Health and Development in India : Moving Towards the Right to Health

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> 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*

I. Background

A. The Development Paradigm

The Constitution of India provides a framework for a socialist pattern of development. While civil and political rights are enshrined as fundamental rights, social and economic rights like health, education and housing are considered directive principles. As such, the State continually fails to fulfill these rights, addressing them mostly through Five Year Plans and other policy initiatives.

Although post-independence India adopted a development paradigm to give the most poverty stricken people limited entitlements to various resources, it also allowed for the private sector to flourish in unprecedented ways. Consider the example of drug production in India. Although the State actively manufactured basic drugs, it supplied a large amount to the private formulation industry at subsidized rates. As a result of this approach, by the late 1980s the public sector drug industry had withered away and the private pharmaceutical industry had gained enough stature to become a global player.[2] Another example concerns the production of qualified doctors. Until the mid 1980s, there were only public medical schools. Despite graduating from these publicly funded institutions, an average 80% of the graduates either entered the private sector or migrated abroad.

While the development paradigm clearly supported private sector growth, it did not completely ignore the public sector. The government's drug price control helped to keep the drug prices under leash and their health care policies assured most people a basic level of health care services. It must be remembered, however, that this development approach was never rights-based, and so the selective entitlements that were offered under the various development programs had only a limited impact on the people of India. Accordingly, large-scale poverty and wide-spread disease persists across the country.

Tables 1 and 2 give an overview of the expenditure in India. These tables clearly show that for the past fifty years economic services have been allocated over four-fifths of the resources, leaving the social sectors like health to receive only residual resources. Consequently, health care

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[2] Presently the Indian Pharmaceutical industry manufactures drug formulations to the tune of Rs. 210 billion and of this exports Rs. 98 billion, that is 47%. The Indian pharmaceutical industry is the 4th largest in the world and accounts for 8% of world production by volume. (MoCF, 2001)

facilities are far below any acceptable standard. India has not even reached half of the level in provision of health care that most developed countries reached between the two world wars.

The public health care system has always been a weak spot in the State's development strategy. The upper classes had little concern for it because the private health sector, at least for non-catastrophic care, was already well established and reasonably accessible. They mostly invested in development schemes that would maximize their financial returns. The poorer classes, meanwhile, were consumed with their daily struggles for survival, putting non-catastrophic health care attention low on their list of priorities.

With this kind of a development strategy, key social development issues like health, education, and housing were sidelined, never becoming the political issues which would drive a new development strategy. Thus, it seems clear that without a rights based approach to planned development, systems and policies of the government can yield only limited results and outcomes. The right to health and health care cannot be fulfilled through the current development agenda. Rather, it must be deemed an independent right in the constitution of India.

Table 1 : PLAN EXPENDITURE BY MAJOR SECTORS (Rupees Million) (Figures in brackets are percentage to total)

	Plan One 1951-56	Plan Two 1956-61	Plan Three 1961-66	Annual Plan 1966-69	Plan Four 1969-74	Plan Five 1974-79	Annual Plan 1979-80	Plan Six 1980-85	Plan Seven 1985-90	Annual Plan 1990-92	Plan Eight 1992-97	Plan Nine Outlay 1997-2002
ECONOMIC	14940	38170	70847	56495	127936	325923	102090	915072	1807460@	1015948@	3895410@	6574690
SERVICES (A)	**(76.0)**	**(81.7)**	**(82.6)**	**(85.3)**	**(81.1)**	**(82.7)**	**(83.8)**	**(83.7)**	**(82.6)**	**(82.5)**	**(80.2)**	**(76.5)**
1. Agriculture & rural dev.	2900 (14.8)	5490 (11.7)	10889 (12.7)	11071 (16.7)	23204 (14.7)	48649 (12.3)	19965 (16.4)	152006 (13.9)	315094 (14.4)	176010 (14.3)	702003	1207970
2. Irrigation & flood control	4340 (22.2)	4300 (9.2)	6647 (7.8)	4710 (7.1)	13541 (8.6)	38765 (9.8)	12879 (10.6)	109299 (10.0)	165899 (7.6)	82060 (6.7)	313989	554200
3. Power	1490 (7.6)	4520 (9.7)	12523 (14.6)	12125 (18.3)	29317 (18.6)	73995 (18.8)	22405 (18.4)	307513 (28.1)	616893 (28.2)	368347 (29.9)	1289045	2223750
4. Village & small ind'ry	480 (2.19)	1870 (4.0)	2408 (2.8)	1261 (1.9)	2426 (1.5)	5925 (1.5)	2557 (2.1)	19451 (1.8)	32493 (1.5)	18191 (1.5)	72657	} } 651480
5. Industry & Minerals	550 (2.8)	9380 (20.1)	17263 (20.1)	15104 (22.8)	28644 (18.2)	89886 (22.8)	23835 (19.6)	150024 (13.7)	259711 (11.9)	111197 (9.0)	406231	}
6. Transport & Commu'n	5180 (26.4)	12610 (22.0)	21117 (24.6)	12224 (18.5)	30804 (19.5)	68703 (17.4)	20449 (16.8)	176779 (16.7)	379736 (17.4)	239503 (19.4)	1015479	1666530
SOCIAL	4720	8550	14918	9759	29852	68339	19675	177845	379836	215257	959161	2017310
SERVICES(B)	(24.0)*	(18.3)*	(17.4)	(14.7)	(18.9)	(17.3)	(16.2)	(16.3)	(17.4)	(17.5)	(19.8)	(23.5)
1. Education	} } } } 1490 } (7.6)	2730 (5.9)	5887 (6.9)	3068 (4.6)	7743 (4.9)	17103 (4.4)	2630 (2.2)	29766 (2.7)	76855 (3.5)	49155 (4.0)	215987	
2. Scientific Research	} }		716 (0.8)	471 (0.7)	1308 (0.8		914 (0.7)	10204 (0.9)	30239 (1.4)	16204 (1.3)	71095	184580
3. Health	652 (3.3)	1408 (3.0)	2259 (2.6)	1402 (2.1)	3355 (2.1)	7608 (1.9)	2231 (1.8)	20252 (1.8)	36886 (1.7)	19656 (1.6)	81376	193741
4. Family Planning	1 (0)	50 (0.1)	249 (0.3)	704 (1.1)	2780 (1.8)	4918 (1.3)	1185 (1.0)	13870 (1.3)	31208 (1.4)	18055 (1.5)	59728	151202
5. Water & Sanitation	} } } 330 } (1.7) }	850 (1.8)	1057 (1.2)	1027 (1.0)	4589 (2.9)	10916 (2.8)	3876 (3.2)	} } } 103753 } (9.5) }	**	**	**	
6. Housing & Urban Dev	} }		1276 (1.5)	733 (1.1)	2702 (1.7)	11500 (2.9)	3688 (3.0)	} }	48362 (2.2)	30323 (2.5)	138043	
7. Other welfare	1920 (9.8)	2690 (5.8)	3474 (4.1)	2354 (3.5)	7375 (4.7)	16294 (4.1)	5151 (4.2)	}	156285** (7.2)	81864** (6.6)	392934**	
GRAND TOTAL	**19660* (100.0)**	**46720* (100.0)**	**85765 (100.0)**	**66254 (100.0)**	**157788 (100.0)**	**394262 (100.0)**	**121765 (100.0)**	**1092917 (100.0)**	**2187296 (100.0)**	**1231205 (100.0)**	**4854572 (100.0)**	**8592000 (100.0)**

* Includes rehabilitation; ** Water and Sanitation included in Other welfare; @ includes general and general economic services

Sources : 1. Basic Statistics Relating to the Indian Economy : 1950 to 1981, CSO, GOI, 1983, Pg. 148-149. 2. Economic Survey 1986-87, Min of Finance, GOI, 1987, Pg S-31 and S-32 (for Vth to VIth Plan). 3. Indian Planning Experience: A statistical profile, Planning Commission, GOI, New Delhi, 2000 Pg 33-36 (Pan VII, VIII and IX)

