Are human rights and health care universal ?

fashionable question, "how can we live right and sustainably". Some writers say that, "Bioethics is not about thinking that we can always find *one correct solution* to ethical problems." I beg to differ and believe that there is actually only one answer to each of those questions and each answer is unique and intrinsic to each culture and that has to be respected.

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Are Human Rights and Health Care Universal?: Reflections on Health Care in India*?*

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Introduction

Human rights and the right to health care have explicit intrinsic connections and have emerged as powerful concepts with regard to human dignity and fullness of life. A rights-based approach to health uses International Human Rights treaties and proposes norms to hold governments accountable for their obligations. It recognizes the fact that the right to health is a fundamental right of every human being and it implies the enjoyment of the highest attainable standard of health that governments have the bounden responsibility for the health of the citizens which can be fulfilled only through the provision of adequate health care and social concern. The same should get integrated into research, advocacy strategies and research tools, including monitoring; community education and mobilization; litigation and policy formulation. The right to the highest attainable standard is encapsulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights.

The enjoyment of the highest standard, in any given milieu is one of the fundamental human rights without distinction of race, religion, political belief or social condition. Article 25 of the Universal Declaration of Human Rights is concerned with the right to health. According to this article, everyone has the right to a standard of living with reasonable health of oneself, including food, clothing, housing, medical care as necessary to ensure fullness of life. The preamble of the World Health Organization states that the enjoyment of the highest standard of health is a fundamental right of every human being. Aristotelian philosophy is based on the principle that it is society's obligation to maintain and improve people's health. Therefore, public health should focus on the individual's capacity to function, and health policy should aim to maintain and improve this capacity by meeting health needs. The relationship between health and economic development is two- directional. Health affects labor productivity as well as investments in physical and human capital and savings rates. In the other direction, income can affect health and demography by improving the ability to obtain food,

sanitation and housing and by providing incentives to reduce the family size.

As we are in the later part of the first decade of 21st Century, the awareness on health care has increased enormously and everyone wants to lead a healthy life. National Governments and State Governments should be positive to provide medical care for all. But, do these facilities and benefits reach out or are they available to all the citizens of the country? What are the existing draw backs and problems? How to overcome such problems to universalize the health care to all irrespective of their economical and social status? These would be discussed in the paper.

Paradigm shift: Policy to human rights approach

Our past experience over a period of more than sixty years has not given any comprehensive and universal access approach by developing selective schemes or programs. Hence, our historical experience tells us that we should abandon the policy approach and adopt the human rights route to assuring universal access to all people for healthcare. The State is today talking of health sector reform and hence it is the right time to switch gears and move in the direction of right to health and healthcare.

The right to healthcare is primarily a claim to an entitlement, a positive right, not a protective fence. As entitlements rights are contrasted with privileges, group ideals, societal obligations, or acts of charity, and once legislated they become claims justified by the laws of the state (Chapman, 1993). The emphasis thus needs to shift from 'respect' and 'protect' to focus more on 'fulfill'. For the right to be effective optimal resources that are needed to fulfill the core obligations have to be made available and utilized effectively.

Further, using a human rights approach also implies that the entitlement is universal. This means there is no exclusion from the provisions made to assure healthcare on any grounds whether purchasing power, employment status, residence, religion, caste, gender, disability, and any other basis of discrimination. But this does not discount the special needs of disadvantaged and vulnerable groups who may need special entitlements through affirmative action to rectify historical or other inequities suffered by them.

Thus establishing universal healthcare through the human rights route is the best way to fulfill the obligations mandated by international law and domestic constitutional provisions. International law, specifically ICESCR, the Alma Ata Declaration, among others, provide the basis for the core content of right to health and healthcare. But country situations are very different and hence there should not be a global core content, it needs to be country specific. In India's case a certain trajectory has been followed through the policy route and we have an existing baggage, which we need to sort out and fit into the new strategy.

