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Review Article

Is India ready for fundamental right to health?

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ABSTRACT

The right to health, a vital indicator of human development and thus, the economic and social development, has been an age-old phenomenon in India. Although, no explicit recognition to the right to health or healthcare has been given under the Indian constitution, the hon'ble supreme court, through various judicial interpretations, has repeatedly observed that right to health is a part of fundamental right to life and personal liberty enshrined under article 21. However, the fundamental policy question being raised in recent years is whether to guarantee health as a separate fundamental right in India. The issues for consideration are multifarious, the most important being- whether we have reached the level of economic and health systems development so as to make this a justiciable right-implying that its denial is an offense.

Keywords: Right to health, Fundamental right to health, Right to health in India

INTRODUCTION

The right to the highest attainable standard of health (referred to as the "right to health") was first depicted in 1946 in the constitution of the world health organization, and has been subsequently incorporated into various global agreements and proclamations. The most authoritative elucidation of this right can be found in article 12 of the international covenant on economic, social and cultural rights (ICESCR). This covenant has garnered ratification from 9 out of the 11 SEAR member states, including India.[1] To understand it better, the core components of "right to health" as per the aforesaid Article 12 consist of 3 As' (availability, accessibility and acceptability) along with quality.

Here, availability refers to the need for a sufficient number of functioning public health care facilities, goods and services, as well as programmes for all. Accessibility requires the health facilities, goods and services to be accessible to everyone without discrimination, and this includes physical and information accessibility, as well as economical accessibility i.e. affordability. The third A-acceptability relates to respect for medical ethics, being culturally appropriate, and sensitive to gender.[2]

The available, accessible, and acceptable facilities, goods, and services must then be scientifically and medically approved and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.[3]

Thus, discernably, right to health is an 'inclusive right' that covers a wide canvas, encompassing issues of preventive, promotive, curative, rehabilitative and

palliative healthcare across rural and urban areas, infrastructure availability, health human resource availability, as also issues extending beyond health sector into the domains of socioeconomic and other determinants of health like poverty, equity, literacy, sanitation, nutrition, drinking water availability, etc.

LITERATURE REVIEW

The right to this vital indicator of human development and thus, the economic and social development has been an age-old phenomenon in India. It may be traced back to the common law principles under the law of torts. Independent India has approached the public as the right holder and the state as the duty-bound primary provider of health for all. Although, no explicit recognition to the right to health or healthcare has been given under the Indian constitution, the role of hon'ble supreme court in protecting the health of the public at large has been noteworthy. The supreme court, through various judicial interpretations has repeatedly observed that right to health is a part of fundamental right to life and personal liberty enshrined under article 21.[4-6] Moreover, there are multiple references in the constitution to public health and on the role of the states in providing healthcare to citizens. The directive principles of state policy (DPSP), enshrined in chapter IV of the constitution of India, require the state, among other duties, to protect their health and strength from abuse[7] ensure just and humane conditions of work and maternity relief and raise nutrition levels, improve the standard of living and consider improvement of public health as its primary duty.[8,9] Additionally, article 51 A (g) under part IV-A of the constitution states that "it shall be the duties of every individual to protect and improve the natural environment including forests, lakes, rivers and wild life, and to have compassion for living creatures." Accordingly, the hon'ble supreme court held that environmental, ecological, air and water pollution, etc., should be regarded as amounting to violation of right to health guaranteed by article 21 of the constitution.[10]

However, the fundamental policy question being raised in recent years is whether to guarantee health as a fundamental right in India. The aspects under scrutiny are diverse, with the primary concern being whether the nation has attained a sufficient degree of economic and healthcare infrastructure advancement to deem this right legally enforceable, thereby implying that withholding it would constitute a punishable act. The prerequisites for a formal guarantee of health as a right can also be found in national health policy (NHP), 2017.

Tracing back to the core components of right to health, it would be pertinent to say that, India has built up a vast health infrastructure and initiated several national health programmes towards achievement of universal health coverage over last five decades in government, voluntary and private sectors under the guidance and direction of various committees (Bhore, Mudaliar, Kartar Singh and Srivastava), the constitution, the planning commission, the central council of health and family welfare, and consultative committees attached to the ministry of health and family welfare (MoHFW).

