

# The Right to Health Care

## Moving from idea to reality

- Abhay Shukla, CEHAT

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*"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. Should it ever come to pass, Medicine, whatever it may then be, will become the common good of all."*

- Rudolf Virchow, c.1850

### Background: Inequity in health and access to health care

India is known to have poor health indicators in the global context, even in comparison with many other developing countries. However, we also bear the dubious distinction of being among the more inequitable countries of the world, as far as health status of the poor compared to the rich is concerned. This underscores the fact that there is a tremendous burden of unnecessary morbidity and mortality, which is borne almost entirely by the poor. Some striking facts in this regard are -

- Infant mortality among the economically lowest 20% of the population is 109, which is **2.5 times** the IMR among the top 20% population of the country.
- Under-five mortality among the economic bottom 20% of the population (bottom quintile) is 155, which is not only unacceptably high but is also **2.8 times** the U5MR of the top 20% (top quintile).
- Child mortality (1-5yrs age) among children from the 'Low standard of living index' group is **3.9 times** that for those from the 'High standard of living index' group according to recent NFHS data (IIPS, 2002). Every year, 2 million children under the age of five years die in India, of largely preventable causes and mostly among the poor. If the entire country were to achieve a better level of child health, for example the child mortality levels of Kerala, then 16 lakh deaths of under-five children would be avoided every year. This amounts to **4380 avoidable deaths every day**, which translates into **three avoidable child deaths every minute**.
- Tribals, who account for only 8% of India's population, bear the burden of **60% of malarial deaths** in the country.

Such gross inequalities are of course morally unacceptable and are a serious social and economic issue. In addition, such a situation may also be considered a *gross violation of the rights of the deprived sections of society*. This becomes even more serious when viewed in the context of **gross disparities in access to health care** -

- The richest quintile of the population, despite overall better health status, is **six times more likely** to access hospitalisation than the poorest quintile. This actually means that the poor are unable to afford and access hospitalisation in a large proportion of illness episodes, even when it is required
- The richest quintile have **three times higher level** of coverage for measles immunization compared to the poorest quintile. Similarly, a mother from the richest 20% of the population is **3.6 times more likely** to receive antenatal care from a medically trained person, compared to a mother from the poorest 20%. The delivery of the richer mother is **over six times more likely** to be attended by a medically trained person than the delivery of the poor mother.
- As high of 82% of outpatient care is accessed from the private sector, met almost entirely by out-of-pocket expenses, which is again often unaffordable for the poor.

- About three-fourths of spending on health is made by households and only one-fourth by the government. This often pushes the already vulnerable poor into indebtedness, and in over 40% of hospitalisation episodes, the costs are met by either sale of assets or taking loans.
- The per capita public health expenditure in India is abysmally low at Rs. 21 per person, among the lowest in the world. India has one of the most privatized health systems in the world (only five countries on the globe are worse off in this respect), effectively denying the poor access to even basic health care.

The gist of these sample facts is that the existing system of ‘leave it to the market’ effectively means *‘leave health care for the rich and leave the poor to fend for themselves’*.

One implication that emerges from the above discussion is that the problem of large-scale ill health in India should not be seen as primarily a technical-medical issue. The key requirement is not newer medical technologies, more sophisticated vaccines or diagnostic techniques. The fact that the prosperous sections of the population enjoy a reasonably good health status implies that *the technical means to achieve good health do broadly exist in our country today* (though there is definitely a need to better adapt these to our country’s conditions and traditions, and certain improved techniques might help in specific contexts). *In fact, for the vast majority, the key barriers to good health are not the lack of technology but poverty and health system inequity.* Poverty, a manifestation of social inequity, leads to large sections of the population being denied adequate nutrition, clean drinking water and sanitation, basic education, good quality housing and a healthy local environment, which are all prerequisites for health. At the same time, we have a **highly inequitable health system** which denies quality health care to all those who cannot afford it (the fact that even those who **can** afford it do not always get rational care is another important, but somewhat separate issue!). In this paper, which is primarily addressed to those working in the health sector, we will focus on the critical *health system* issues, with a rights-based approach. Let us see how we can view this entire situation from a rights based perspective.