Present scenario

Specific features of this historical development can be depicted as follows:

- A very large and unregulated private health sector with an attitude that the existing policy is the best one as it gives space for maximizing their interests needs to be checked. A complete absence of professional ethics and absolute disinterest in organizing around issues of self-regulation, improvement of quality and accountability, and need for an organised health care system needs to be addressed.
- A declining public health care system which provides selective care through a multiplicity of schemes and programs, and discriminates on the basis of residence (rural-urban) in providing for entitlements for healthcare should be looked into.
- The existing inequities in access to healthcare based on employment status and purchasing power should be reviewed.
- Inadequate development of various pre-conditions of health such as water supply and sanitation, environmental health and hygiene and access to food should be taken care of.
- Very large numbers of unqualified and untrained practitioners should be checked.
- Declining investments and expenditure in public health needs special care.
- Adequate resource availability when we account for out-of-pocket expenses needs attention.
- Human power and infrastructure that are reasonably adequate, though inequitably distributed, are the needs of the hour.
- Wasteful expenditures due to lack of regulation and standard protocols for treatment should be avoided.

Thus the operationalisation of the right to healthcare will have to be developed keeping in mind what we have and how we need to change it.

Right to Quality Healthcare:

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

The quote used as the Preamble is very relevant to the notion of right to healthcare. Sigerist said this long ago and since then most of Europe and many other countries have made this a reality. And today when such demands are raised in the developing countries, India being one of them, it is said that this is no longer possible - the welfare state must wither away and make way for global capital! Europe is also facing pressures to retract the socialist measures, with working class struggles had gained since 19th century. So we are in a hostile era of global capital which wants to make profit out of anything it can lay its hands on. But we are also in an era when social and economic rights, apart from the civil and political rights, are increasingly on the international agenda and an important cause for advocacy.

Thus health and health care are now being viewed very much within the rights perspective and this is reflected in Article 12 *"The right to the highest attainable standard of health"* of the International Covenant on Economic, Social and Cultural Rights to which India has acceded. According to the General Comment 14 the Committee for Economic, Social and Cultural Rights states that the right to health requires

availability, *accessibility*, *acceptability*, and *quality* with regard to both health care and underlying preconditions of health. The Committee interprets the right to health, as defined in article 12.1, 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 sexual and reproductive health.

Understanding of health and health care

The understanding of health and health care are spelt out below:

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

(a) *Availability:* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) *Accessibility:* Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

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

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

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

(d) *Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. (Committee on Economic, Social and Cultural Rights Twenty-second session 25 April-12 May 2000)

Universal access to good quality healthcare equitably is the key element at the core of this understanding of right to health and healthcare. To make this possible the State agencies are obligated to *respect, protect and fulfill* the above in a progressive manner:

The right to health, like all human rights, imposes three types or levels of obligations on State parties: the obligations to *respect*, *protect* and *fulfill*. In turn, the obligation to fulfill contains obligations to facilitate, provide and promote. The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to *fulfill* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. (Ibid)

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

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

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

The Committee also confirms that the following are obligations of comparable priority:
(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
(b) To provide immunization against the major infectious diseases occurring in the community;
(c) To take measures to prevent, treat and control epidemic and endemic diseases;
(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
(e) To provide appropriate training for health personnel, including education on health and human rights. (Ibid)

The above guidelines from General Comment 14 on Article 12 of ICESCR are critical to the development of the framework for right to health and healthcare. As a reminder it is important to emphasize that in the Bhore Committee report of 1946 we already had these guidelines, though they were not in the 'rights' language. Thus within the country's own policy framework all this has been available as guiding principles for now 56 years.

The growth over the years of healthcare services, facilities, human power etc. has been inadequate and the achievements not enough to make any substantive impact on the health of the people. The focus of public investment in the health sector has been on medical education and production of doctors for the private sector, support to the pharmaceutical industry through states own participation in production of bulk drugs at subsidized rates, curative care for urban population and family planning services. The poor health impact we see today has clear linkages with such a pattern of investment:

