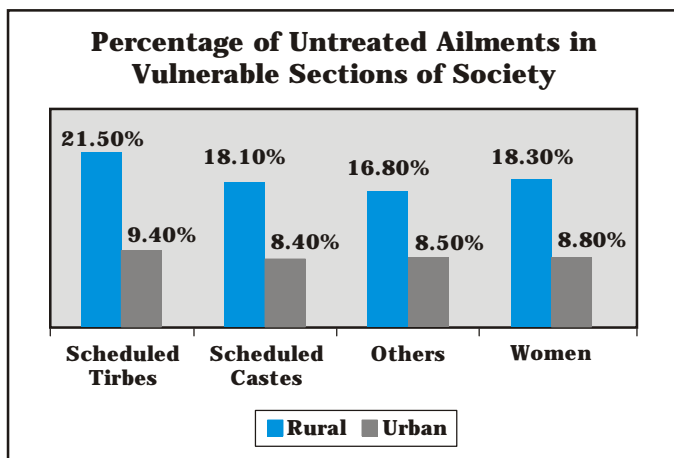
• **Unequal access to health care and poor outcomes based on socio-economic status**

The lowest socio-economic strata in India are totally deprived of health care facilities leading to poor health outcomes as accessibility to basic health care depends on the socio-economic status of an individual.

For the **socio-economically poor households** access and outcomes as compared to the socio-economically well off class are significantly more adverse for the former: infant and child mortality rates is of the magnitude of 2 ½ times,<sup>14</sup> prevalence of malaria 3 times, prevalence of tuberculosis 4 times, access to antenatal care nearly 4 times, completed immunisation 2 times, childbirth by doctors 4 times, malnourishment amongst women in reproductive age-group 3 times.<sup>15</sup>

**Rural-urban differentials** showed that the proportion of not receiving treatment because of 'financial problem' and 'lack of medical facility' to be higher in rural areas than in urban areas<sup>16</sup>. Thus 21.5% of Scheduled Tribes, 18.1% of Scheduled Castes and 16.8% of Others were not treated for ailments in rural areas while 9.4% of Scheduled Tribes, 8.4% of Scheduled Castes and 8.5% of Others remained untreated in urban areas<sup>17</sup>.

*54 million tribals of various ethnic origins residing in forested areas and accounting for 8% of the total population contributed 30% of total malaria cases, 60% of total Plasmodium falciparum cases and 50% of malaria deaths in the country<sup>18</sup>.*



**Women are at a higher risk** of having untreated ailments in rural areas (18.3%) than in urban areas (8.8%) as well as in comparison with their male counterparts, (15.8%) in rural areas and (8.1%) in urban areas<sup>19</sup>.

- **Non-availability of essential determinants** of health like water supply and sanitation, environmental health and hygiene and access to food<sup>20</sup> as shown in Box No1:

**Box No1:**

- Piped water is available to only 25% of the rural population and 75% of urban population
- 50% of the urban population and 75% of the rural population does not purify/filter the water
- Flush and pit toilets are available to only 19% of the rural population as against 81% of those in towns and cities
- Electricity for domestic use is accessible to 48% rural and 91% urban dwellers
- For cooking fuel 73% of villagers still use wood. LPG and biogas is accessed by 48% urban households but only 6% rural households
- 41% village houses are kachcha whereas only 9% of urban houses are so

Source: National Family Health Survey, India, 1998<sup>21</sup>

The Indian health scenario is characterised by a declining public health system, resulting in urban-rural disparities and putting the onus of health care on out-of-pocket expenditure, which is overburdening the impoverished masses of the country. The unrestrained growth of the private health sector has resulted in denial of health care to the people of this country thus making a mockery of the concept of Welfare State enshrined in the Constitution of India in Article 38<sup>22</sup>. It is found that the State is increasingly abdicating from its primary duty of the Welfare State and has failed to provide basic primary health care services, which are easily available, accessible and affordable to all. The recommendations of National Health Policies have not been implemented in letter and spirit. There is a need to translate the recommendations into reality. This can be possible when comprehensive legislative framework is drafted taking into consideration the ground realities. This legislative framework can be made effective if there is an amendment in the Constitution making Right to Health Care a fundamental right. This will be a step forward towards establishing universally accessible health care for all.

“...health will finally be seen not as a blessing to be wished for, but as a human right to be fought for”  
-**Kofi Annan UN Secretary General**

Promoting and protecting health and respecting, protecting and fulfilling human rights are inextricably linked:

- Violations or lack of attention to human rights can have serious health consequences (e.g. harmful traditional practices, slavery, torture and inhuman and degrading treatment, violence against women and children).
- Health policies and programmes can promote or violate human rights in their design or implementation (e.g. freedom from discrimination, individual autonomy, rights to participation, privacy and information).
- Vulnerability to ill-health can be reduced by taking steps to respect, protect and fulfil human rights (e.g. freedom from discrimination on account of race, sex and gender roles, rights to health, food and nutrition, education, housing).

Source: <http://www.who.int/hhr/en/>

## What are the International Instruments Endorsing Right to Health?

The National Health Policies have provided guidelines for the decision makers, however concrete health rights have to be ensured by a legal framework for their effective implementation. A comprehensive legislative framework will include the detail structure to make Right to Health Care functional. It would be desirable if this legislative framework is complemented by Right to Health Care as a fundamental right, which will be enforceable. In our quest to draft contents of comprehensive legislative framework and content for fundamental right, there are numerous International Instruments, which provide an insight into the issue of health as a basic human right.

- **Establishing Health (and access to health care) as a Human Right** - Considered from the perspective of international law, the ‘enjoyment of the highest attainable standard of health’ has been recognized as a ‘fundamental right’ by the international community since the adoption of the constitution of WHO in 1946<sup>23</sup>.
- **On December 10, 1948 the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights, Article 25<sup>24</sup>** reads:  
(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
- **The International Covenant on Economic, Social and Cultural Rights (1966), in its Article 12**, clearly recognises the right of everyone to

the enjoyment of the highest attainable standard of physical and mental health and the creation of conditions, which would assure medical service and medical attention to all in the event of sickness<sup>25</sup>.

The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the Right to Health in international human rights law. **The UN Committee on Economic, Social and Cultural Rights (CESCR) in its twenty-second session in Geneva in 2000, in its General Comment No.14 defines Article 12.1 - Right to Health** - as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels<sup>26</sup>.