Table 2: Pattern of Investment on Health and Family Welfare (Rs. Millions)

Period	Total Plan Investment	Health *+ISM&H*	%	Family Welfare	%
First Plan (Actuals) (1951-56)	19600	652	3.33	1	0.01
Second Plan (Actuals) (1956-61)	46720	1408	3.01	50	0.11
Third Plan (Actuals) (1961-66)	85765	2259	2.63	249	0.29
Annual Plans (Actuals) (1966-69)	66254	1402	2.12	704	1.06
Fourth Plan (Actuals) (1969-74)	157788	3355	2.13	2780	1.76
Fifth Plan (Actuals) (1974-79)	394262	7608	1.93	4918	1.25
Annual Plan (1979-80)	116500	2682	2.30	1162	1.00
Sixth Plan (Actuals) (1980-85)	1092917	20252	1.85	13870	1.27
Seventh Plan (Actuals) (1985-90)	2187296	36886	1.69	31208	1.43
Annual Plans (1990-91, 1991-92)	1231205	19656	1.60	18055	1.47
Eighth Plan (Actuals) (1992-97)	4854572	81376	1.68	59728	1.23
Ninth Plan (Anticipated Exp.) (1997-2002)	9410410	154072	1.64	145890	1.55
Tenth Plan (draft outlay)	15256390	317950	2.08	271250	1.78

Source : **Indian Planning Experience - A** Statistical Profile, *Planning Commission, GOI, New Delhi, 2000.* Ninth Five Year Plan, Planning Commission, GOI, New Delhi, 1998. Draft Tenth Five Year Plan, www.planningcommission.nic.in/

B. The History of Health Policy

During World War II it became evident that independence for India was around the corner. As part of the Post War Reconstruction initiative, the Health Survey and Development Committee, under the Chairmanship of Sir Joseph Bhore, was created on October 18, 1943. The formation of this committee marked the first time that such a large project had been undertaken to document the prevailing health conditions in India and recommend a plan for the future. The four volume Bhore Committee Report was submitted to the Government of India in 1946. It emphasized a need for a comprehensive and universal health care system, and it made recommendations[Annex A] that, if implemented, would have been India's first steps on the path to a right to health. Although the opportunity to build a foundation for the right to health right was presented, the development paradigm had no space for such provisions.

Indeed, there was no attempt in the post-colonial period to radically restructure the health care system as per the framework provided by the Bhore Committee. Rather, a series of five year plans were instituted which seemed to allow the health care inequalities to continue to grow. For the Five Year Plans the health sector constituted schemes that had targets to be fulfilled. Each plan period had a number of schemes and every subsequent plan added more and dropped a few. Thus health sector development continued to be confined in enclaves – the civil lines and cantonments. The access favored urban populations; especially those employed in civil and military services and other organized sectors like railways, mines, factories etc. through social security packages. The rural areas were completely neglected, except for some "public health" measures, mainly epidemic prevention and control. Doctors were trained for the private sector through state financing, bulk drugs were supplied at subsidized rates to private formulation units and this facilitated the development and strengthening of the private health sector in India.

1950-1975

In the fifties and sixties the entire focus of the health sector in India was to manage epidemics. Mass campaigns were started to eradicate the various diseases. These separate countrywide campaigns with a techno-centric approach were launched against malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera. Cadres of workers were trained in each of the vertical programs. The National Malaria Eradication Program (NMEP) alone required the training of 150,000 workers spread over in 400 units in the prevention and curative aspects of malaria control (Banerji, 1985).

The policy of going in for mass campaigns was in continuation of the policy of colonialists who subscribed to the percepts of modern medicine that health could be looked after if the germs which were causing it were removed. But the basic cause of the various diseases is social, i.e. inadequate nutrition, clothing, and housing, and the lack of a proper environment. These were ignored. National programs were launched to eradicate the diseases. The NMEP was started in 1953 with aid from the Technical Cooperation Mission of the U.S.A. and technical advice of the W.H.O. Malaria at that period was considered an international threat. DDT spraying operations was one of the most important activities of the program. The tuberculosis program involved vaccination with BCG, T.B. clinics, and domiciliary services and after care. The emphasis however was on prevention through BCG. These programs depended on international agencies like UNICEF, WHO and the Rockefeller Foundation for supplies of necessary chemicals and vaccines. Along with financial aid came political and ideological influence. Experts of various international agencies influenced the policy framework, program design, and financial commitments etc.

During the First and Second Five Year Plans, the basic structural framework of the public health care delivery system remained unchanged. Urban areas continued to receive over three-fourths of the medical care resources while rural areas received "special attention" under the Community Development Program (CDP). However, history stands in evidence to what this special attention meant. The CDP was failing even before the Second Five Year Plan began. The government's own evaluation reports confessed this failure. (Planning Commission, 1958)[3]

The health sector organization under CDP was to have a primary health unit (a very much diluted form from what was suggested by the Bhore Committee) per development Block (in the fifties this was about 70,000 population spread over 100 villages) supported by a Secondary health unit (hospital with mobile dispensary) for every three such primary health units. The aim of this health organization was "the improvement of environmental hygiene, including provision and protection of water supply; proper disposal of human and animal wastes; control of epidemic diseases such as malaria, cholera, small pox, TB etc.; provision of medical aid along with appropriate preventive measures, and education of the population in hygienic living and in improved nutrition" (FYPI, 227).

It is clear from the above statement of objectives of the health organization under CDP that medical care had little priority within the structure of such an organization. In contrast, in the urban areas (which developed independent of CDP) hospitals and dispensaries that provided

[3] SC Dube in his India's Changing Villages says that the CDP created a class of local change agents who had contact with the world of officials and politicians and who ultimately became power brokers (Dube, SC 1958)

mainly curative services (medical care) proliferated. Thus at the start of the third Five year Plan there was only one Primary Health Unit per 140,000 rural population (14 times, less than what the Bhore Committee recommended) in addition to one hospital per 320,000 rural population and one hospital bed per 7000 rural population. In sharp contrast urban areas had one hospital per 36,000 urban population and one hospital bed per 440 urban residents.[4] Thus it became clear that if access to healthcare in rural areas was to be improved it had to move out of the community development framework and acquire an identity in its own right, like in the urban areas.

To evaluate the progress made in the first 2 plans and to make recommendation for the future path of development of health services the **Mudaliar Committee** was set up in 1959. The report of the committee recorded that the disease control programmes had some substantial achievements in controlling certain virulent epidemic diseases. Malaria was considered to be under control. Deaths due to malaria, cholera, smallpox etc. were halved or sharply reduced and the overall morbidity and mortality rates had declined. The death rate had fallen by 17% during 1956-61. The expectation of life at birth had risen to 42 years. However, the tuberculosis program lagged behind. The report also stated that for a million and half estimated open cases of tuberculosis there were not more than 30,000 beds available.[5]

The Mudaliar Committee further admitted that basic health facilities had not reached atleast half the nation. The PHC programme was not given the importance it should have been given right from the start. There were only 2800 PHCs existing by the end of 1961. Instead of the "irreducible minimum in staff" recommended by the Bhore Committee, most of the PHC's were understaffed, large numbers of them were being run by ANM's or public health nurses in charge (Mudaliar, 1961). The fact was that the doctors were going into private practice after training at public expense. The emphasis given to individual communicable diseases programme was given top priority in the first two plans. But primary health centers, through which the gains of the former could be maintained, were given only tepid support (Batliwala, 1978).