- The investment in medical education has helped create a mammoth private health sector, not only within India, but in many developed countries through export of over one-fourth of the doctors produced over the years. Even though since mid-eighties private medical colleges have been allowed, still 75-80% of the outturn is from public medical schools. This continued subsidy without any social return is only adding to the burden of inequities and exploitation within the healthcare system in India.
- Public sector participation in drug production was a laudable effort but soon it was realized that the focus was on capital goods, that is bulk drug production, and most supplies were directed to private formulation units at subsidized rates. It is true that the government did control drug prices, but post mid-seventies the leash on drug prices was gradually released and by the turn of the nineties controls disappeared. Ironically, at the same time the public pharmaceutical industry has also disappeared – the little of what remains produces a value of drugs lesser than their losses! And with this withering away of public drug production and price control, essential drugs availability has dropped drastically. Another irony in this story is that while today we export 45% of our drug production, we have to import a substantial amount of our essential drug requirements.
- Most public sector hospitals are located in urban areas. In the eighties, post-Alma Ata and India ratifying the ICESCR, efforts were made towards increasing hospitals in rural areas through the Community Health Centres. This was again a good effort but these hospitals are understaffed by over 50% as far as doctors are concerned and hence become ineffective. Today urban areas do have adequate number of beds (including private) at a ratio of one bed per 300 persons but rural areas have 8 times less hospital beds as per required norms (assuming a norm of one bed per 500 persons). So there is gross discrimination based on residence in the way the hospital infrastructure has developed in the country, thereby depriving the rural population access to curative care services. Further, the declining investment in the public health sector since mid-eighties, and the consequent expansion of the private health sector, has further increased inequity in access for people across the country. More recently a facility survey across the country by the Ministry of Health and Family Welfare clearly highlights the inadequacies of the public health infrastructure, especially in the rural areas. This survey is a major indictment of the underdevelopment of the public healthcare system - even the District Hospitals, which are otherwise well endowed, have a major problem with adequacy of critical supplies needed to run the hospital. The rural health facilities across the board are ill provided. (MOHFW, 2001)
- Family planning services is another area of almost monopolistic public sector involvement. The investment in such services over the years has been very high, to the tune of over 15% of the total public health budget. But over and above this the use of the entire health infrastructure and other government machinery for fulfilling its goals must also be added to these resources expended. This program has also witnessed a lot of coercion and grossly violated human rights. The hard line adopted by the public health system, especially in rural areas, for pushing population control has terribly discredited the public health system and affected adversely utilization of other health programs. The only silver lining within this program is that in the nineties immunisation of children and

mothers saw a rapid growth, though as yet it is still quite distant from the universal coverage level.

Then there are the underlying conditions of health and access to factors that determine this, which are equally important in a rights perspective. Given the high level of poverty and even a lesser level of public sector participation in most of these factors the question of respecting, protecting and fulfilling by the state is quite remote. Latest data from NFHS-1998 tells the following story:

- Piped water is available to only 25% of the rural population and 75% of urban population.
- Half the urban population and three-fourths of the rural population does not purify/filter the water in any way.
- 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.
- As regards housing 41% village houses are *kachha* whereas only 9% of urban houses are so.
- 21% of the population chews *paan masaala* and/or tobacco*,* 16% smoke and 10% consume alcohol.

Besides this, environmental health conditions in both rural and urban areas are quite poor, working conditions in most work situations, including many organized sector units, which are governed by various social security provisions, are unhealthy and unsafe. In fact most of the court cases in India using Article 21 of the Fundamental Rights and relating it to right to health have been cases dealing with working conditions at the workplace, workers rights to healthcare and environmental health related to pollution.

Other concerns are related to the question of economic accessibility. It is astounding that large-scale poverty and predominance of private sector in healthcare have to co-exist. It is in a sense a contradiction and reflects the State's failure to respect, protect and fulfill its obligations by letting vast inequities in access to healthcare and vast disparities in health indicators, to continue to persist, and in many situations get worse. Data shows that out of pocket expenses account for over 4% of the GDP as against only 0.9 % of GDP expended by state agencies, and the poorer classes contribute a disproportionately higher amount of their incomes to access health care services both in the private sector and public sector. (Ellis et al, 2000; Duggal, 2000; Peters et al, 2002). Further, the better off classes use public hospitals in much larger numbers with their hospitalization rate being six times higher than the poorest classes, and as a consequence consume an estimated over three times more of public hospital resources than the poor (NSS-1996; Peters et al, 2002).

Related to the above is another concern vis-à-vis international human rights conventions' stance on matters with regard to provision of services. All conventions talk about *affordability* and never mention 'free of charge'. In the context of poverty this notion is questionable as far as provisions for social security like health, education and housing go. Access to these factors socially has unequivocal consequences for equity, even in the absence of income equity. Free services are viewed negatively in global debate, especially since we have had a unipolar world, because it is deemed to be disrespect to individual responsibility with regard to their healthcare. (Toebes, 1998, p.249) For instance in India there is great pressure on public health systems to introduce or enhance user fees, especially from international donors, because they believe this will enhance responsibility of the public health system and make it more efficient (Peters et al, 2002). In many states such a policy has been adopted in India and immediately adverse impacts are seen, the most prominent being decline in utilization of public services by the poorest. It must be kept in mind that India's taxation policy favours the richer classes. Our tax base is largely indirect taxes, which is a regressive form of generating revenues. Direct tax revenues, like income tax is a very small proportion of total tax revenues. Hence the poor end up paying a larger proportion of their income as tax in the form of sales tax, excise duties etc on goods and services they consume. Viewed from this perspective the poor have already pre-paid for receiving public goods like health and education from the state free of cost at the point of provision. So their burden of inequity increases substantially if they have to pay for such services when accessing from the public domain.