- **The 1978 declaration of Alma-Ata** strongly reaffirms that health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector<sup>27</sup>.

The declaration called upon the nations to ensure availability of the essentials of primary health care including awareness concerning health problems and the methods for preventing and controlling them; proper nutrition; supply of safe water and basic sanitation; maternal and child health care including family planning; immunization against major infectious diseases and prevention and control of locally endemic diseases<sup>28</sup>.

- **The Convention on the Elimination of All Forms of Discrimination Against Women (1979), Article 12** talks of eliminating discrimination against women in enjoyment of

the right to protection of health and access to health care including family planning services, safety in working conditions, and safeguarding the function of reproduction.<sup>29</sup> This is an important step towards women's access to health care.

- **The Convention of the Rights of the Child (1989), Article 24** recognises the right of the child to the enjoyment of highest attainable standard of health and to the facilities for the treatment of illness and rehabilitation of health<sup>30</sup>. India is signatory or has ratified all of the above.

## What are the Constitutional Provisions and Case Laws Related to the Right to Health in India?

There are numerous laws and Supreme Court Judgements, which reflect Right to Health as a basis for human existence.

### Constitutional Law of India

- **Article 21: Protection of life and personal liberty**

*No person shall be deprived of his life or personal liberty except according to procedure established by law.*

The Right to Life (Article 21) enshrined as a fundamental right in the Constitution makes a case for provision of emergency medical care, and protection from all threats to life<sup>31</sup>. The fundamental rights are guaranteed to all citizens. These civil liberties take precedence over any other law of land<sup>32</sup>.

- **Article 47 states:** *“The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties<sup>33</sup>...”*

Article 47, which is a Directive Principle of State Policy, relates to nutrition, standard of living and health.

Although the Directive Principles are asserted to be “fundamental in the governance of the country,” they are not legally enforceable. They are guidelines for creating a social order characterized by social, economic, and political justice, liberty, equality, and fraternity as enunciated in the Constitution's preamble.

### The Supreme Court Judgements

- In the case of **Consumer Education and Research Centre v. Union of India<sup>34</sup> [1995 (3) SCC 42]**: The government has a positive duty to provide the basic conditions necessary to lead a life that is more than mere animal existence,

including a Right to Health, Right to Clean Environment, Right to Privacy.

- In the case of **Parmanand Katara v. Union of India<sup>35</sup> [1989 (4) SCC 286]**, the Supreme Court said that whether the patient was innocent or a criminal, it is an obligation of those in charge of community health to preserve the life of the patient.

- In an important judgement the case of **Paschim Banga Khet Mazdoor Samity vs. State of West Bengal<sup>36</sup>, [1996 (4) SCC 37]**, the Supreme Court of India ruled that -

In a welfare state the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. ... Article 21 imposes an obligation on the State to safeguard the right to life of every person. ... The Government hospitals run by the State and the medical officers employed 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 a violation of his right to life guaranteed under Article 21<sup>37</sup>.* (Emphasis added)

- In the cases **Bandhua Mukti Morcha v. Union of India and others, 1982** concerning bonded workers, the Supreme Court gave orders interpreting Article 21 as mandating the right to medical facilities for the workers<sup>38</sup>.

Right to Health includes the right to health care and the right to determinants of health such as food security, water supply, housing and sanitation etc. All of these are prerequisites of sound health. The above judgements also have reflected importance of health as a prerequisite for Right to Life. Thus it

can be inferred that Right to Health is an important human right and its denial can be detrimental to the existence of human life. It is necessary to make Right to Health Care a fundamental right in the Indian Constitution rather than limiting it to the Directive Principles of State Policy.

Basic social services are being recognised as fundamental rights with the 93<sup>rd</sup> Amendment in the Constitution accepting education as a fundamental right. This also creates a favourable condition for the justification of the demand to make Right to Health Care a fundamental right.

## What is the Suggested Core Content for a Comprehensive Legislative Framework on Right to Health Care?

***‘Rights are toothless wonders without the support of law and finances’ – John Samuel***

*In the current era of globalisation, liberalisation and privatisation there is a growing trend of the government’s withdrawal from the public health sector and the unregulated growth of private sector. The daily denial of a healthy life, to crores of people, because of deep structural injustice, within and beyond the health sector have brought to the forefront the need to make the Right to Health Care a fundamental right. While moving towards this goal it is necessary to have a comprehensive legislative framework endorsing right to health care. The minimum core content for it is suggested as follows<sup>39</sup>:*

### **1. Entitlement to basic public health services.**

Adequate physical infrastructure, skilled human power in all health care facilities, availability of the complete range of specific services appropriate to the level and availability of all basic medications and supplies should be the components of the public health system. The infrastructure and services need to be clearly defined and displayed at various levels.

Basic medical services should be available at primary and secondary level to all.

Elimination of rural-urban disparities in provision of health services should be an immediate task. Basic public health services have to be made accessible to all citizens without discrimination.

### **2. Establishing rights and regulations related to private medical sector.**

1. Access to emergency medical care and care based on minimum standards from private medical services.

Since the Right to Life is a fundamental right, it is applicable in situations of emergency medical care where no hospital or doctor, including those in the private sector, can refuse minimum essential first aid and medical care to a citizen in times of emergency, irrespective of the person’s ability to pay for it.

2. There is an urgent need to make provision in the legislation to regulate qualifications of doctors, required infrastructure, investigation and treatment procedures especially in the private medical sector. Standard guidelines for investigations, therapy and surgical decision making need to be adopted and followed, combined with legal restrictions on common medical malpractices. Maintaining complete patient records, notification of specific diseases and observing a ceiling on fees also needs to be observed by the private medical sector.

### **3. Availability of essential drugs at affordable cost.**

1. Availability of all basic medications free of cost through the public health system.

2. A National Essential Drug Policy ensuring the production and availability of an entire range of essential drugs at affordable prices.

The Union as well as the State Governments should publish comprehensive lists of essential drugs for their areas. A ceiling on the prices of these drugs must be decided and scrupulously adhered to, with production quotas and a strict ban on irrational combinations and unnecessary additives to these drugs.