The Third Five Year Plan launched in 1961 discussed the problems affecting the provision of primary health centers (PHC). It directed attention to the shortage of health personnel, delays in the construction of PHC buildings and inadequate training facilities for staff required in the rural areas. (FYP III, 657) The Third Five Year Plan highlighted inadequacy of health care institutions, doctors and other personnel in rural areas as being the major shortcomings at the end of the second Five Year Plan (Ibid, 652). The doctor syndrome loomed large in the minds of planners, and increase in supply of humanpower in health meant more doctors and not other health personnel. While the 3rd plan did give serious consideration to the need for more auxiliary personnel no mention was made of any specific steps to reach this goal. Only lip service was paid to the need for increasing auxiliary personnel but in the actual training and establishment of institutions for these people, inadequate funding became the constant obstacle. On the other hand, the proposed outlays for new Medical Colleges, establishment of preventive

[4] Clear evidence that as early as beginning of the sixties availability of medical care in urban India was already well within the acceptable standard norm of WHO of one hospital bed per 500 persons, whereas rural India was 16 times worse off as regards such access.

[5] It must be noted that tuberculosis was not getting as much assistance under the technical cooperation mission as malaria and small pox, which were global threats. The volume of grants is not the issue here because it was insignificant; the question is that the agenda for public health was being determined internationally and the government followed that line and allocated budgets in accordance with international thinking and not local needs and demands.

and social medicine and psychiatric departments, completion of the All India Institute of Medical Sciences and schemes for upgrading departments in Medical Colleges for post graduate training and research continued to be high (Batliwala, 1978).

In this way we see that the allocation patterns continued to belie the stated objectives and goals of the overall policy in the plans. The urban health structure continued to grow and its sophisticated services and specialties continued to multiply. The 3rd plan gave a serious consideration for suggesting a realistic solution to the problem of insufficient doctors for rural areas "that a new short term course for the training of medical assistants should be instituted and after these assistants had worked for 5 years at a PHC they could complete their education to become full fledged doctors and continue in public service" (FYP III, 662). The Medical council and the doctors lobby opposed this and hence it was not taken up seriously.[6]
The Fourth Five Year Plan focused on these inadequacies in the rural areas as well, though few improvements were instituted. It was reiterated that the PHC's base would be strengthened along with sub-divisional and district hospitals, which would be referral centers for the PHCs. The importance of PHCs was stressed to consolidate the maintenance phase of the communicable diseases programme (FYP IV, 1969, 390). This acknowledgement was due to the fact that the entire epidemiological trend was reversed in 1966 with the spurt in incidence of malaria that rose from 100,000 cases annually between 1963-65, to 149,102 cases (GOI, 1982).

1975-1990

It was with the Fifth Five Year Plan that the government ruefully acknowledged that the urban health infrastructure was expanding at the cost of the rural sectors. (FYP V, 1974, 234) Despite statistics indicating that the infant mortality rate was going down and life expectancy was going up, the number of medical institutions, health facilities, doctors, nurses and beds was still inadequate in the rural areas. This awareness is reflected in the objectives of Fifth Five Year Plan: (Ibid, 234).

1) Increasing the accessibility of health services to rural areas through the strengthened Minimum Needs Program (MNP) and the correction of the regional imbalances.
2) Improving the quality of the education and training of health personnel.
3) Intensifying the control and eradication of communicable diseases.
4) Developing referral services by removing deficiencies in district and sub-division hospitals.
5) Further developing referral services by providing specialists attention to common diseases in rural areas.

Major innovations took place with regard to the health policy and method of delivery of health care services. The reformulation of health programmes was to consolidate past gains in various fields of health such as communicable diseases, medical education and provision of infrastructure in rural areas. This was envisaged through the MNP which would "receive the highest priority and will be the first charge on the development outlays under the health sector (Ibid, 234). It was an integrated packaged approach to the rural areas. The plan further envisaged that the delivery of health care services would be through a new category of health

[6] At that point of time the Maharashtra government went ahead with the short term course and created a cadre of RMPs for rural areas, but a decade later it realized that these doctors would flock to urban areas and hence de-recognised the course. Today Chattisgarh is implementing a short term course because there is an acute shortage of doctors in that newly formed state.

personnel to be specially trained as multi-purpose health assistants and supported at the village level by a new cadre of community health workers. However, the infrastructure target still remained one PHC per CDP Block (as in the FYP-I, but the average Block's population was now 125,000 !). But it was only in the Sixth Five Year Plan, including the announcement of the first National Health Policy in 1983, that the transformation of India's rural health infrastructure finally happened.

National Health Policy of 1983

Until 1983 there was no formal health policy. As a consequence of the global debate on alternative strategies during the seventies, the signing of the Alma Ata Declaration on primary health care and the recommendations of the ICMR-ICSSR Joint Panel, the government decided that although their strategies may have served the needs in the past, a new approach was now required:

> It is felt that an integrated, comprehensive approach towards the future development of medical education, research and health services requires to be established to serve the actual health needs and priorities of the country. It is in this context that the need has been felt to evolve a National Health policy. (MoHFW, 1983, p 1)

The salient features of the National Health Policy (NHP) of 1983 were:

1) It was critical of the curative-oriented western model of health care.
2) It emphasized a preventive and rehabilitative primary health care approach.
3) It recommended a decentralized system of health care, focusing on low expenditure, deprofessionalisation (the use of volunteers and paramedics) and community participation.
4) It called for an expansion of the private curative sector to help reduce the government's burden.
5) It recommended the establishment of a nationwide network of epidemiological stations that would facilitate the integration of various health interventions.
6) It set up targets for achievement that were primarily demographic in nature.

During the decade following the 1983 NHP, rural health care received special attention. A massive program of expansion of PHC facilities was undertaken in the Sixth and Seventh Five Year Plans to achieve the target of one PHC per 20,000-30,000 people and one subcenter per 2500-5000 people. This target has been achieved to a great extent, though few states (BIMAROU[7]) still lag behind. However, various studies examining rural primary health care have noted that, although the infrastructure is in place in most areas, they are grossly underutilized because of poor facilities, inadequate supplies, insufficient hours, weak managerial skills and lack of proper monitoring mechanisms.

[7]BIMAROU is an acronym for Bihar, Madhya Pradesh, Rajasthan, Orissa and Uttar Pradesh. These states are the worst performers on both the economic and social development index.

A recent facility survey across India by the Ministry of Health and Family Welfare highlights the inadequacies of the public health infrastructure, especially in the rural areas.[8] Even the District Hospitals, which are otherwise well endowed, have a shortage of critical supplies needed to run the hospital. Across the board, the rural health facilities are ill provided. (MOHFW, 2001)

With regards to the other tasks listed by the 1983 NHP, decentralisation and deprofessionalisation have taken place in a limited context, but there has been no community participation. The rural population continues to use private care, and when they do use public facilities, they prefer the urban hospitals (NSS-1987, Duggal&Amin,1989, Kannan et.al.,1991, NCAER,1991, NCAER,1992, George et.al.,1992, NSS-1996). Various studies show that the private health sector accounts for over 75% of all primary care treatment sought and over 40% of all hospital care (NSS-1987, Duggal&Amin,1989, Kannan et.al.,1991, NCAER,1991, George et.al.,1992). These numbers are not a good sign for a country where over three-fourths of the population lives at or below subsistence levels. In fact, the recent 52nd round NSS survey provides strong evidence of the declining utilization of public health services from 1987-1996. During this period the use of public health services for both outpatient and inpatient care declined by nearly 30% (NSS-1996, 2000, 25-31). The rural health care system has not even been able to provide for the recommended epidemiological stations.

The 1983 NHP by itself was not sufficient to meet the demands of the masses, especially those residing in rural areas, as its goal of "universal, comprehensive, primary health care services" seems far from being achieved. Rather, India's health policy has been moving increasingly from a commitment of comprehensive health care on the eve of Independence and its reiteration in the 1983 NHP to a policy of selective health care with a narrowing down of concern for only family planning, immunization and control of certain diseases. Table 3 gives a good idea of how the health infrastructure in India has evolved over the years.

1990-present

During the Eighth Five Year Plan, a committee to review public health called the Expert Committee on Public Health Systems was set up. It made a thorough appraisal of public health programs, finding that there was a resurgence of communicable diseases and a need to drastically improve disease surveillance. The recommendations of this committee formed the basis of the Ninth Five Year Plan.