MoHFW has undertaken several initiatives towards promoting universal healthcare with NHM being the flagship programme of the government. NHM was launched in the year 2013 subsuming national rural health mission and national urban health mission and it envisages achievement of universal access to equitable, affordable and quality health care services that are accountable and responsive to people's needs.

The core values of NHM include safeguarding the health of the poor, vulnerable and disadvantaged section of the society and aims at ensuring increased access and utilization of quality health services to minimize disparity on account of gender, poverty, caste, other forms of social exclusion and geographical barriers.[11]

Furthermore, NHP, 2017 envisages as its goal the attainment of the highest possible level of health and wellbeing for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. Key principles of NHP include, inter alia, equity, and providing gender sensitive, effective, safe and convenient healthcare services.[12]

For attainment of the aforementioned principles and objectives, an additional budget of 30% has been allocated towards high focus districts, aspirational district and tribal areas under NHM programme.

In the last few years, these efforts have been further strengthened through initiatives such as free medicine services, free diagnostics services, free dialysis services, etc. As per national health accounts estimates, the out-of-pocket expenses have also reduced from 58.7% in 2016-17 to 47.1% in 2019-20.

Such initiatives clearly indicate that India is moving in the right direction for ensuring 'health for all.'

In addition to the above, NHP also envisages health system strengthening including health infrastructure and human resource which must be ensured as per norms of Indian public health standards.

Nonetheless, 'health' being a state subject, states have been imparted with the flexibility to strengthen their infrastructural system based on their local needs and context. States are free to propose financial support under NHM for such regulatory items which are mandated while building infrastructure. Financial support for the same is also provided under various centrally sponsored schemes i.e. PM Ayushman Bharat health infrastructure mission (PM ABHIM) and FC-XV health grants also

provide support for strengthening grass root public health institutions and public health governance capacities.

The other pillars of Ayushman Bharat (AB) include AB-HWC and PM-JAY. The HWC component provides comprehensive primary health care (CPHC) to all citizens while the PM-JAY component aims at providing a health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalization to over 10.74 crores poor and vulnerable families (approximately 50 crore beneficiaries).

Not only this, government of India, recognizing the need to introduce a uniform system for maintenance of electronic health records, launched a flagship digital initiative-Ayushman Bharat digital mission. The said mission aims to develop the backbone necessary to support the integrated digital health infrastructure of the country.

Many states have already taken steps in establishing grievance redressal systems viz, help desks, suggestion boxes, mobile based feedbacks etc. Additionally, 'mera aspatal' also provides a feedback mechanism and is integral to Kayakalp incentive to the facilities.

To address the issue of gender bias and to empower women further, various initiatives have been taken under NHM some of which include, janani suraksha yojana (JSY), janani shishu suraksha karyakram, Pradhan Mantri surakshit matritva abhiyan-PMSMA, SUMAN, one stop centres (OSC), etc. Recent amendments to the medical termination of pregnancy (MTP) act, 2021 has further empowered women by providing comprehensive abortion care to all.

Although, from an analysis of the above, article 12 of ICESCR seems manifested. However, the concern remains the same-whether these developments have actually reached the ground level-considering the spectrum of contrasting landscapes that India offers.

To assess the status of knowledge regarding school health services among schoolteachers, a cross sectional study conducted in a northern Indian state revealed that they were lacking the rudimentary knowledge regarding environment and sanitation; communicable and noncommunicable diseases; and health education for school children.[13] And thus comes the lack of accessibility to information which despite government's efforts, needs further strengthening.

With regards to physical accessibility, the question "What is the level of access of our population to healthcare of good quality?" is an extremely relevant one. As per rural health statistics (RHS) 2021-22, there is a shortfall of 25% in the health facilities at subcentre, 31% at PHCs and 36% at CHCs.[14] Though striving hard, this gap still needs to be bridged. Moving in this direction, the Indian government has made some key policy shifts like from normative to targeted approach to reach underserved areas with "time to care approach" for infrastructure and human resource development.[15] The aim is to strengthen the delivery of CPHC, through establishment of "health and wellness centres", with the principle of "time to care" to be no more than 30 minutes.