### **4. Availability of information to patients, patient’s rights and redressal mechanism.**

The entire range of treatment and diagnosis related information should be made available to every patient in either private or public medical facility. Every patient should be entitled to information regarding the entire range of treatment and diagnosis in public or private facilities regarding staff qualifications, fees and facilities for any medical centre before they decide to take the treatment. Confidentiality, consent and protection of dignity of a patient should be ensured to every patient. Patient-friendly grievance redressal mechanism needs to be made functional, with technical guidance and legal support being made available to all those who approach this system. This would provide an effective check on various forms of malpractices.

## 5. Monitoring and accountability mechanisms.

There is a need to have people's monitoring of public health services at the national level complemented by state level policy by following the principle of decentralisation as outlined in the 73<sup>rd</sup> and 74<sup>th</sup> Amendment of the Indian Constitution. The 73<sup>rd</sup> Amendment empowers Panchayati Raj Institutions<sup>40</sup> as bodies of self-government in rural India whereas the 74<sup>th</sup> Amendment<sup>41</sup> decentralises the urban governance. *The monitoring mechanism should be based on the principles of accountability, transparency and responsiveness, since good governance is essential to the effective implementation of all human rights.*

We need to propose an effective system of people's monitoring of public health services which would be organised at the various levels in rural as well as urban areas. Putting in place effective monitoring mechanisms and widespread public awareness about the entitlements would be essential for this right to become operational in any meaningful form. Community monitoring of health services would increase the accountability of these services and lead to greater people's involvement in the process of implementing them.

## 6. Health care rights relating to various sections of population which have special needs.

Ensuring special services to fulfil specific health needs and ensuring non-discrimination regarding access to general health services for Women, Children, HIV-AIDS affected persons, unorganized workers, urban deprived communities, persons with mental health problems, elderly, disabled, migrants, communities facing displacement or involuntary resettlement, health care during conflict situations like communal violence or war. A special framework should be prepared for guaranteeing non-discriminatory health care access to the above mentioned sections of the society<sup>42</sup>.

The above listed components of health care are the minimum that must be assured, if a universal health care system has to be effective and acceptable. It is essential to specify adequate minimum standards of health care facilities, which should be made available to all people irrespective of their social, geographical and financial position (see Box 2). Promulgation of National legislation with the suggested core contents on Health Care would be the prelude to making Right to Health Care a fundamental right.

### Box No. 2

#### Basic Package of Primary Health Care Services that Should be Provided Universally<sup>43</sup>

- General practitioner/family physician services for personal health care.
- First level referral hospital care and basic speciality services (general medicine, general surgery, obstetrics and gynaecology, paediatrics and orthopaedic), including dental and ophthalmic services.
- Immunisation services against all vaccine preventable diseases.
- Maternity and reproductive health services for safe pregnancy, safe abortion, delivery and post-natal care and safe contraception.
- Pharmaceutical services - supply of only rational and essential drugs as per accepted standards.
- Epidemiological services including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures.
- Ambulance services.
- Health education.
- Rehabilitation services for the physically and mentally challenged and the elderly and other vulnerable groups.
- Occupational health services with a clear liability on the employer.
- Safe and assured drinking water and sanitation facilities, minimum standards in environmental health and protection from hunger to fulfil obligations of underlying preconditions of health (*the latter 3 would be outside the domain of the Ministry of Health*).

*"Should medicine ever fulfil its great ends, it must enter into the larger political and social life of our time; it must indicate the barriers which obstruct the normal completion of the life cycle and remove them."*

- Rudolf Virchow

## Making the Right to Health Care a Fundamental Constitutional Right !

We need to move towards the objective of establishing Right to Health Care as a Fundamental Right in the Indian Constitution. This would be a prolonged and challenging process, and would involve political mobilisation and influencing public and political opinion on a large scale, besides formulating an appropriate bill based on legal inputs. Comprehensive legislative framework can provide

the necessary foundation for initiating the constitutional amendment to make Right to Health Care a Fundamental Right. Promulgation of Right to Health Care as a fundamental right along with the legislative framework would make this right paramount and enforceable. Box 3 lists critical action points to make health care a fundamental right.

### Box No. 3

#### Proposed Strategy for Making Health Care a Fundamental Right<sup>44</sup>

1. Making the Right to Health Care a legally enforceable entitlement by Constitutional Amendment
2. A national level comprehensive health legislation with a detailed plan and timetable for realisation of the Right to Health Care adhering to the principle of decentralisation
3. Developing essential public health infrastructure required for health care; investing sufficient resources in health and allocating these funds in a cost-effective and fair manner
4. Providing basic health services to all, focusing on equity and social justice so as to improve the health status of poor and vulnerable sections of society and towards removing regional imbalances or rural-urban disparities
5. Adopting a comprehensive strategy based on a gender perspective so as to overcome inequalities in women's access to health facilities
6. Adopting measures to identify, monitor, control and prevent the transmission of major epidemic and endemic diseases
7. Making reproductive health and family planning information and services available to all persons and couples without any form of coercion
8. Implementing an essential drug policy

## Need for an Effective System for Universal Access to Health Care

To make the above-mentioned recommendations feasible a number of policy decisions have to be taken. In our endeavour to achieve the ultimate objective of universal access to basic health care for all, there is a need to spell out structural requirements or the outline of the model, which will need support of the legislation. The structure, terms and conditions should be clearly incorporated in the legislative framework.

The legislation would be ineffective if it is not complemented by increase in allocation of financial resources by the Government. It has been found that countries which have allocated large amounts of financial resources in health care have provided better standard of living to its citizens. The most important area for policy initiative would be the efforts needed to be generated through various alternative modes of financing.

Resources could be generated through innovative methods - health cess could be collected by local governments as part of the municipal/house taxes, proportion of sales turnover and/or excise duties of health degrading products (if we cannot get rid of them) like alcohol, cigarettes, paan-masalas etc. should be earmarked for the health sector. All these methods are used in other countries to enhance health sector finances. These methods should be introduced if a universal health care system has to assure equity<sup>45</sup>.

We must strive to move towards a system where **every citizen has assured access to basic health care, irrespective of capacity to pay**. A number of countries in the world have made provisions in this direction, ranging from the Canadian system of Universal health care<sup>46</sup> and NHS in Britain to the Cuban system of health care for every citizen.

In the Indian context, while the Right to Health Care needs to be enshrined in the Constitution as a fundamental right, there still is a need to develop a complementary system of Universal access to health care<sup>47</sup>.