The above inequity in access gets reflected in health outcomes, which reflect strong class gradients. Thus infant and child mortality, malnutrition amongst women and children, prevalence of communicable diseases like tuberculosis and malaria, attended childbirth are between 2 to 4 times better amongst the better off groups as compared to the poorest groups (NFHS-1998). In this quagmire of poverty, the gender disparities also exist but they are significantly smaller than the class inequities. Such disparity, and the consequent failure to protect by the state the health of its population, is a damning statement on the health situation of the country. In India there is an additional dimension to this inequity – differences in health outcomes and access by social groups, specifically the scheduled castes and scheduled tribes. Data shows that these two groups are worse off on all counts when compared to others. Thus in access to hospital care as per NSS-1996 data the STs had 12 times less access in rural areas and 27 times less in urban areas as compared to others; for SCs the disparity was 4 and 9 times, in rural and urban areas, respectively. What is astonishing is that the situation for these groups is worse in urban areas where overall physical access is reasonably good. Their health outcomes are adverse by 1.5 times that of others (NFHS-1998).

Another stumbling block in meeting state obligations is information access. While data on public health services, with all its limitations, is available, data on the private sector is conspicuous by its absence. The private sector, for instance does not meet its obligations to supply data on notifiable, mostly communicable,

diseases, which is mandated by law. This adversely affects the epidemiological database for those diseases and hence affects public health practice and monitoring drastically. Similarly the local authorities have miserably failed to register and record private health institutions and practitioners. This is an extremely important concern because all the data quoted about the private sector is an under-estimate as occasional studies have shown. The situation with regard to practitioners is equally bad. The medical councils of all systems of medicine are statutory bodies but their performance leaves much to be desired. The recording of their own members is not up to the mark, and worse still since they have been unable to regulate medical practice there are a large number of unqualified and untrained persons practicing medicine across the length and breadth of the country. Estimates of this unqualified group vary from 50% to 100% of the proportion of the qualified practitioners (Duggal, 2000; Rhode et al, 1994). The profession itself is least concerned about the importance of such information and hence does not make any significant efforts to address this issue. This poverty of information is definitely a rights issue even within the current constitutional context as lack of such information could jeopardize right to life.

Finally there are issues pertaining to acceptability and quality. Here the Indian state fails totally. There is a clear rural-urban dichotomy in health policy and provision of care; urban areas have been provided comprehensive healthcare services through public hospitals and dispensaries and now even a strengthened preventive input through health posts for those residing in slums. In contrast rural areas have largely been provided preventive and promotive healthcare alone. This violates the principle of non-discrimination and equity and hence is a major ethical concern to be addressed.

Medical practice, especially private, suffers from a complete absence of ethics. The medical associations have as yet not paid heed to this issue at all and over the years malpractices within medical practice have gone from bad to worse. In this malpractice game the pharmaceutical industry is a major contributor as it induces doctors and hospitals to prescribe irrational and/or unnecessary drugs. All this has drastic impacts on quality of care. In clinical practice and hospital care in India there exist no standard protocols and hence monitoring quality becomes very difficult. For hospitals the Bureau of Indian Standards have developed guidelines, and often public hospitals do follow these guidelines (BIS, 1989; Nandraj and Duggal, 1997). But in the case of private hospitals they are generally ignored. Recently efforts at developing accreditation systems has been started in Mumbai (Nandraj et al, 2000), and on the basis of that the Central government is considering doing something at the national level on this front so that it can promote quality of care.