The Ninth Five Year Plan, which is approaching its end, provides a good review of all of the programs, puts forth an effort to learn from past failures and gives new and creative suggestions for solving some of the problems facing the health care system. For instance, given the difficulty of finding physicians to work in the PHC and CHC systems, it proposes creating part-time

[8] This first phase of this survey done in 1999, which covered 210 district hospitals, 760 First Referral Units, 886 CHCs and 7959 PHCs, shows the following results: **Percent of Different Units Adequately Equipped**

Units	Infrastructure	Staff	Supply	Equipment	Training
Dist. Hospitals	94	84	28	89	33
FRUs	84	46	26	69	34
CHCs	66	25	10	49	25
PHCs*	36	38	31	56	12

*Only 3% of PHCs had 80% or more of the critical inputs needed to run the PHC, and only 31% had upto 60% of critical inputs (India Facility Survey Phase I, 1999, IIPS, Ministry of Health and Family Welfare, New Delhi, 2001)

positions that can be offered to local qualified private practitioners. Because states remain at different levels of development and have different health care needs, it advises coming up with state specific strategies (FYP IX, 458). It remains to be seen whether these ideas can be translated into practices.

The Ninth Plan also reviews the population policy and the family planning program, referencing the Bhore Committee report by stating that the core of this program is maternal and child health services. It realizes that antenatal care, safe delivery and immunization are critical in reducing infant and maternal mortality. The Child Survival and Safe Motherhood (CSSM) transformed into the Reproductive and Child Health (RCH) program on the basis of the ICPD-Cairo agenda, and it receives multi-agency external funding support to provide need based, demand driven, high quality integrated reproductive and child health care (Ibid, 519 and 557).

Perhaps the most interesting section of the Ninth Five Year Plan is its review of the 1983 NHP, concluding that a reformulation of the 1983 NHP is necessary. The new policy should not only focus on improving health care, but also on the measuring and monitoring of the health care delivery systems and the health status of the population (Ibid, 503). Taking lead from the Ninth Five Year Plan, the Ministry of Health and Family Welfare took up the task of formulating a new health policy.

On the eve of the 10th Plan, the National Health Policy of 2001 was announced, inviting feedback from the public for the first time. It acknowledges that the public health care system is grossly short of defined requirements, the morbidity and mortality due to easily curable diseases is unacceptably high and the resource allocations are generally insufficient:

> It would detract from the quality of the exercise if, while framing a new policy, it is not acknowledged that the existing public health infrastructure is far from satisfactory. For the out-door medical facilities in existence, funding is generally insufficient; the presence of medical and para-medical personnel is often much less than required by the prescribed norms; the availability of consumables is frequently negligible; the equipment in many public hospitals is often obsolescent and unusable; and the buildings are in a dilapidated state. In the in-door treatment facilities, again, the equipment is often obsolescent; the availability of essential drugs is minimal; the capacity of the facilities is grossly inadequate, which leads to over-crowding, and consequentially to a steep deterioration in the quality of the services. (para 2.4.1 NHP 2001).

The NHP 2001 seeks to achieve an acceptable standard of good health among the general population of the country. (para 3.1). Indeed, it should be lauded for attempting to regulate the private health sector through statutory licensing as health researchers and activists have long advocated for a way to build accountability within the private health sector. The express concern for establishing a well worked out referral system, teaching health volunteers simple medical skills and improving overall health statistics is also admirable. However, it remains unclear how the goals will be achieved given the framework of the policy. For instance, goal 10 aims to "increase utilization of public health facilities from current level of <20 to >75%", thereby allowing the reversal of the existing utilization patterns that favor the private sector. While this goal is commendable, it is worrisome that many prescriptions of the policy seem to favor strengthening the private health sector. Overall, the 2001 NHP is a collection of unconnected

statements, a dilution of the role of public health services and an unabashed promotion of the private health sector.

Table 3: HEALTH CARE DEVELOPMENT IN INDIA 1951-2004

			1951	1961	1971	1981	1991	1996	1997	2001-02	Latest**
1	Hospitals*	Total	2694	3054	3862	6805	11174	15170	15188	18436	22000
		% Rural	39	34	32	27		34	34	30	30
		%Private				43	57	68	68	62	75
2	Hospital & dispensary beds*	Total	117000	229634	348655	504538	806409	892738	896767	914543	1500000
		% Rural	23	22	21	17		23	23	21	21
		%Private				28	32	37	37	35	50
3	Dispensaries*		6600	9406	12180	16745	27431	25653	25670	22291	
		% Rural	79	80	78	69		41	40	50	
		% Private				13	60	57	56	54	
4	PHCs		725	2695	5131	5568	22243	21917	22446	22842	23500
5	Sub-centres				27929	51192	131098	134931	136379	137311	140000
6	Doctors	Allopaths	60840	83070	153000	266140	393640	462745	496941	605840	660000
		All Systems	156000	184606	450000	665340	920000		1080173	1297310	1430000
7	Nurses		16550	35584	80620	150399	311235	565700	607376	805827	880000
8	Medical colleges	Allopathy	30	60	98	111	128	165	165	189	195
9	Out turn	Graduates	1600	3400	10400	12170	13934				20000
		Postgraduates		397	1396	3833	3139		3656		6000
10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3	38.4	91.3	104.9	220	280
11	Health outcomes	IMR/000	134	146	138	110	80	72	71	66	65
		CBR/000	41.7	41.2	37.2	33.9	29.5	27	27	25	24
		CDR/000	22.8	19	15	12.5	9.8	9	8.9	8.1	8
	Life Expectancy	years	32.08	41.22	45.55	54.4	59.4	62.4	63.5	64.8	65
	Births attended by trained practitioners	Percent				18.5	21.9	28.5			
12	Health Expenditure Rs. Billion	Public	0.22	1.08	3.35	12.86	50.78	101.65	113.13	211	249
		Private@	1.05	3.04	8.15	43.82	173.60		399.84		
		CSO private		2.05	6.18	29.70	82.61	329.00	373.41	1100	1464
	Health Expenditure as percent of GDP	Public	0.25	0.71	0.84	1.05	0.92	0.91	0.88	0.89	0.91
		Private CSO		1.34	1.56	2.43	1.73	2.95	3.00	5.32	5.40
	Health Expenditure as % to Govt. Total	Public	2.69	5.13	3.84	3.29	2.88	2.98	2.94	2.72	2.60

@ Data from - 1951:NSS 1st Round 1949-50; 1961: SC Seals All India District Surveys,1958; 1971: NSS 28th Round 1973-74; 1981: NSS 42nd Round 1987; 1991 and 1995: NCAER – 1990; 1995: NSS 52nd Round 1995-96;

*Data on hospitals, dispensaries and beds pertaining to the private sector is grossly under reported and figures for 2001-02 for public facilities also suffers from under-reporting as a number of states do not send uptodate information. Thus the actual figures should be much higher, and especially so for the private sector

**Latest years – rounded figures are estimates by author and figures pertain to years 2003/2004

Source : 1. Health Statistics / Information of India, CBHI, GOI, various years; 2. Census of India Economic Tables, 1961, 1971, 1981, GOI 3.OPPI Bulletins and Annual reports of Min. of Chemicals and Fertilisers for data on Pharmaceutical Production 4.Finance Accounts of Central and State Governments, various years 5. National Accounts Statistics, CSO, GOI, various years 6.Statistical Abstract of India, GOI, various years 7. Sample Registration System - Statistical Reports, various years 8. NFHS - 2, India Report, IIPS, 2000

II. The Right to Health[9]

A. The Constitutional Framework

India joined the UN at the start on October 30, 1945, and it was involved with the Universal Declaration of Human Rights (UDHR) proclaimed on December 12, 1948. In fact, the UDHR influenced the formulation of India's constitution. Most civil and political rights were guaranteed under India's constitution as fundamental rights, but most economic, social and cultural rights were originally not. The Constitution made a forceful appeal to the State through the Directive Principles of State Policy to work towards assuring these rights through the process of governance, but it clearly stated that any court could choose to not enforce them.[10]

When health and health care are examined in the original constitutional and legal framework, it is evident that the Constitution and laws of the land did not accord health and health care the status of rights. There were some instances in case law wherein various directive principles had been used to demand access to health care, especially in emergency situations. At times Article 21 of the Constitution, the right to life, has been invoked. A brief on some of the well-known cases is included at the end of the paper.[Annex B] These cases are exceptional, however, and even if the Supreme or High Courts upholds some decisions as being a right, the orders are rarely respected in daily practice unless one returns to the courts to reiterate the orders.