The existing massive private medical sector in India, which commands over three-fourth of the doctors and provides a similar proportion of outpatient care, needs to be addressed and tackled in any system to provide Universal health care coverage. Introducing a system of Universal social health insurance or some form of compulsory coverage such as national health insurance as in Canada or Germany is necessary. Insurance services could be provided by making a combination of a significantly strengthened and community-monitored public health system, along with some publicly regulated and financed private providers, under a single umbrella. The entire system would be based on public financing and cross-subsidy, with free services to the majority population of rural and urban people including vulnerable sections, and affordable premium amounts (which could be integrated with the taxation system) for higher income groups<sup>48</sup>.

The patient should be assured of a range of services with minimum standards, whether given from the public health system or publicly financed and provided by regulated private providers.

This would of course imply a *significantly higher public expenditure on health services*, about 3% of the GNP towards public health care to start with. This should then be progressively raised to the level of *5% of GNP spent on Public health to give a full range of services to all*.<sup>49</sup>

The new National Health Policy claims on paper the intention to more than double the financial allocation for the public health system and bring it to the level of 2% of the GDP, and to increase utilisation of public health facilities to above 75% by the end of this decade<sup>50</sup>. In this context, ensuring the Right to Health Care as a fundamental right has become imperative for a nation, which as the 'world's largest democracy' claims to accord certain basic rights to its citizens, including the Right to Life in its broadest sense.

## Conclusion

Health is a social, economic and political issue and above all a human right. Inequity and poverty are the root cause of ill health leading to malnutrition and starvation deaths in the marginalised sections of the society. The current health scenario favours the urban affluent class, which is only about 10% of the total population. There is a need to remove regional imbalances. Declining health expenditures have adversely affected health outcomes worsening the health scenario. There is a need to restructure the existing health system. The highly privatised health system has deprived the masses of even primary health care leading to out-of-pocket expenditure, which they can ill-afford. The National Health Policies did not achieve their targets thus creating a need for a comprehensive legislative framework. There is a need to restructure the existing health system to usher equity and social justice. This can be achieved through promulgation of a comprehensive legislative framework, which should create conditions conducive to restore the balance in the health sector. The legislation should be complemented by making 'Right to Health Care' a fundamental right, which will be an enforceable

right. The ultimate aim of Universal Access to Health Care could be achieved through the restructuring of health finance and introduction of universal coverage of health care.

Over the last two years, the Jan Swasthya Abhiyan (JSA), the Indian chapter of the People's Health Movement has taken up Right to Health Care as a major national campaign. In this process the JSA has been able to involve National Human Rights Commission (NHRC) to support the conduct of public hearings across length and breadth of the country. These public hearings brought forth cases of denial of health care and at a National Consultation in December 2004, the NHRC and JSA were able to consolidate the demand for Right to Health Care by promulgating a National Action Plan to Operationalise Right to Health Care. This Action Plan is reproduced as Annexure 1. We hope that the above discussion and the NHRC Action Plan will generate a debate amongst policy makers, bureaucrats, legislators and civil society groups to begin a process which would lead to making health care a universally accessible right.

## **Annexure 1 - NHRC Recommendations for a National Action Plan to Operationalise the Right to Health Care<sup>51</sup>**

### **Recommendations to Government of India / Union Health Ministry**

- **Enactment of a National Public Health Services Act, recognizing and delineating the Health rights of citizens**, duties of the Public health system, public health obligations of private health care providers and specifying broad legal and organisational mechanisms to operationalise these rights. This act would make mandatory many of the recommendations laid down, and would make more justiciable the denial of health care arising from systemic failures, as have been witnessed during the recent public hearings.  
This act would also include **special sections to recognise and legally protect the health rights of various sections of the population, which have special health needs:** Women, children, persons affected by HIV-AIDS, persons with mental health problems, persons with disability, persons in conflict situations, persons facing displacement, workers in various hazardous occupations including unorganised and migrant workers etc.
- **Delineation of model lists of essential health services at various levels:** village/community, sub-centre, PHC, CHC, Sub-divisional and District hospital to be made available as a right to all citizens.
- **Substantial increase in Central Budgetary provisions for Public health**, to be increased to 2-3% of the GDP by 2009 as per the Common Minimum Programme.
- **Convening one or more meetings of the Central Council on Health** to evolve a consensus among various state governments towards operationalising the Right to Health Care across the country.
- Enacting a **National Clinical Establishments Regulation Act** to ensure **citizen's health rights concerning the Private medical sector** including right to emergency services, ensuring minimum standards, adherence to Standard treatment protocols and ceilings on prices of essential health services. Issuing a Health Services Price Control Order parallel to the Drug Price Control Order. Formulation of a Charter of Patients Rights.
- **Setting up a Health Services Regulatory Authority** - analogous to the Telecom regulatory authority- which broadly defines and sanctions what constitutes rational and ethical practice, and sets and monitors quality standards and prices of services. This is distinct and superior compared to the Indian Medical Council in that it is not representative of professional doctors alone - but includes representatives of legal health care providers, public health expertise, legal expertise, representatives of consumer, health and human rights groups and elected public representatives. Also this could independently monitor and intervene in an effective manner.
- Issuing **National Operational Guidelines on Essential Drugs** specifying the right of all citizens to be able to access good quality essential drugs at all levels in the public health system; promotion of generic drugs in preference to brand names; inclusion of all essential drugs under Drug Price Control Order; elimination of irrational formulations and combinations. Government of India should take steps to publish a National Drug Formulary based on the morbidity pattern of the Indian people and also on the essential drug list.
- **Measures to integrate National health programmes with the Primary Health Care system** with decentralized planning, decision-making and implementation. Focus to be shifted from bio-medical and individual based measures to social, ecological and community based measures. Such measures would include compulsory health impact assessment for all development projects; decentralized and effective surveillance and compulsory notification of prevalent diseases by all health care providers, including private practitioners.
- **Reversal of all coercive population control measures**, that are violative of basic human rights, have been shown to be less effective in stabilising population, and draw away significant resources and energies of the health system from public health priorities. In keeping with the spirit of the NPP 2000, steps need to be taken to eliminate and prevent all forms of coercive population control measures and the two-child norm, which targets the most vulnerable sections of society.
- Active participation by Union Health Ministry in a National mechanism for health services monitoring, consisting of a **Central Health Services Monitoring and Consultative Committee** to periodically review the implementation of health rights related to actions by the Union Government. This would also include deliberations on the underlying structural and policy issues, responsible for health rights violations. Half of the members of this Committee would be drawn from National level health sector civil society platforms. NHRC would facilitate this committee. Similarly, operationalising **Sectoral Health Services Monitoring Committees** dealing with specific health rights issues (Women's health, Children's health, Mental health, Right to essential drugs, Health rights related to HIV-AIDS etc.)
- The structure and functioning of the **Medical Council of India** should be immediately reviewed to make its functioning more democratic and transparent. Members from Civil Society Organisations concerned with health issues should also be included in the Medical Council **to conform medical education to serve the needs of all citizens, especially the poor and disadvantaged.**