First Steps Towards a Right to Healthcare:

To establish a right to healthcare with the above scenario certain first essential steps will be compulsory:

- equating directive principles with fundamental rights through a constitutional amendment;
- incorporating a National Health Act (similar to the Canada Health Act) which will organize the present healthcare system under a common umbrella organization as a public-private mix governed by an autonomous national health authority which will also be responsible for bringing together all resources under a single-payer mechanism;
- generating a political commitment through consensus building on right to healthcare in civil society;
- development of a strategy for pooling all financial resources deployed in the health sector; and
- redistribution of existing health resources, public and private, on the basis of standard norms (these would have to be specified) to assure physical (location) equity

As an immediate step, within its own domain, the State should undertake to accomplish the following:

- Allocation of health budgets as block funding, that is on a per capita basis for each population unit of entitlement as per existing norms. This will create redistribution of current expenditures and reduce substantially inequities based on residence. Local governments should be given the autonomy to use these resources as per local needs but within a broadly defined policy framework of public health goals.
- Strictly implementing the policy of compulsory public service by medical graduates from public medical schools, as also make public service of a limited duration mandatory before seeking admission for post-graduate education. This will increase human resources with the public health system substantially and will have a dramatic impact on the improvement of the credibility of public health services.
- Essential drugs as per the WHO list should be brought back under price control (90% of them are off-patent) and/or volumes needed for domestic consumption must be compulsorily produced so that availability of such drugs is assured at affordable prices and within the public health system.
- Local governments must adopt location policies for setting up of hospitals and clinics as per standard acceptable ratios, for instance one hospital bed per 500 population and one general practitioner per 1000 persons. To restrict unnecessary concentration of such resources in areas fiscal measures to discourage such concentration should be instituted.
- The medical councils must be made accountable to assure that only licensed doctors are practicing what they are trained for. Such monitoring is the core responsibility of the council by law which they are not fulfilling, and as a consequence failing to protect the patients who seek care from unqualified and untrained doctors. Further continuing medical education must be implemented strictly by the various medical councils and licenses should not be renewed (as per existing law) if the required hours and certification is not accomplished.
- Integrate ESIS, CGHS and other such employee based health schemes with the general public health system so that discrimination based on employment status is removed and such integration will help more efficient use of resources. For instance, ESIS is a cash rich organization sitting on funds collected from employees (which are parked in debentures and

shares of companies!), and their hospitals and dispensaries are grossly under-utilised. The latter could be made open to the general public.

- Strictly regulate the private health sector as per existing laws, but also an effort to make changes in these laws to make them more effective. This will contribute towards improvement of quality of care in the private sector as well as create some accountability.
- Strengthen the health information system and database to facilitate better planning as well as audit and accountability.

Carrying out the above immediate steps, for which we need only political commitment and not any radical transformation, will create the basis to move in the direction of first essential steps indicated above. In order to implement the first-steps the essential core contents of healthcare have to be defined and made legally binding through the processes of the first-steps. The literature and debate on the core contents is quite vast and from that we will attempt to draw out the core content of right to health and healthcare keeping the Indian context discussed above in mind.

The Core Content of Right to Healthcare

In the words of Chapman: *"Operatively, a basic and adequate standard of healthcare is the minimum level of care, the core entitlement, that should be guaranteed to all members of society: it is the floor below which no one will fall"* (Chapman, 1993). She further states that the basic package should be fairly generous so that it is widely acceptable by people, it should address special needs of special and vulnerable population groups like under privileged sections (e.g. scheduled castes and tribes in India), women, physically and mentally challenged, elderly etc it should be based on cost-conscious standards but judge to provide services should not be determined by budgetary constraints, and it should be accountable to the community as also demand the latter's participation and involvement in monitoring and supporting it. All this is very familiar terrain, with the Bhore Committee saying precisely the same things way back in 1946.

We would like to put forth the **core content** as the Primary care services that should include at least the following:

- General practitioner/family physician services for personal health care.
- First level referral hospital care and basic specialty services (general medicine, general surgery, obstetrics and gynecology, 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 postnatal 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 fulfill obligations of underlying preconditions of health.

The above listed components of primary care are the minimum that must be assured, if a universal health care system has to be effective and acceptable. And these have to be within the context of first-steps and not to wait for progressive realisation – these cannot be broken up into stages, as they are the core minimum. The key to equity is the existence of a minimum decent level of provision, a floor that has to be firmly established. However, if this floor has to be stable certain ceilings will have to be maintained toughly, especially on urban health care budgets and hospital use (Abel-Smith, 1977). This is important because human needs and demands can be excessive and irrational. Those wanting services beyond the established floor levels will have to seek it outside the system and/or at their own cost.