However, the International Covenant on Economic, Social and Cultural Rights (ICESCR) mandates right to health through Article 9 and Article 12, and India ratified this covenant back on April 10, 1979. Thus, India has become obligated to take measures to assure health and health care as a right.

Post-ratification efforts through the Sixth Five Year Plan and the 1983 NHP were the first steps in honoring this commitment. Indeed, the rural public health infrastructure was expanding considerably and more resources were being allotted to the health sector, but the economic crisis of the 1990s and the unsatisfactory 2001 NHP draft delivered devastating blows to the health sector. Even the commitment to Health For All by the WHO was in decline as was evident during the 1998 World Health Assembly when it announced its disappointing policy for Health for All in the 21st Century. With the inter-governmental commitment to assure the right to the highest attainable standard of health waning, it is becoming increasingly difficult for India to honor its commitment to ICESCR. The Committee of the Economic, Social and Cultural Rights, which is supposed to monitor the implementation of ICESCR, is failing to get countries like

[9] The debate on terminology on 'right to health' and 'right to healthcare' is endless and here we will not get into this bottomless pit. Suffice to say that right to health is not independent of right to healthcare and hence they must be seen in tandem. The WHO definition was influenced largely by Sigerist, who argued that state of health is a physical, mental and social condition and "health is, therefore, not simply the absence of disease – it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts on the individual" (Sigerist, 1941, p.68). This broad definition, including social well-being is often criticised for being too broad and as a consequence the concern for access to healthcare is lost. While Sigerist gave this broad definition he also emphasized that healthcare protection and provision was the right of the citizen and a duty of the state to respect this. The focus in this paper is on the right to access healthcare and other related rights, and as a consequence health. Hence, the use of the phrase 'right to health and healthcare' in the present paper. For a debate on the definitions and further references see Brigit Toebes, 1998.

[10] Article 37 pertaining to the application of the principles contained in Part IV of the constitution states, **"**The provisions contained in this Part shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws"

India to take measures to implement the provisions of the ICESCR, and India has yet to even file its initial report under the ICESCR.[11]

There are other international acts, treaties and declarations that India is a party to and which have a bearing on right to health. Extracts from these documents are reproduced in the endnote.[Annex C] Articles 41, 42 and 47 of the Directive Principles[12] enshrined in Part IV of the Constitution provide the basis to evolve the right to health and health care:

> **41. Right to work, to education and to public assistance in certain cases:** The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.
>
> **42. Provision for just and humane conditions of work and maternity relief:** The State shall make provision for securing just and humane conditions of work and for maternity relief.
>
> **47. Duty of the State to raise the level of nutrition and the standard of living and to improve public 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 and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

For a small part of the working population, assurance of health care exists with social security and social insurance. Because only a select group of people can enjoy this privilege, the health care policy is one of discrimination and inequity, thereby violating not only the non-discrimination principle of international law, but also Article 14 of the constitution, the Right to Equality, under the chapter of Fundamental Rights.

Thus, the constitutional provisions of social security, social insurance, a decent standard of living and adequate public health services, coupled with the collective policy statements and supported by international legal commitments, form the basis of the right to health and health care in India. The only legal and constitutional principle missing is the principle of justiciability. The 93rd amendment to the Constitution has provided limited justiciability with regards to education, and it is clear that a similar amendment concerning health care should be adopted, especially since inadequate health care can put lives at risk.

However, there is a problem concerning the justiciability of international law and India. Like its colonial exploiter Britain, India follows the principle of dualism. This means that for international law to be applicable in India, it needs to be separately legislated. Since none of the international human rights treaties have been incorporated or transformed into domestic laws in India, they have only an evocative significance and may be used by the Courts or petitioners to derive inspiration. (Nariman,1995) On a number of occasions, therefore, many of these human

[11] Article 51 of the Constitution titled promotion of international peace and security gives assurance that India will honour its international commitments, including respect for international laws and treaties which it has signed and ratified – "The State shall endeavour to- (a) promote international peace and security; (b) maintain just and honourable relations between nations; (c) foster respect for international law and treaty obligations in the dealings of organised peoples with one another; and (d) encourage settlement of international disputes by arbitration"

[12] "The courts are much more aware of and attentive to their obligation to implement socio-economic uplift programmes and to ensure decent welfare for all. The state has a duty to all citizens to adhere to that part of the Constitution which describes the directive principles as 'fundamental' to the governance of the country. The courts have therefore been using the directives as an instrument to determine the extent of public interest in order to limit the extension of fundamental rights. In doing so they have upheld a number of statutes on the grounds of public interest, which in other circumstances may have been nullified." (De Villiers, 1992).

right treaties, which India has ratified, have been used by the Courts of India in conjunction with the fundamental rights described in their constitution.[13]

While international law may be invoked, as discussed above, the absence of justiciability is a major stumbling block. International law sets forth many policies and ideals, but there is substantial room within India's own legal framework for the right to health and health care to evolve. There needs to be an emphasis on principles, not simply policies, in the laws of India so that health, along with education, social security and housing, can be separately constituted as independent rights.

B. The Current Health Care System

The constitution of India has made health care services largely a responsibility of the state governments, but has left enough maneuverability for the central government. However, the central government has frequently used this maneuverability to expand its sphere of control over the health sector[14], allowing it to play a far more significant role in the health sector than demanded by the constitution. It has pushed various national programs (vertical programs for leprosy, tuberculosis, blindness, malaria, smallpox, diarrhea, filaria, goiters and now HIV/AIDS) in which the states have had little input regarding the design and components of these programs. The states agree to the programs due to the central government funding that accompanies them. In addition, the central government has its own programs of family planning and universal immunization that the states must implement. Indeed, the central government's intervention in the state's domain of health care activities is an important feature to be considered in any analysis of public health care services.

The administrative structure of public health care services in India is two-winged: the Secretariat of the Health Ministry and the Directorate of Health Services. Both of these wings are under the Ministry of Health, the former under the Secretary of the Ministry and the latter under the Director General (Director in States). At the central government level there is a Ministry of Health and Family Welfare with a Department of Health, Department of Family Welfare and Department of Indian Systems of Medicine and Homoeopathy, and the Directorate General of Health Services. The Departments of Health, Family Welfare and ISM&H each have a secretary with a hierarchy of additional, joint, deputy and under-secretaries looking after the various programs of the three departments. This elaborate structure at the central government level

[13] In a judgment on sexual harassment at the work place, in which the CEDAW and Beijing Declaration was invoked, the Supreme Court outlined this approach as follows – Any international convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into these provisions to enlarge the meaning and content thereof, to promote the object of the constitutional guarantee (Vishaka v/s State of Rajasthan, writ petition number 666-70 of 1992, quoted in Toebes, 1998)

[14] The Constitutional provisions (Schedule 7 of article 246) are classified into three lists, including a Concurrent list which both centre and states can govern but the overriding power is with the centre. The list here includes original entry numbers **Central List:** 28.Port quarantine, including hospitals connected therewith; seamen's and marine hospitals 55.Regulation of labour and safety in mines and oilfields **State List:** 6.Public health and sanitation; hospitals and dispensaries 9.Relief of the disabled and unemployable **Concurrent List:** 16.Lunacy and mental deficiency, including places for the reception or treatment of lunatics and mental deficients 18.Adulteration of foodstuffs and other goods. 19.Drugs and poisons, subject to the provisions of entry 59 of List I with respect to opium 20A.Population control and family planning 23.Social security and social insurance; employment and unemployment. 24.Welfare of labour including conditions of work, provident funds, employers' liability, workmen's compensation, invalidity and old age pensions and maternity benefits 25.Education, including technical education, medical education and universities, subject to the provisions of entries 63, 64, 65 and 66 of List I; vocational and technical training of labour.] 26.Legal, medical and other professions 30.Vital statistics including registration of births and deaths. (http://alfa.nic.in/const/schedule.html)

illustrates the extent of involvement of the Centre in what is essentially the sphere of the provincial government. To facilitate interaction between the central government and state governments, there is a Central Council of Health and Family Welfare that is comprised of health ministers and secretaries from each state along with a few nominated members. This council is also the primary advisory and policy-making body for health care in India.