- People's access to emergency medical care is an important facet of right to health. Based on the Report of the Expert Group constituted by NHRC (Dr. P.K.Dave Committee), short-term and long-term recommendations were sent to the Centre and to all States in May 2004. In particular, the Commission recommended:
  - (i) Enunciation of a National Accident Policy;
  - (ii) Establishment of a central coordinating, facilitating, monitoring and controlling committee for Emergency Medical Services (EMS) under the aegis of Ministry of Health and Family Welfare as advocated in the National Accident Policy.
  - (iii) Establishment of Centralized Accident and Trauma Services in all districts of all States and various Union Territories along with strengthening infrastructure, pre-hospital care at all government and private hospitals.
- Spurious drugs and sub-standard medical devices have grave implications for the enjoyment of human rights by the people. Keeping this in view all authorities are urged to take concrete steps to eliminate them.
- Access to Mental health care has emerged as a serious concern. The NHRC reiterates its earlier recommendations based on a Study "Quality Assurance in Mental Health" which were sent to concerned authorities in the Centre and in States and underlines the need to take further action in this regard.

### **Recommendations to State Governments / State Health Ministries**

- **Enactment of State Public Health Services Acts/Rules**, detailing and operationalising the National Public Health Services Act, recognizing and delineating the Health rights of citizens, duties of the Public health system and private health care providers and specifying broad legal and organisational mechanisms to operationalise these rights. This would include **delineation of lists of essential health services at all levels:** village/community, sub-centre, PHC, CHC, Sub-divisional and District hospital to be made available as a right to all citizens. This would take as a base minimum the National Lists of essential services mentioned above, but would be modified in keeping with the specific health situation in each state.

These rules would also include **special sections to recognise and protect the health rights of various sections of the population, which have special health needs:** Women, children, persons affected by HIV-AIDS, persons with mental health problems, persons in conflict situations, persons facing displacement, workers in various hazardous occupations including unorganised and migrant workers etc.

- Enacting **State Clinical Establishments Rules** regarding **health rights concerning the Private medical sector**, detailing the provisions made in the National Act.
- **Enactment of State Public Health Protection Acts** that define the norms for nutritional security, drinking water quality, sanitary facilities and other key determinants of health. Such acts would complement the existing acts regarding environmental protection, working conditions etc. to ensure that citizens enjoy the full range of conditions necessary for health, along with the right to accessible, good quality health services.
- **Substantial increase in State budgetary provisions for Public health** to parallel the budgetary increase at Central level, this would entail at least doubling of state health budgets in real terms by 2009.
- **Operationalising a State level health services monitoring mechanism**, consisting of a **State Health Services Monitoring and Consultative Committee** to periodically review the implementation of health rights, and underlying policy and structural issues in the State. Half of the members of this Committee would be drawn from State level health sector civil society platforms. Corresponding **Monitoring and Consultative Committees** with civil society involvement would be formed in all districts, and to monitor urban health services in all Class A and Class B cities.
- **Instituting a Health Rights Redressal Mechanism** at State and District levels, to enquire and take action relating to all cases of denial of health care in a time bound manner.
- **A set of public health sector reform measures** to ensure health rights through strengthening public health systems, and by making private care more accountable and equitable. The minimum aspects of a health sector reform framework that would strengthen public health systems must be laid down as an essential precondition to securing health rights. **An illustrative list of such measures is as follows:**
  1. State Governments should take steps to **decentralize the health services** by giving control to the respective Panchayati Raj Institutions (PRIs) **from the Gram Sabha** up to the district level **in accordance with the XI Schedule of the 73<sup>rd</sup> and 74<sup>th</sup> Constitutional Amendment<sup>52</sup> of 1993**. Enough funds from the plan and non plan **allocation** should be devolved to the PRIs at various levels. The local bodies should be given the responsibility to formulate and implement health projects **as per the local requirements** within the **local** overall framework of the health policy of the state. The elected representatives of the PRIs and the officers should be given adequate training in local level health planning. Integration between the health department and local bodies should be ensured in formulating and implementing the health projects at local levels.

2. The adoption of a **State essential drug policy** that ensures full availability of essential drugs in the public health system. This would be through adoption of a graded essential drug list, transparent drug procurement and efficient drug distribution mechanisms and adequate budgetary outlay. The drug policy should also promote rational drug use in the private sector.
3. The health department should prepare a State Drug Formulary based on the health status of the people of the state. The drug formulary should be supplied at free of cost to all government hospitals and at subsidized rate to the private hospitals. Regular updating of the formulary should be ensured. Treatment protocols for common disease states should be prepared and made available to the members of the medical profession.
4. The adoption of an integrated community health worker programme with adequate provisioning and support, so as to reach out to the weakest rural and urban sections, providing basic primary care and strengthening community level mechanisms for preventive, promotive and curative care.
5. The adoption of a detailed plan with milestones, demonstrating how essential secondary care services, including emergency care services, which constitute a basic right but are not available today, would be made universally available.
6. The public notification of medically underserved areas combined with special packages administered by the local elected bodies of PRI to close these gaps in a time bound manner.
7. The adoption of an integrated human resource development plan to ensure adequate availability of appropriate health human power at all levels.
8. The adoption of transparent non-discriminatory workforce management policies, especially on transfers and postings, so that medical personnel are available for working in rural areas and so that specialists are prioritised for serving in secondary care facilities according to public interest.
9. The adoption of improved vigilance mechanisms to respond to and limit corruption, negligence and different forms of harassment within both the public and private health system.
10. All health personnel upto the district PRI level must be administratively and financially accountable to the PRI at each level from the Gram Panchayat to the District level. Adequate financial resources must be made available at each level to ensure all basic requirements of health and medical care for all citizens.