## **The Right to Health Care as a component of the Right to Health**

Looking at the issue of health under the equity lens, it becomes obvious that the massive burden of morbidity and mortality suffered by the deprived majority is not just an unfortunate accident. It constitutes *the daily denial of a healthy life, to crores of people, because of deep structural injustice, within and beyond the health sector.* This denial needs to be addressed in a rights based framework, by systematically establishing the right of every citizen of this country, to a healthy life. More specifically, health care can no longer be viewed as just a technical issue to be left to the experts and bureaucrats, an issue of charity to be dealt with by benevolent service delivering institutions, or a commodity to be sold by private doctors and hospitals. The role of all these actors needs to be redefined and recast in a framework where every person, including the most marginalized, is assured of basic health care and *can demand and access this as a right.*

It is clear that achieving a decent standard of health for all requires a range of far reaching social, economic, environmental and health system changes. There is a need to bring about broad transformations both within and beyond the health care sector, which would ensure an adequate standard of health for all. To promote the **Right to Health** requires action on two related fronts (WHO, 2002):

### ***Promoting the Right to underlying determinants of health***

This involves working for the right 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’ (WHO, 2002). Agencies engaged in the health sector cannot deal with most of these issues on their own, though they need to highlight the need for better services and conditions, and can advocate for improvements in these areas in a rights based framework. Organisations working in the health sector can support other agencies working directly in these areas, to help bring about relevant improvements.

### ***Promoting the Right to Health Care***

Given the gross inequities in access to health care and inadequate state of health services today, one important component of promoting the Right to Health would be to ensure access to appropriate and good quality *health care* for all. This would involve reorganisation, reorientation and redistribution of health care resources on a societal scale. The responsibility of taking forward this issue lies primarily with agencies working in the health sector, though efforts in this direction would surely be supported by a broad spectrum of society.

In the remaining portion of this paper, we will focus on the process of establishing *the Right to health care* as a imminent task, to be taken up by organisations in the health sector in the broader context of Right to Health outlined above.

## **The justification for establishing the Right to Health Care**

We may view the justification for this right at three levels - constitutional-legal, social-economic and as a human right issue.

### ***The constitutional and legal justification***

The right to life is recognised as a fundamental right in the constitution (Article 21) and this right has been quoted in various judgements as a basis for preventing avoidable disease producing conditions and to protect health and life. The *directive principles of the Indian constitution* include article 47, which specifies the duty of the state in this regard:

**47.** Duty of the state to raise the level of nutrition and the standard of living and to improve health:- 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 ...

In an important judgement (*Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal and another, 1996*), 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.* (emphasis added)

Similarly 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.

Basic social services are now being recognised as fundamental rights with the 93<sup>rd</sup> amendment in the constitution accepting Education as a fundamental right. Despite the controversy and problems regarding the actual provisions of the Bill, it is now being accepted that essential social services like education can be enshrined in the fundamental rights of the Constitution. This forms an appropriate context to establish the right to health care as a constitutionally recognised fundamental right.

### ***The social and economic justification***

It is now widely recognised that besides being a basic human right, provision of adequate health care to a population is one of the essential preconditions for sustained and equitable economic growth. The proponents of 'economic growth above all' may do well to heed the words of the Nobel Laureate economist Amartya Sen:

'Among the different forms of intervention that can contribute to the provision of social security, the role of health care deserves forceful emphasis ... A well developed system of public health is an essential contribution to the fulfilment of social security objectives. ...we have every reason to pay full attention to the importance of human capabilities *also as instruments* for economic and social performance. ... Basic education, good health and other human attainments are not only directly valuable ... these capabilities can also help in generating economic success of a more standard kind ... (from *India: Economic Development and Social Opportunity* by Jean Dreze and Amartya Sen)

### ***The human rights justification***

The right to basic health care is recognised internationally as a human right and India is a signatory to the International Covenant on Economic, Social and Cultural Rights which states in its Article 12 -

The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health... The steps to be taken...shall include those necessary for ...The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Reference can be made to other similar international conventions, wherein the Government of India has committed itself to providing various services and conditions related to the right to health, e.g. the Alma Ata declaration of 'Health for all by 2000'. The National Human Rights Commission has also concerned itself with the issue of 'Public health and human rights' with one of the areas of discussion being 'Access to health care'. The time has come to begin asking as to how these human rights related commitments and concerns will be translated into action in a realistic, time-bound and accountable framework.

## **The core content of the Right to Health Care in the first phase**

Moving towards establishing the Right to Health Care is likely to be a process with various phases. First let us see what could be the *core content* of this right in the first phase, which could be achieved in the short to medium term.

### ***Right to a set of basic public health services***

In the context of the goal of 'Health for All' and various Health Policy documents, an entire range of health care services are supposed to be provided to all from village level to tertiary hospital level. As of today these services are hardly being provided adequately, regularly or of the required quality. Components of the public health system to be ensured in a rights based framework include:

1. Adequate physical infrastructure at various levels
2. Adequate skilled humanpower in all health care facilities
3. Availability of the complete range of specific services appropriate to the level
4. Availability of all basic medications (also see below)

The expected infrastructure and services need to be clearly identified and displayed at various levels and converted into an enforceable right, with appropriate mechanisms to functionalise this. For example, in a justiciable framework, basic medical services especially at Primary and Secondary levels cannot be refused to anyone – for example a PHC cannot express inability to perform a normal delivery or a Rural hospital cannot refuse to perform an emergency caesarean section. *In case the requisite service is not provided by the facility when required, the patient would be entitled to approach a private hospital and receive care, for which the hospital would receive time-bound reimbursement of costs incurred, at standard rates.* This would firstly constitute a strong pressure on the public health system to perform and deliver all services, and secondly, would ensure that the patient receives the requisite care when required, without incurring personal expenses. This forms the one of the first steps towards accessing the right to health care.