With regards to the Panchayat Raj Acts that seek to decentralize governance, it has been suggested that a large part of the health sector be put under the control of local authorities.[15] However, this change has not yet been implemented and it may prove difficult to do so, especially since fiscal decentralization has not taken place.

C. The Economic and Social Inequities

Poverty is the bane of India. Three-fourths of people live at or below subsistence levels, meaning that 70-90% of their incomes goes to food and related consumption. Only a small section of the population, largely what is called the organized sector, has some form of health insurance coverage. Those working in either the government or private industries can obtain state mandated social security like Employee State Insurance Scheme, Central Government Health Scheme and Maternity Benefit Scheme. A lucky few may also receive it through employer provided health services or reimbursements. It is estimated that about 12% of India's population may be said to have right to health care, at least during the working life of the main earner in the family. (Ellis, Randal et.al, 2000) Ironically, India has one of the largest private health sectors in the world with over 80% of ambulatory care being supported through out-of-pocket expenses. The private sector has virtual monopoly of ambulatory curative services in both rural and urban areas and over half of hospital care. In fact, in 1997 an estimated 68% of hospitals, 56% dispensaries and 37 % of beds were in the private sector.

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[15] An example of the Karnataka Panchayat Act is given here: **Panchayat level :** XVIII. Rural sanitation: (1) Maintenance of general sanitation. (2) Cleaning of public roads, rains, tanks, wells and o ther public places. (3) Maintenance and regulation of burning and burial grounds. (4) Construction and maintenance of public latrines. (5) Disposal of unclaimed corpses and carcasses. (6) Management and control of washing and bathing ghats. XIX. Public health and family welfare: (1) Implementation of family welfare programs. (2) Prevention and remedial measures against epidemics (3) Regulation of sale of meat, fish and other perishable food articles (4) Participation in programmes of human and animal vaccination (5) Licensing of eating and entertainment establishments. (6) Destruction of stray dogs. (7) Regulation of curing, tanning and dyeing of skins and hides. (8) Regulation of offensive and dangerous trades. XX. Women and child development: (1) Participation in the implementation of women and child welfare programmes. (2) Promotion of school health and nutrition programmes. XXI. Social welfare including welfare of the handicapped and mentally retarded: (1) Participation in the implementation of the social welfare programmes, including welfare of the handicapped, mentally retarded and destitute. (2) Monitoring of the old-age and widows pension schemes.
Taluk Panchyat level : XIX. Health and family welfare: (1) Promotion of health and family welfare programmes. (2) Promotion of immunisation and vaccination programmes. (3) Health and sanitation at fairs and festivals. XX. Women and child development: (1) Promotion of programmes relating to development of women and children. (2) Promotion of school health and nutrition programmes. (3) Promotion of participation of voluntary organisations in Women and child development programmes. XXI. Social welfare including welfare of the handicapped and mentally retarded: (1) Social welfare programmes including welfare of handicapped, mentally retarded and destitute. (2) Monitoring the Old Age and Widow's pensions and pensions for the handicapped
Zillah Panchayat level: XIX. Health and family welfare: (1) Management of hospitals and dispensaries excluding those under the management of Government or any other local authority. (2) Implementation of maternity and child health programmes. (3) Implementation of family welfare programmes. (4) Implementation of immunization and vaccination programmes. XX. Women and child development: (1) Promotion of programmes relating to development of women and children. (2) Promotion of school health and nutrition programmes. (3) Promotion of participation of voluntary organizations in women and child development programmes. XXI. Social welfare, including welfare of the handicapped and mentally retarded: Promotion of social welfare programmes, including welfare of handicapped, mentally retarded and destitute. (http://www.kar.nic.in/rdpr/acts-frameset.html)

The private health sector constitutes a strong lobby in India. There is virtually no regulation of this sector. The medical councils only register the qualified doctors and issue them a license to practice. There is no monitoring evaluation, continuing education, price regulation or prescription vetting by either the medical councils or the government. Furthermore, the private health care sector is strongly backed by the private pharmaceutical industry (largely multinational) that also constitutes a powerful lobby, and it is this which has hindered the implementation of progressive policy initiatives, including the recommendations of the Hathi Committee Report.[16] Pharmaceutical formulation production in India is presently worth over Rs. 200 billion and over 98% of this is in the private sector. The private health services and the pharmaceutical industry are organized in such a way to perpetuate one of the most powerful private health sectors in the world. Thus, India has a large, unregulated, expensive and dominant private health sector, and an inadequately resourced, selectively focused and declining quality public health sector, with the former having curative monopoly and the latter carrying the burden of preventive and promotive care.

Most public hospitals are built in cities, but only 25% of the one billion people in India live in such cities. The poor, therefore, must sometimes seek medical attention from the private providers. However, the lack of guidelines regulating the private sector results in a large proportion of under qualified private providers who either have training in other systems of medicine (like the traditional Indian systems ayurveda, unani and siddha) or have no training at all, and these are the providers whom the poor are going to be able to afford. Unfortunately, even more worrisome than the lack of accessible public hospitals is the 30% decline in use of the public health care facilities in both rural and urban areas over the decade. What could be causing this occurrence? Firstly, the cost of seeking treatment in public hospitals has increased over five-fold (in private it is nearly seven), but the purchasing power of the poorer classes has not changed in any substantial way. Secondly, there has been a decline in the investments and expenditures in the public health sector. These trends are closely linked with the economic crisis and subsequent changes since the early 1990s, leading to the privatization of services, deregulation of drug prices and increased reliance on market mechanisms to address welfare needs. (Shukla A, 2001).

Moreover, the public hospitals have a shortage of skilled doctors. It is true that medical education is imparted largely through state owned or funded institutions at a highly subsidized cost to the students. There are 165 recognized allopathic medical colleges in the country producing over 20,000 medical graduates every year; and out of these, 75% are produced in public institutions. However, the outturn from these institutions does not benefit the public health services because 80% of the outturn from public medical schools either joins the private sector or migrates abroad.

The inequities across the classes are severe. The disparity between the top 18% (socio-economically high) households and the bottom 36% (socio-economically low) households is shocking. With respect to the low income households, the infant and child mortality rate is two

[16] The Hathi Committee's recommendations pertained to removal of irrational drug combinations, generic naming of essential drugs, development of a National Formulary for prescription practice.

times greater[17], the incidence of malaria three times greater, the incidence of tuberculosis four times greater and the malnourishment among women in reproductive age-group three times greater while the access to antenatal care is nearly four times less, the number of completed immunization two times less and the rate of childbirth with a doctor four times less. (NFHS-1998).

Disparities also exist between the rural and urban areas. Table 3 shows that India presently has 17,000 hospitals (34% rural), 25,670 dispensaries (40% rural) and about one million beds (23% rural). The rural areas in addition have 24,000 PHCs and 140,000 sub-centers. However, when this data is represented proportionately to its population, it is seen that the urban areas have 4.48 hospitals, 6.16 dispensaries and 308 beds per 100,000 people in sharp contrast to the rural areas that have 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and 44 beds per 100,000 people. The urban hospitals are essentially curative centers, providing outpatient and inpatient services for primary, secondary and tertiary care. Rural hospitals, oppositely, have mostly preventive and promotive services like communicable disease control plans, family planning initiatives and immunization schemes. Curative care programs are the weakest component of the rural health institutions in spite of a very high demand for such services in those areas, and as a result, this demand must be met by either the city hospitals or the private practitioners.