- Ensuring the implementation of the Supreme Court order regarding **food security, universalising ICDS programmes and mid day school meal programmes**, to address food insecurity and malnutrition, which are a major cause of ill-health.
- People's access to emergency medical care is an important facet of right to health. Based on the Report of the Expert Group constituted by NHRC (Dr. P.K.Dave Committee), short-term and long-term recommendations were sent to the Centre and to all States in May 2004. In particular, the Commission recommended:
  - (i) Enunciation of a National Accident Policy;
  - (ii) Establishment of a central coordinating, facilitating, monitoring and controlling committee for Emergency Medical Services (EMS) under the aegis of Ministry of Health and Family Welfare as advocated in the National Accident Policy.
  - (iii) Establishment of Centralized Accident and Trauma Services in all districts of all States and various Union Territories along with strengthening infrastructure, pre-hospital care at all government and private hospitals.
- Spurious drugs and sub-standard medical devices have grave implications for the enjoyment of human rights by the people. Keeping this in view all authorities are urged to take concrete steps to **monitor and eliminate** them.
- Access to Mental health care has emerged as a serious concern. The NHRC reiterates its earlier recommendations based on a Study "Quality Assurance in Mental Health" which were sent to concerned authorities in the Centre and in States and underlines the need to take further action in this regard.

#### **Recommendations to NHRC**

- NHRC would oversee the monitoring of health rights at the National level by initiating and facilitating the **Central Health Services Monitoring Committee**, and at regional level by appointing **Special Rapporteurs on Health Rights** for all regions of the country.
- Review of all laws/statutes relating to public health from a human rights perspective and to make appropriate recommendations to the Government for bringing out suitable amendments.

#### **Recommendations to SHRCs**

- SHRCs in each state would facilitate the **State Health Rights Monitoring Committees** and oversee the functioning of the State level health rights redressal mechanisms.

#### **Recommendations to Jan Swasthya Abhiyan and civil society organisations**

- JSA and various **other** civil society organisations would work for the widest possible raising of awareness on health rights - 'Health Rights Literacy' among all sections of citizens of the country.

## References

- 1 Duggal Ravi, 2004, *Operationalising Right to Healthcare in India*, The ICFAI Journal of Healthcare Law, Vol 2 No.3, August.
- 2 Indian Council for Research on International Economic Relations (ICRIER), 2001, *Changing the Indian Health System*, Draft Report, New Delhi.
- 3 Government of India, 2002, *National Health Policy 2002*, <http://mohfw.nic.in/np2002.htm>
- 4 Duggal Ravi, 2004, *Operationalising Right to Healthcare in India*, The ICFAI Journal of Healthcare Law, Vol 2 No.3, August 2004.
- 5 Chakraborty S., 2003, *Private Health Provisions in Uttar Pradesh, India*, in Yazbeck, Abodo S, Peters David, (edi.), *Health Policy Research in South Asia: Building Capacity for Reform*; The World Bank, Washington DC, pp.258.
- 6 Ministry of Health and Family Welfare 2002, *Health Information of India* Central Bureau of Health Intelligence, Directorate General of Health Services, pp.152.
- 7 Duggal Ravi, 1993, *For A New Health Policy*, A Discussion Paper, CEHAT, Mumbai.
- 8 Phadke Anant, Fernandes Audrey, et.al, 1995, *A Study of Supply and Use of Pharmaceuticals in Satara District*, Foundation for Research in Community Health (FRCH), Pune.
- 9 Jesani Amar, 1996, *Cross Practice at the Cross-Roads*, Issues in Medical Ethics, Vol.4, No.4, October-December 1996, pp103.
- 10 Kumar Sanjay, 2004, *Much health care in rural India comes from unqualified practitioners*. BMJ 328:975. doi:10.1136/bmj.328.7446.975-b, *Practice without a degree*, on website of Indian Journal on Medical Ethics, <http://www.issuesinmedicalethics.org/123fp072.html>
- 11 Krishnan Kavita, 2003, *Bill to aid crackdown on Mumbai's quacks*, Mid Day Dec.22.
- 12 Ministry of Health and Family Welfare, 2002, *Health Information of India* Central Bureau of Health Intelligence, Directorate General of Health Services.
- 13 Duggal Ravi and Gangolli Leena, 2005, *Introduction in Leena Gangolli, Ravi Duggal and Abhay Shukla (eds), Review of Healthcare in India*, CEHAT, Mumbai.
- 14 It is estimated that 2 million children under 5 years of age die every year because of the high child mortality rate. If the entire country experienced the child mortality rate of Kerala the number of such deaths each year would fall by a whopping 1.6 million (Shukla A, 2001: *Right to Health Care*, Health Action, May 2001).
- 15 NFHS-1998, 2000: *National Family Health Survey -2: India*, IIPS, Mumbai.
- 16 Dilip T.R., 2005, *Extent of Inequity in Access to Health Care Services in India*, in Leena Gangolli, Ravi Duggal and Abhay Shukla (edi.) *Review of Health Care in India*, CEHAT, Mumbai.
- 17 Ibid
- 18 Gangolli Leena and Gaitonde Rakhal, 2005, *Programmes for Control of Communicable Diseases*, in Leena Gangolli, Ravi Duggal and Abhay Shukla (edi.) *Review of Health Care in India*, CEHAT, Mumbai.
- 19 Dilip T.R., 2005, *Extent of Inequity in Access to Health Care Services in India*, in Leena Gangolli, Ravi Duggal and Abhay Shukla (edi.) *Review of Health Care in India*, CEHAT, Mumbai.
- 20 Duggal Ravi, 2003, *Operationalizing Right to Healthcare in India*, *Right to Health Care: Moving From Idea to Reality*, Proceedings of the Seminar held at The Asian Social Forum, Hyderabad, 3 and 4 January, CEHAT, Mumbai.
- 21 *National Family Health Survey, India, 1998*, International Institute for Population Sciences, Mumbai.
- 22 Legal Service India.com, *Indian Constitution, Part IV, Directive Principles of State Policy, Article 38 'State to secure social order for the promotion of the welfare of the people'*. [http://www.legalserviceindia.com/constitution/const\\_india.htm](http://www.legalserviceindia.com/constitution/const_india.htm), website referred - 28-4-2005.
- 23 World Health Organisation, 1946, *Constitution of World Health Organisation*, <http://www.who.int/about/definition/en/>, [http://policy.who.int/cgi-bin/om\\_isapi.dll?infobase=Basicdoc&softpage=Browse\\_Frame\\_Pg42](http://policy.who.int/cgi-bin/om_isapi.dll?infobase=Basicdoc&softpage=Browse_Frame_Pg42), website referred - 21-4-2005.
- 24 UN General Assembly, *Fiftieth Anniversary of Universal Declaration of Human Rights 1948-1998*, <http://www.un.org/Overview/rights.html>
- 25 UN International Covenant on Economic, Social and Cultural Rights, 1966, *International Covenant on Economic, Social and Cultural Rights 1966 Preamble, Part III, Article 12*. <http://www.ibiblio.org/ais/icescr.htm>, website referred - 21-4-2005.
- 26 UN Committee on Economic, Social and Cultural Rights (CESCR), 2000, *General Comment No.14*, [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/40d009901358b0e2c1256915005090be?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument), website referred - 21-4-2005.
- 27 World Health Organisation: Regional Office for Europe, 2004, *About WHO, Declaration of Alma-Ata*, [http://www.euro.who.int/aboutwho/policy/20010827\\_1](http://www.euro.who.int/aboutwho/policy/20010827_1), website referred - 26-4-2005.