Therefore 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. There has been some amount of debate on standards of personnel requirements [doctor: population ratio, doctor: nurse ratio] and of facility levels [bed: population ratio, PHC: population ratio] but no global standards have as yet been formulated though some ratios are popularly used, like one bed per 500 population, one doctor per 1000 persons, 3 nurses per doctor, health expenditure to the tune of 5% of GDP etc.

We are at a stage in history where political will to do something progressive is conspicuous by its absence. We may have constitutional commitments and backing of international law but without political will nothing will happen. To reach the goals of right to health and healthcare discussed above civil society will have to be involved in a very large way and in different ways.

The initiative to bring healthcare on the political agenda will have to be a multi-pronged one and fought on different levels. The idea here is not to develop a plan of action but to indicate the various steps and involvements that will be needed to build a consensus and struggle for right to healthcare. We make the following suggestions:

- Policy level advocacy for creation of an organized system for universal healthcare
- Research to develop the detailed framework of the organized system
- Lobbying with the medical profession to build support for universal healthcare and regulation of medical practice
- Filing a public interest litigation on right to healthcare to create a basis for constitutional amendment

- Lobbying with parliamentarians to demand justice be protected in directive principles
- Holding national and regional consultations on right to healthcare with involvement of a wide array of civil society groups
- Running campaigns on right to healthcare with networks of peoples organizations at the national and regional level
- Bringing right to healthcare on the agenda of political parties to incorporate it in their manifestoes
- Pressurizing international bodies like WHO, Committee of ESCR, UNCHR, as well as national bodies like NHRC, NCW to do effective monitoring of India's state obligations and demand accountability
- Preparing and circulating widely shadow reports on right to healthcare to create international pressure

The above is not an exhaustive list. The basic idea is that there should be widespread dialogue, awareness raising, research, documentation and legal/constitutional discourse. CEHAT has developed an action plan towards facilitating the realization of this agenda collaboratively with a range of civil society actors through a national initiative on right to health and healthcare in India.

Overview

It is evident that the neglect of the public health system is an issue larger than government policy making. The latter is the function of the overall political economy. Under capitalism only a well-developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy (which directly benefit capital accumulation) is more urgent (from the business perspective) than the social sectors, hence the latter get only a residual attention by the state. The policy route to comprehensive and universal healthcare has failed miserably. It is now time to change gears towards a rights-based approach. The opportunity exists in the form of constitutional provisions and discourse, international laws to which India is a party, and the potential of mobilizing civil society and creating a socio-political consensus on right to healthcare. USIBC President Ron Somers said: "Access to effective and affordable healthcare is essential to ensure India's remarkable growth," while announcing the initiative of the body representing over 250 of the largest US firms investing in India and about 25 of India's largest global companies.

Government is only part of the solution. We must harness the dynamism of the private sector for this effort to be successful. The goal is to make patient outcomes as good in India as they are in any other part of the world. India's healthcare system is quickly expanding, but faces considerable challenges – to be expected in a country rapidly transitioning into a global economic power. It must satisfy the rising demands and expectations of the burgeoning middle class, while addressing the needs of those not benefiting from economic development. Nevertheless, India has an opportunity to avoid the problems that healthcare systems in many developed countries are experiencing by transforming financing and delivery, redefining the accountabilities of stakeholders, and improving quality and access.

India has had notable health achievements since Independence in 1947. The country's population has increased from 361 milliion 1951 to 1.13 billion in 2007 (a 313 percent increase). Life expectancy has more than doubled (32 years to 68.6), infant mortality rate has decreased 76.3 percent (146 per 1000 babies to 34.6) and crude death rate has fallen 73.7 percent (25.1 per 1000 population to 6.6).

Other achievements include eradication of some diseases (small pox and guinea worm) and near elimination of others (for example, leprosy and polio).

India's doctors and hospitals are also increasingly receiving recognition for the quality of care they provide. Their services cost a fraction of those of their India's burgeoning middle class has greater access to excellent healthcare, but the vast majority of citizens have limited access to basic healthcare of varying quality. While government health services are by law free, patients must often pay for drugs out-of pocket to get sustained treatment. More than 40 percent of hospitalized patients borrow money or sell assets for medical care and 24 percent become impoverished due to medical crises.