Similarly the state has an explicit obligation to maintain public health through a set of preventive and promotive services and measures. These of course include coverage by immunisation, antenatal care, and prevention, detection and treatment of various communicable diseases. However, it should also encompass the operation of epidemiological stations for each defined population unit (say a block), organizing multi-level surveillance and providing a set of integrated preventive services to all communities and individuals.

### ***Right to emergency medical care and care based on minimum standards from private medical services***

Although the right to health care is not a fundamental right in India today, the right to life is. In keeping with this 'Emergency Medical Care' in situations where it is lifesaving, is the right of every citizen. No doctor or hospital, *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. The Supreme Court judgement quoted above (*Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal and another, 1996*), directly relates to this right and clear norms for emergency care need to be laid down if this right is to be effectively implemented. As a parallel, we can look at the constitutional amendments enacted in South Africa, wherein the Right to Emergency Medical care has been made a fundamental right.

At the same time there is an urgent need for a comprehensive legislation to regulate qualification 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. The Govt. of Maharashtra is in the process of enacting a modified act to address many of these issues, and the National Health Policy 2002 stipulates the enactment of suitable regulations for regulation of minimum standards in the private medical sector in the entire country by the year 2003. This would include statutory guidelines for the conduct of clinical practice and delivery of medical services. There is a need to shape such social regulation of this large medical sector within the larger, integrated framework of Right to health care.

### ***Right to essential drugs at affordable cost***

Attaining this right would consist of two components:

1. Availability of certain 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 state Governments need to 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.

### ***Right to patient information and redressal***

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 has a right to information regarding staff qualifications, fees and facilities for any medical centre even before they decide to take treatment from the centre. Information about the likely risks and side effects of all major procedures can be made available in a standard format to patients. Information regarding various public health services which people have a right to demand at all levels should be displayed and disseminated. This should include information about complaint mechanisms and for redressal of illegal charging by public health personnel.

Superseding the CPA, a much more 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 malpractice. In case the services mandated under this right are not given by a particular facility, the complainant need not take recourse to lengthy legal procedures. Rather, the grievance redressal mechanism with participation of consumer and community representatives should be empowered to take prompt, effective and exemplary action.

### ***Right to monitoring and accountability mechanisms***

Keeping in mind the devolution of powers to the Panchayati Raj system, we need to propose an effective system of people's monitoring of public health services which would be organised at the village, block and district levels. Community monitoring of health services would significantly increase the accountability of these services and will lead to greater people's involvement in the process of implementing them. The Union Ministry of Health and Family Welfare, with support from WHO, has been successfully implementing an innovative pilot project for 'Empowering the rural poor for better health' in six talukas of the country. Taking this and various other experiments into account, a basic framework for such monitoring needs to be developed.

## **The broader objective - a system for universal health care and basic health care as a fundamental constitutional right**

While trying to achieve these specific rights in the first phase, our overall goal should be 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 and NHS in Britain to the Cuban system of health care for every citizen. In the Indian context, the right to health care needs to be enshrined in the Constitution as a fundamental right. One conception of the minimum content of the fundamental right to health care is outlined in the accompanying box.

### **Proposed minimum content of the fundamental right to health care**

1. *Making the right to health care a legally enforceable entitlement by legal enactment*
2. *A national health policy with a detailed plan and timetable for realization of the core right to health care*
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 communities and persons; focusing on equity so as to improve the health status of poor and neglected communities and regions*
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*

*(Adapted from Audrey R. Chapman, The Minimum Core Content of the Right to Health)*

One realistic scenario to make this right functional could be a system of universal social health insurance. The services could be given by a combination of a strengthened and community-monitored public health system along with publicly regulated and financed private providers, under a single umbrella. The entire system would be based on public subsidisation and cross-subsidy, with free services to the majority population of rural and urban working people including vulnerable sections, and affordable premium amounts (which could be integrated with the taxation system) for higher income groups. One key aspect would be that this should be a *Universal system* (not targeted), which would ensure coverage of the entire population and also retain a strong internal demand for good quality services. (Of course, certain very affluent sections may choose to pay their share of taxation / premium and yet opt out and access private providers.) Another issue is that there would be *no fees or nominal fees at the time of actual giving of services*. Finally, the patient would be assured of a range of services with minimum standards, whether given from the public health system or publicly financed and regulated private providers. The entire system could be managed in a decentralised manner, with consumer's monitoring of quality and accessibility of services.