- 28 Declaration of Alma-Ata, 1978, *International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September*, [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf), website referred – 21-4-2005.
- 29 UN Convention on the Elimination of All Forms of Discrimination Against Women, 1979, Text of Convention, Part III, Article 12, <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>, website referred – 21-4-2005.
- 30 UN General Assembly, 1989, 'Convention on the Rights of the Child' Document A/RES/44/25 (12 December 1989) with Annex, <http://www.cirp.org/library/ethics/UN-convention/>website referred – 21-4-2005.
- 31 Shukla Abhay, 2003, Right to Health Care: Moving From Idea to Reality, Proceedings of the Seminar held at The Asian Social Forum, Hyderabad – 3 and 4 January, CEHAT, Mumbai.
- 32 Fundamental Rights, India, <http://reference.allrefer.com/country-guide-study/india/india148.html>
- 33 Report of the National Workshop on Right to Health Care: September 5,2003 & National Consultation on Health Care as Human Right:September 6, 2003, Jan Swasthya Abhiyan, CEHAT, Mumbai.
- 34 Inaugural Address by Justice Anand, 2003, in the Report of the National Workshop on Right to Health Care: September 5, 2003 & National Consultation on Health Care as a Human Right: September 6, 2003 Jan Swasthya Abhiyan, CEHAT, Mumbai.
- 35 Ibid
- 36 Ibid
- 37 Shukla Abhay, 2003, *Right To Health Care: Moving From Idea To Reality*, Proceedings of the Seminar held at The Asian Social Forum, Hyderabad – 3 and 4 January, CEHAT.
- 38 Ibid
- 39 The suggested core content is a modified version of core content of the Right to Health Care adapted from Shukla Abhay, 2003, *Right To Health Care: Moving From Idea To Reality*, Proceedings of the Seminar held at The Asian Social Forum, Hyderabad – 3 and 4 January, CEHAT, pp 41-43.
- 40 [nird.org.in/clic/panch\\_demo.html](http://nird.org.in/clic/panch_demo.html) Panchayat Raj: Local Democracy in Action.
- 41 [http://urbanindia.nic.in/mud-final-site/legislations/legis\\_pow\\_union.htm](http://urbanindia.nic.in/mud-final-site/legislations/legis_pow_union.htm), Legislations administered by the Ministry.
- 42 Shukla Abhay, 2003, *Right To Health Care: Moving From Idea To Reality*, Proceedings of the Seminar held at The Asian Social Forum, Hyderabad – 3 and 4 January, CEHAT.
- 43 Duggal Ravi, 2004, *Operationalising Right to Healthcare in India*, The ICFAI Journal of Healthcare Law, Vol 2 No.3, August.
- 44 The Box No.3 is a modified version of proposed minimum content of the fundamental right to health care available on pg no.45 in Shukla Abhay, 2003, *Right To Health Care: Moving From Idea To Reality*, Proceedings of the Seminar held at The Asian Social Forum, Hyderabad – 3 and 4 January, CEHAT. The author has adapted the contents from Audrey R. Chapman, *The Minimum Core Content of the Right to Health*.
- 45 Duggal Ravi,1993, For A New Health Policy: A Discussion Paper, CEHAT, Mumbai.
- 46 The Canada Health Act is a legislation, which mandates a well-defined package of healthcare for all irrespective of their capacity to pay.
- 47 Shukla Abhay, 2003, *The Right to Health Care :Moving from Idea to Reality*, Proceedings of the Seminar held at The Asian Social Forum, Hyderabad, Jan 3rd and 4th, CEHAT, Mumbai.
- 48 Ibid
- 49 Ibid
- 50 Ibid
- 51 National Human Rights Commission and Jan Swasthya Abhiyan, 2004, National Public Hearing on Right to Health Care, 16-17 December, New Delhi.
- 52 The XII th Schedule of the 74th Constitutional Amendment Act of India, defines 18 new tasks in the functional domain of the Urban Local Bodies.

## SELECTED LIST OF BOOKS, REPORTS AND ARTICLES

### Books & Reports

CEHAT, *Report of the National Workshop on Right to Health Care, September 5, 2003 and National Consultation on Health Care as Human Right, September 6, 2003*, January 2004, Pgs 2+21 [Rs. 10/-]

*The report consists of the proceeding of the workshop on right to health care and health care as human right. The workshop included a series of presentations, which provide the background to the issue of health care as a human right, and also looked at key elements of health care for most vulnerable groups, women, children, adivasis, displaced people, communities under conflict, people affected by HIV, etc.*

CEHAT, *Right to Health Care: Moving From Idea to Reality*, January 2004 Pgs. 4+119 [Rs. 60/-] [ISBN 81-89042-28-9]

*This report consists of the proceedings of the seminar held at the Asian Social Forum, Hyderabad. It contains presentation and background papers on access to quality of health care, which were presented at the seminar. The seminar emphasized that access to quality of health care is not only a human need, a right of citizenship and a public good, but it is also a pre-requisite to good health, which is essential to achieve and enjoy fruits of equitable development.*

JAN SWASTHYA ABHIYAN & CEHAT, *Handbook One for Documentation and Presentation of Evidence Concerning Denial of the Right to Health Care*, June 2004, pgs. 6+46+4 [Rs.25/-]