An examination of healthcare systems in other countries underscores the importance of achieving a value-based, affordable, sustainable healthcare system in India. In a recent study by the IBM Institute for Business Value demonstrated that unrelenting pressures are pushing many healthcare systems along an unsustainable path. If left unaddressed, many countries will reach a breakpoint in their current paths, forcing immediate and major forced restructuring. What does this mean for India? Without significant changes, an unsustainable path for India could have public health, economic, social and political ramifications. For example, the healthcare infrastructure will remain fragmented, focused on acute, reactive, episodic care and will be inaccessible, particularly in rural areas. There is also the potential impact on premature morbidity/mortality due to unaffordable, inaccessible and inconsistent quality of healthcare. And the IBM Global Business Services insufficient healthcare delivery capacity would exacerbated, as providers are burdened by such issues as workforce shortages, costs of treating the uninsured and overcrowding. There are other ramifications of the *status quo*. Economically, continued depletion in the quality and quantity of general work force and lead to lower national output in national income. Between 2005 and 2015, for example, heart disease, stroke and diabetes are expected to account for Rs 1,040,800 crores (US$ 236 billion) in lost productivity. Socially, there would likely be a reduced transfer of skills and wealth across generations and continued developmental losses for children. Politically, India could fail to deliver healthcare as a fundamental public right for all citizens. Moreover, there would be a possible loss of global competitiveness as the country's health status is unable to effectively support its ambitious economic growth plans.

Conclusion

Everyone born in the world should live a full human life. To make this possible, a health care system and hygienic environment and effective livelihood need to be assured for all citizens. In the world today medical advancement is progressing very fast and the quality of life is on the increase, thereby making people live longer and longer. While the medical advancement in the industrialized countries is making progress the availability of medical facilities in many developing countries are abysmal. It is the responsibility of the State to provide with adequate health care especially for the children who are the future hope of the nation and the globe.

In the first place the people, especially those in the rural areas, should be given awareness with regard to health care especially preventive measures to be taken to avoid infection and diseases. Health cares should be not only accessible but affordable – The State should come to the rescue of the poor in providing effective health care system. Primary care centers should be given priority and in State run medical centers all facilities should be extended without any difficulty – Strict laws should be enforced against corruption in providing medical aids and negligence of duty in emergency.

The neighbourhood outreach programme could be introduced in educational institutions especially in medical institutions where the students spend considerable time with the poor, in the slums in cities and rural areas, teaching them hygiene and helping them have health care facilities. The medical students could be asked to spend a couple of years of their service in the rural areas.

Also traditional medicine, such as herbal, Ayurvedic, Sidha etc, could be encouraged by the State which could give effective medical facilities at much lower cost of care. The State should make it clear that the people are the wealth of the nation and health is the first concern as well as area of investment for any nation.

Do the Developing Countries with High Disease Burdens Need to Take a More Active Role in Defining Health and Disease?

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Do developing countries with high disease burden need to take a more active role in developing, or adhering to, a conceptualization of health and disease that is more relevant for them? This paper argues that there are number of reasons to make a rather compelling case to answer in the affirmative.

First, the facts. There can be no doubt that great health disparities still persist among the countries in the world. In spite of great advances in medical technology, medicine, and treatment, and high-spirited initiatives such as Alma Ata (1978), the disparities in health status remain stark between the populations of the developed countries and the developing countries in particular. To date, the poorer countries, as a matter of fact, see more of death, disease and disability.

The WHO fact sheets show that the developing countries in Africa and Asia bear a disproportionately high disease burden from an array of major fatal communicable and endemic diseases. For example, though incidences fell in certain countries, WHO reports that in 2008 Malaria is endemic in 109 countries and *preventable* deaths from Malaria is close to a million lives, with mostly that of children under 5, in Africa[32]. The 1.2 billion people who are at high risk from Malaria are mostly living in the developing nations of Africa (49%) and Southeast Asia (37%). Similarly, the WHO tuberculosis (TB) 2009 report[33] mentions twenty-two high-burden countries, covering 80% of world's TB cases, which almost without exception belong to the developing world. The report also mentions that the co-infection of HIV-TB and the drug-resistant variety of TB in some of these countries are matters of great concern, as one out of four TB deaths in 2007 was HIV-related. Since the burden of non-communicable diseases was found to be no less on the developing

[32] WHO. World Malaria Report 2008. Geneva: WHO. Available at: http://apps.who.int/malaria/wmr2008/ [Accessed on 29 May 2009].

[33] WHO. Key Points: Gobal TB Control 2009. Geneva: WHO. Available at: www.who.int/tb/publications/global_report/2009/key_points/