Now even if a healthcare facility is physically accessible, what is the quality of care that it offers? Is that care continuously available? While the NHM has done much to improve the infrastructure in the government healthcare system, data from the several field visits conducted under NHM reveal that many of the primary health centers (PHCs) in India still lack basic infrastructural facilities such as beds, wards, toilets, drinking water facility, clean labor rooms for delivery, and regular electricity. Fathoming the need, GoI is supporting ramping up of health infrastructure in rural, peri-urban/small towns and tribal areas through additional resources under ECRP II, FC XV and PM-ABHIM.[16]

But what about the human workforce? Do we possess a sufficient quantity of personnel, are they adequately trained, is their distribution fair, and do they exhibit reasonably elevated levels of motivation when it comes to delivering the service? According to the RHS (2021-22), about 13.8% of the sanctioned posts of auxiliary nurse midwives are vacant, which rises to 40.1% of the posts of male health workers at sub centres. 23.8% of doctor posts and 23.7% of staff nurses (almost a quarter of sanctioned posts) at rural PHCs are vacant.[17] To address this, the public health management cadre has been introduced, which not only aims to strengthen management of both, health, and hospital services in public health sector but also strive to add more dedicated and professionally trained personnel to address the specific and complex needs of the Indian healthcare delivery system and strengthening capacities for managerial functions.

But as Matshona Dhliwayo said: *"Roses do not bloom hurriedly; for beauty, like any masterpiece, takes time to blossom."*

Thus, before proceeding towards the road to health as a fundamental right and obligations therewith, we need to halt and ponder upon all of this analytically and judiciously-'With this ground level analysis, are we in a position to penalize the medical servants for any lapse in offering health care? Aren't they themselves struggling to offer the best services in the best possible manner with the available resources.'

Furthermore, other factors to be borne in mind while assessing the need for a separate legislation to provide for such rights, include the already existing legislative framework on health and it's components offered by various other statutes such as the constitution of India (Article 14, 15, 21, 42 and 47 etc.); Indian contract act, 1872 (for relationship between a medical professional and his patient); drugs and cosmetic act rules, 2016 (for

informed consent); section 134 of the motor vehicles act, 1988, section 12 of clinical establishments (Registration and regulation) act, 2010, and section 357C of the code of criminal procedure, 1973 (for emergency medical aid); Indian medical council (professional conduct, etiquette and ethics) regulations 2002 (for ethical conduct, confidentially, emergency treatment); the consumer protection act 1986, charter of patients' rights, etc.

SCENARIO IN DEVELOPED COUNTRIES

In the United Kingdom, the entitlement to health isn't formally acknowledged as a legally protected right. Nevertheless, human rights are upheld under the law, binding all public authorities, including the NHS. Despite this, NHS hospitals grapple with the challenge of reducing extensive waiting lists. Recent statistics from January 2023 reveal that approximately 7.21 million individuals await treatment, with 3 million of them waiting for over 18 weeks, and a subset of 379,245 patients enduring wait times exceeding a year for treatment.[18-20]

France has instituted a government-financed healthcare system in the form of national health insurance. Although not all medical expenses are covered, France consistently garners high rankings for its effective provision of healthcare services to the populace.

Japan, recognized as one of the world's most advanced nations, mandates health insurance coverage for all residents.

USA, Mexico, South Korea, Turkey, in these countries, the actual realization of the right to health remains elusive. These nations rely on health insurance systems rather than comprehensive healthcare provisions. Despite these countries advocating for human rights on a global scale, the right to health hasn't been entrenched as a fundamental human entitlement within their borders. Despite having adequate medical and health facilities, these services lack government funding.[2]

CONCLUSION

To conclude, rather than getting carried away by the symbolism of making health a distinct right, the real focus of public concern and debate ought to be the mode of delivery. In other words, will health being a discrete fundamental right under the Constitution or by means of a whole new legislation, really make a difference? For reasons discussed above and many others, in any case India is on the road to achieve universal healthcare. It can be said that guaranteeing health as a justiciable right would satisfy the welfarist or rather activist concern, but in practicality, the concern will not be satisfied by a piece of legislation or else all the developed nations would have already stepped into those shoes. Thus, before we decide to guarantee the fundamental humanitarian principle of health as a constitutional right to the world's most populous country, 3As plus Q needs to be ensured in an utterly smooth manner at grass root level that is the population.

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