*This document is a collection of guidelines and protocols to document testimonies of denial of health care. Appended by questionnaires concerning sub-centres, PHCs and CHCs and formats to collate information emerging from various protocols.*

Schuftan, Claudio *Health and Human Rights Readers*, September 2003, Pgs.8+111 [Rs. 80/-] [ISBN 81-89042-17-3]

*This book is a compilation of fifty-two 'Readers in Human Rights', The Readers discuss a wide range of issues such as Human Rights based planning; the role of the state, UN and civil society; Health sector reform and the unmet needs of the poor; Health Care Financing; vulnerability, access and discrimination; the role of NGOs; globalisation, health rights and health sector reform; the right to adequate nutrition; the difference between project and process; and health rights and the law. The information would be useful to health activists, health professionals and health sector NGO workers who seek a clearer grasp of health rights and a stimulating guide to action.*

### Articles & Papers

CEHAT, *Human Rights Violence and Health*, (CEHAT's Work on Human Rights and Health Care 1991-98), October 1998, Pgs.18

Duggal, Ravi *Health Care as Human Right*, Radical Journal of Health, Vol. III, No. 3 (New Series), July-September 1998, Pgs. 141-142.

Joga Rao S V, *Fundamental Right to Health and Health Care* in Review of Health Care in India, Published by CEHAT, 2005, pgs 279-294.

Pitre, Amita *Health Rights Experiments*, Health Action, Vol. 14, No. 5, May 2001, Pgs. 11-14

Khot, Anagha and Menon, Sumita *Monitoring Right to Health in India*, Paper presented at the Annual meet of the International Federation of Health and Human Right Organisation, Netherlands, May 27, 2002, Pgs. 12.

Khot, Anagha and Menon, Sumita *Monitoring Right to Health in India*, Paper presented at the Annual meet of the International Federation of Health and Human Right organisation, Netherlands, May 27, 2002, Pgs. 12

Mahabal, Kamayani Bali *Health and Human Rights are Inextricably Intertwined*, Vol. 4, No.21, December 1-15, 2003, Pgs. 15,17

Mahabal, Kamayani Bali *Right to Health Behind Bars*, Express Healthcare Management, Vol.5, No.4, March 1-15, 2004, Pgs. 14

Mistry, Mani *Health Rights of the Urban Poor*, Paper Presented at the Medico Friend Circle Annual Meet on Resurgence of Infectious Diseases and the Indian Society, Wardha, January 1-3, 1998, Pgs.7

Phadke, Anant *Doctors do not have the Right to Refuse treatment to HIV-Positive Patients*, Issues in Medical Ethics, Vol. XI, No. 3, July-September 2003, Pgs. 77-78

Phadke, Anant *Right to Health Care: Towards an Agenda*, Economic and Political Weekly, Vol. 38, No.41, October 11-17, 2003, Pgs. 4308-4309

Pitre, Amita *Health Rights Experiments*, Health Action, Vol. 14, No. 5, May 2001, Pgs. 11-14

Prakash, Padma; George, Annie and Rupande, Panalal *Sexism in Medicine and Women's Rights*, The Indian Journal of Social Work, Focus Issue, Patients' Rights, Vol. LIV, No. 2, April 1993, Pgs.199-204

Shukla, Abhay *Creating a Consensus on the Right to Health Care*, Paper presented at National Meeting on Right to Health Care, Mumbai, February 14, 2002, Pgs. 6.

Shukla, Abhay *Creating a Consensus on the Right to Health Care* Paper presented at National Meeting on Right to Health Care, Mumbai, February 14, 2002, Pgs. 6

Shukla, Abhay *Right to Health Care*, Health Action, Vol. 14, No. 5, May 2001, Pgs. 6-10

Shukla, Abhay *The Right to Health Care: Moving from idea to reality*, Asian Social Forum, Hyderabad, January 2003, Pgs. 11

Shukla, Abhay and Pitre, Amita *The Right to Health Care*, Advocacy Internet, Volume 3, Issue 05, September - October 2001, Pgs. 5-8

These publications are available at CEHAT, for further details contact Publication Unit, CEHAT.

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### **About CEHAT**

CEHAT, in Hindi means "Health". CEHAT is the research centre of Anusandhan Trust and is actively involved in research, action, service and advocacy on health and allied themes. Our projects are focused on four themes, (1) Health Services and Financing (2) Health Legislation, Ethics and Patients' Rights (3) Women's Health and (4) Investigation and Treatment of Psycho-Social Trauma. We have a multi disciplinary team with experience in Medicine, Social Sciences, Social Work, Journalism and Law, which undertakes research and advocacy for betterment of disadvantaged masses of our society, for strengthening people's health movements and strives towards realising right to health and health care.

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### **IFHHRO Annual Conference 2005 Engendering Health and Human Rights**

The Annual Conference of IFHHRO is being held in Mumbai, on 30<sup>th</sup> September and 1<sup>st</sup> October 2005. The theme is Engendering Health and Human Rights which covers all aspects related to women's discrimination and gender based violations. There will be one plenary on following themes on each day and a number of parallel sessions on sub-themes.

#### **Theme 1 : Gender Based Violence And Discrimination**

Sub-themes:

1. Women's health and human rights concerns in situations of war and conflict, including ethnic, communal, race and caste dimensions
2. Domestic violence as an issue of violation of health and human rights
3. Dealing with sexual assault and harassment for protection of rights of victims and survivors
4. Misuse of technology and gender discrimination
5. Rights violations of reproductive technologies
6. Discrimination in access to healthcare, especially reproductive health

#### **Theme 2 : Addressing the Missing Links of Gender Equity in Health and Human Rights**

Sub-themes:

7. Good practices and strategies for engendering health and human rights
8. Monitoring gender concerns in rights violations
9. Data and evidence on gender inequities in the human rights context

#### **Special Session for Training Institutes**

1. CEDAW and human rights
2. Orientation on gender equity concerns in health and human rights
3. Orientation in sexual assault evidence recording for better protection of rights of victims/survivors

The response of health professionals and their perceptions, attitudes, practices etc. will be an integral part of this discourse.

The last date of registration for the conference is 30<sup>th</sup> July 2005.

**For details refer to the CEHAT website: [www.cehat.org](http://www.cehat.org)**