Given this domineering position of the private health sector and the seemingly all-encompassing poverty, one cannot be optimistic about the statistics concerning health in India. In Table 3 there do appear to be substantial improvements in some health rates, including IMR, CBR, CDR and life expectancy, but the position of India globally has not changed significantly vis-à-vis these indicators. In fact, the latest Human Development Report shows a downward trend in India's global ranking[18]. (UNDP, 2002). This decline, along with the slowing of growth of India's human development score, may be linked to the declining investments and expenditures in the public health sector. In the mid 1980s public health expenditure had peaked because of the large expansion of the rural health infrastructure, but after 1986 there was a decreasing amount of both new investments and expenditures being put into the public health sector. (Duggal et.al., 1995 and Duggal, 2002). This decline is in sharp contrast to the unprecedented increase of out-of-pocket spending, most of which goes largely to the private health sector. (see Table 3)

III. Assessment and Recommendations

A. Assessment

According to the General Comment 14 the Covenant 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 the underlying preconditions of health. In fact, the Bhore

[17] It is estimated that 2 million children under 5 years of age die every year because of the high child mortality rate. If the entire country experienced the child mortality rate of Kerala the number of such deaths each year would fall by a whopping 1.6 million (Shukla A, 2001)

[18] India's human development index rank is down from 115 in 1999 to 124 in 2000, though still better than the 1994 rank of 138. India is on the fringe of medium and low HDI group of countries. India's improvement in the HDI in the last 25 years has been marginal from a score of 0.407 in 1975 to 0.577 in 2000 - this works out to an average increase of 1.6% per annum. The slowing down of growth is shown in the table below: (Source: UNDP HDR, various years)

	1975	1980	1985	1990	1995	2000
HDI score	0.407	0.434	0.473	0.511	0.545	0.577
Annual % increase over previous period	--	1.3	1.8	1.6	1.3	1.1

Committee of 1946 (Annex A) outlines similar criteria in their report, though it was not in the "rights" language. However, written policies do not always result in the necessary action, and although these guidelines for the right to health have been written into India's own policy framework, it is important to review where India stands today vis-à-vis these core principles of availability, accessibility, acceptability and quality.

Availability

Health services in India are largely unavailable. The stunted growth of health care staff, resources and facilities has been inadequate, especially considering the growing population and increasing poverty in the country. Unfortunately, public investment in the health sector has been ignoring the areas of critical importance like training doctors for the public sector, lowering the cost of prescription drugs and increasing the number of rural health care centers, and have been focusing instead on educating a substantial number of doctors for the private sector, producing bulk drugs at subsidized rates for private buyers and expanding the curative care options for the urban population. There is a clear link between these patterns of investment and the poor state of India's health care system, as will be examined below.

The investment in medical education has helped to create a mammoth private health sector not only within India, but also in many developed countries. Although 75%-80% of the graduating doctors are educated in public medical schools, approximately 55% choose to work in the private sector while 25% decide to practice abroad. This continued subsidy without any social return[19] is only adding to the burden of inequities and exploitation within India's health care system.

The public sector participation in drug production was a laudable effort, but over the years it became evident that the focus of the scheme had shifted to bulk drug production, and before long most of the supplies were directed to private formulation units at subsidized rates. Although the government originally controlled drug prices, by the mid-1970s the leash on drug prices was gradually released and by the early 1990s the controls had entirely disappeared. Ironically, at the same time the public pharmaceutical industry has also disappeared. With this withering away of public drug production, essential drugs availability has plummeted. Ironically, at the present time while 45% of India's drug production is exported, a substantial amount of the necessary drug requirements must be imported.[20]

The majority of public hospitals are located in urban areas. Although India's ratification of the ICESCR spurred commendable efforts towards increasing hospitals in rural areas through Community Health Centers, the dreams were never realized. The hospitals are understaffed with over 50% fewer doctors than necessary, and they have become virtually ineffective. Today, urban areas do have adequate number of hospital beds at a ratio of one bed per 300 persons, but rural areas have 8 times less 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

[19] Compulsory public medical service for a limited number of years for medical graduates from the public medical schools is a good mechanism to fulfill the needs of the public healthcare system. The Union Ministry of Health is presently seriously considering this option, including allowing post-graduate medical education only to those who have completed the minimum public medical service, including in rural areas.

[20] Data on availability of essential drugs show that in 1982-83 the gap in availability was only 2.7% but by 1991-92 it had walloped to 22.3%. This is precisely the period in which drug price control went out of the window. (Phadke,A, 1998)

infrastructure has developed in the country, thereby depriving the rural population access to curative care services.[21]

Accessibility

Health care must also be accessible. It must be nondiscriminatory and affordable, allowing all people access to the necessary health facilities and relevant information. However, India's system seems to be lacking in each of these areas. Consider the latest data from NFHS-1998:

- Piped water is available to 75% of the urban population, but only 25% of the rural population.
- 50% of the urban population compared to 75% of the rural population does not purify or filter their water in any way.
- Flush and pit toilets are available to 81% of the urban population as opposed to19% of the rural population.
- Electricity for domestic use is available to 91% of the urban households, but only 48% of the rural households.

The statistics above, combined with the statistics from the preceding paragraph, indicate a serious lack of access to the most basic health care services and healthy living conditions. Perhaps even more alarming is the overwhelming disparity between the health services physically accessible to urban dwellers compared to rural dwellers and wealthy individuals compared to poor individuals. Sadly, disparities also exist between social groups. The difference in access to health care amongst the scheduled castes and scheduled tribes as compared to the rest of the population is astonishing. Access to hospital care as per NSS-1996 data shows 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. This data is astonishing in that the situation for these groups is worse in urban areas where overall physical access is reasonably good. (NFHS-1998)

However, physical and nondiscriminatory access to the health care facilities become irrelevant if the provided services are not affordable. All conventions talk about affordability, but they never mention free of charge. Free services are viewed negatively in global debate because it is deemed to be disrespect to individual responsibility with regard to their health care. (Toebes, 1998, p.249) Indeed, there is great pressure on public health systems in India to introduce or increase user fees because they believe this will enhance the efficiency of the public health system and force its users to be more responsible (Peters, et. al.). Such a policy has been adopted in many of the states in India and adverse results can already be seen. There has been a dramatic decline in utilization of public services by the poorest classes, and now their hospitalization rate is six times less than that of the wealthier classes[22]. As a consequence, the wealthy consume approximately three times more of public hospital resources than the poor, even though the poor contribute a disproportionately higher amount of their incomes to access health care services. (NSS-1996; Peters et.al. 2002; Ellis, et.al, 2000; Duggal, 2000; Peters et.al. 2002) To understand this

[21] NFHS-1998 data shows that in rural areas availability of health services within the village was as follows: 13% of villages had a PHC, 28% villages had a dispensary, 10% had hospitals, 42% had atleast one private doctor (not necessarily qualified), 31% of villages had visiting private doctors, 59% had trained birth attendants, and 33% had village health workers

[22] The poorer classes have reported such low rates of hospitalization, not because they fall ill less often but because they lack resources to access healthcare, and hence invariably postpone their utilization of hospital services until it is absolutely unavoidable.

phenomenon, it must be remembered that India's taxation policy favors the wealthier classes. Indirect taxes, which are a regressive form of generating revenues, make up the majority of total tax revenues while direct taxes, like income tax, make up only a small part. The poor end up using a larger proportion of their income on these indirect taxes such as excise duties and sales tax on the goods and services they purchase. Because of these tax policies, it may be argued that the poor have pre-paid for public goods, like health care, from the state. Undeniably, the burden of inequity increases substantially if the poor have to pay for such services when accessing them from the public domain.