This entire model would of course imply a significantly higher public expenditure on health services. However, with decentralised management and a focus on rational therapy, it has been estimated that it should be possible to organise the basic elements of such a system by devoting 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 to give a full range of services to all. This level of funds could be partly raised by appropriate taxation of unhealthy industries,

reallocations within the health sector (including reorganising existing schemes like ESI) and ending all subsidisation of the private medical sector. This of course needs to be combined with changed budgetary priorities and higher overall allocation for the health sector. Incidentally, 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. This admirable yet vague intention needs to be converted into concrete action by means of strong and sustained pressure from various sections of civil society, coupled with concrete proposals to functionalise universal access to health care.

In this context, ensuring Health care for all is not an unrealistic scenario, but both a practical possibility and an 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.

### **Ways ahead - creating a consensus on the right to health care**

Some of the possible areas of activity of a potential broad coalition which could support a campaign on the issue of Right to Health Care are suggested below.

#### ***Involving diverse social sectors in a dialogue on the Right to Health Care***

While some health activists and groups have mooted the concept of the Right to Health Care, it is an idea which is yet to be widely discussed and accepted in our country. One of the key tasks in the immediate future is to generate discussion at the broadest possible level about this right. Groups to be involved in such a debate include health policy makers, medical and public health academics, private medical professionals, various segments of the NGO sector including both health related and non-health NGOs, trade unions of health care personnel and people's organisations. It is obvious that the viewpoints of various social groups and actors may be greatly divergent on this issue. However, the very process of discussing and debating the issue gives it a primary legitimacy, which then needs to be built upon. This becomes a basis for generating a continuously widening consensus about the basic justification, content and implementation model for the Right to Health Care.

#### ***Collating international experience on the Right to Health Care***

There is valuable international experience available about mandating the Right to Health or Health Care. These experiences need to be collated, and analysed with the Indian context in mind. Especially legislation and provisions made in developing countries are of value in this respect.

Twelve different countries of Latin America, which have Civil law provisions, include the right to health or State duties to protect health in their constitutions. While Chile was the first such country to make such a provision, Argentina, Brazil, and Mexico are also included among these. Cuba with a socialist constitution accords the right to health to its citizens, according it a status equivalent to civil and political rights.

South Africa, after the overthrow of apartheid, in Article 27 of its constitution has specified certain provisions relevant to this right. This includes mandating the right to access to health care services, specifying that the state must take reasonable legislative measures to achieve realisation of this right, and declaring that no one may be refused emergency medical treatment. From another end, we have a new system of Universal health care access in Thailand whose features need to be studied and discussed as relevant to the Indian context.

Similarly, there has been an entire process of developing the concept of right to health and health care in the international human rights discourse. Various United Nations health rights

instruments refer to health related rights. The UN International Covenant on Economic, Social and Cultural Rights (ICESCR), UN Convention on Rights of the Child (CRC) and the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) are some such significant conventions, in which India is a signatory. Given this background, one of the critical tasks ahead of us is to make an in-depth study of these experiences and utilise this for developing the judicial form and implementation-related content of the Right to Health Care in the Indian situation.

### ***Organizing state and national conventions on the Right to Health Care***

One way of developing such a consensus is to organise a series of conventions, on the issue of Right to Health Care, first at state level and ultimately at the national level. Each convention could bring together representatives of key stakeholders outlined above, and could result in a clearer conceptualisation of the core content and processes related to making this right functional. The national convention could also culminate in a dialogue with the Health Minister, promoting the idea of recognising and implementing this right.

### ***Discussing detailed proposals to implement the Right to Health Care***

One of the crucial issues in furthering this campaign is the development of a model for implementing this Right. This needs to be done, keeping in mind the specificities of the Indian health care system, judicial framework (including the fact that Health is a state subject), socio-economic situation including major class, caste and gender disparities and recent processes such as the 93<sup>rd</sup> Constitutional amendment. Considerable groundwork and consultation is required to develop a model, which would take into account the positions of various stakeholders and form the basis for practical implementation of this right.

### ***Forming a multi-sector independent body to monitor implementation of the Right to Health Care***

Finally, there is the need for a multi-sectoral body with representation from various social sectors to monitor the processes of establishment and implementation of the Right to Health Care. Such a body would have the social legitimacy, diverse experience and capacity to continuously assess the movement towards realisation of this right, and help usher in a new phase in the development of the health system and establishment of social-economic rights in this country.

*(This note was prepared by Dr. Abhay Shukla of CEHAT, for the Seminar on 'Right to Health Care' organised on 3-4 January 2003 during the Asian Social Forum at Hyderabad. Several sections of this article are adapted from Abhay's article 'Right to health care' published in Health Action, May 2001)*