India also fails to provide adequate access to information regarding health issues. While data on public health services is available, data on the private sector is conspicuously absent. The private sector, for instance, does not supply data on communicable diseases, even though releasing this information is mandated by law. This practice leads to an inaccurate epidemiological database, dangerously affecting the ability to monitor, contain and prevent certain diseases. Additionally, the local authorities have miserably failed to register and record private health institutions and practitioners, leading to an imprecise estimate of the data quoted regarding the private sector, as occasional studies have shown.[23] The medical councils themselves are not much better. Although they are statutory bodies, they have mismanaged the records of their own members and, even more troublesome, have been unable to regulate medical practices. As a result, there exists a large number of untrained and unqualified persons practicing medicine across India, with some estimating that this group makes up an upwards of 50% of the proportion of the practitioners. (Duggal, 2000; Rhode et.al.1994) The councils feel that they have more pressing concerns than these inaccurate recordings, and so do not make any significant efforts to address this issue. However, even within the current constitutional provisions, this poverty of information could turn into a violation of human rights as lack of such data could jeopardize right to life.

Acceptability and Quality

Lastly, in reference to the criteria of acceptability and quality, India falls deplorably short. As previously explained, there is a clear rural-urban dichotomy in health policy. Urban areas have been provided a somewhat comprehensive health care service through the numerous public hospitals and dispensaries while rural areas have been provided with almost exclusively preventive and promotive health care services. This phenomenon violates the principle of non-discrimination and equity, and so is an important ethical concern to be addressed. Furthermore, many medical practitioners themselves suffer from a complete absence of ethics. Much too often doctors and hospitals allow themselves to be lured by the pharmaceutical industry to prescribe inappropriate and/or unnecessary drugs,[24] and the medical associations have not yet dealt with this important and worsening trend.

[23] A survey in Mumbai in 1994 showed that the offical list with the Municipal Corporation accounted for only 64% of private hospitals and nursing homes (Nandraj and Duggal,1997). Similarly, a much larger study in Andhra Pradesh in 1993 revealed extraordinary missing statistics about the private health sector. For that year official records indicated that AP had 266 private hospitals and 11,103 beds, but the survey revealed that the actual strength of the private sector was over ten times more hospitals with a figure of 2802 private hospitals and nearly four times more hospital beds at 42192 private hospital beds. (Mahapatra, P, 1993)

[24] Data of 80 top selling drugs in 1991 showed that 29% of them were irrational and/or hazardous and their value was to the tune of Rs. 2.86 billion. A study of prescription practice in Maharashtra in 1993 revealed that outright irrational drugs constituted 45% of all drugs prescribed and rational prescriptions were only 18%. The proportion of irrationality was higher in private practice by over one-fifth. (Phadke, A, 1998)

Contributing to the above problems is the fact that India has no standard protocols for its health services, so monitoring quality of them becomes very difficult. The Bureau of Indian Standards has developed several guidelines for hospitals, and while those in the public sector often follow them, those in the private sector generally do not. (BIS, 1989 and 1992; Nandraj and Duggal, 1997) Recently, efforts have been initiated in Mumbai to develop an accreditation system. The central government is already considering the possibility of bringing that system to the national level so that it can promote quality of health care across all of India. (Nandraj, et.al, 2000)[25]

B. Recommendations

After more than half a century of waiting in vain for written policy to assure the people of India a universal and comprehensive health care system, the time has come to adopt a human rights approach to the right to health. The right to health is not a societal obligation, but a claim to an entitlement. It is a positive right that must be fulfilled for everyone, no matter that person's wealth, residence, religion, caste or gender.[26] The human rights approach is the most effective and dependable way to fulfill the obligations mandated by international law and domestic constitutional provisions.

Core Content

International law, specifically the ICESCR and the Alma Ata Declaration, provide the foundations for the core content of right to health. The past actions and current situations of all of the countries are radically different, however, so it seems that there should not be a global core content, but rather a country specific one.[27] India's unique and complicated struggle with health care policy has left it with a particular set of obstacles that must be overcome.

India faces many challenges. It has an overwhelmingly dominant and largely unregulated private health sector, leading to a complete absence of professional ethics and an absolute disinterest in improving the organization, regulation and quality of the health care system. Its severe lack of regulation results in many unqualified and untrained practitioners attempting to practice medicine. The public health sector, meanwhile, provides selective and limited care. It discriminates on the basis of residence, offering an unacceptably small number of programs and services to those who live in rural areas. Declining investments in the public sector and wasteful expenditures due to a lack of standard protocols is only aggravating the problem. Perhaps the most difficult obstacle, however, is the poor state of the underlying determinants of health. A substantial portion of the population has unfiltered water, objectionable sanitation and a shortage of food.[28]

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[25] In Mumbai CEHAT in collaboration with various medical associations and hospital owner associations have set up a non-profit company called Health Care Accreditation Council. This body hopes to provide the basis for evolving a much larger initiative on this front.

[26] A human rights approach would not necessitate that all healthcare resources be distributed according to strict quantitative equality or that society attempt to provide equality in medical outcomes, neither of which would in any case be feasible. Instead the universality of the right to healthcare requires the definition of a specific entitlement be guaranteed to all members of our society without any discrimination. (Chapman, 1993)

[27] Country specific thresholds should be developed by indicators measuring nutrition, infant mortality, disease frequency, life expectancy, income, unemployment and underemployment, and by indicators relating to adequate food consumption. States should have an immediate obligation to ensure the fulfillment of this minimum threshold. (Andreassen et.al., 1988 as quoted by Toebes,1998)

[28] Efforts to prevent hunger have been there through the Integrated Child Development Services program and mid-day meals. Analysis of data on malnutrition clearly indicates that where enrollment under ICDS is optimal malnutrition amongst children is

Given the existing challenges, certain initial steps will be necessary to fulfill the right to health for the people of India. First, directive principles must be firmly linked to fundamental rights through a constitutional amendment. Second, a National Health Act (similar to the Canada Health Act) must be implemented. It will organize the current health care system under a common umbrella organization so that both the public and the private sectors are governed by an autonomous national health authority. This authority will also be responsible for combining all of the financial resources under a single-payer mechanism. Third, a strategy must be developed for pooling these resources deployed in the health sector. Fourth, there must be a redistribution of existing health resources, both public and private, according to yet to be specified standard norms to assure physical equity. Fifth, consensus building must generate a political commitment to securing the right to health.

After the above steps are completed, the State can take the next steps needed to reform the system. First, financial resources should be allocated as block funding on a per capita basis for each population unit of entitlement as per existing norms. This action will redistribute current expenditures and substantially reduce inequities based on residence.[29] Local governments should be given the autonomy to use these resources according to local needs, using a broadly defined policy framework of the public health goals as a guide. Second, local governments should adopt a policy dictating the location of new hospitals as per standard acceptable ratios like, for instance, one hospital bed per 500 people and one general practitioner per 1000 people. Fiscal measures should be instituted to discourage the unnecessary and unhelpful concentration of resources in particular areas.[30] Third, a strict policy should be implemented requiring public service of medical graduates from public medical schools and specifying the minimum amount of public service necessary for admission to a post-graduate institution. This rule will significantly increase the human resources within the public health sector and dramatically improve the credibility of the public health services. Fourth, the medical councils should be held accountable for assuring that only qualified and licensed doctors are practicing.[31] The licenses should not be renewed (as per existing law) if the required hours and certification of the continuing medical education are not complete. Fifth, essential drugs as per the WHO list should be placed under price control (90% of them are off-patent). Adequate amounts of these drugs

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absent, but where it is deficient one sees malnutrition. Another issue is that we have overflowing food-stocks in godowns but yet each year there are multiple occasions of mass starvation in various pockets of the country.

[29]To illustrate this, taking the Community Health Centre (CHC) area of 150,000 population as a "health district" at current budgetary levels under block funding this "health district" would get Rs. 30 million (current resources of state and central govt. combined is over Rs.200 billion, that is Rs. 200 per capita). This could be distributed across this health district as follows : Rs 300,000 per bed for the 30 bedded CHC or Rs. 9 million (Rs.6 million for salaries and Rs. 3 million for consumables, maintenance, POL etc..) and Rs. 4.2 million per PHC (5 PHCs in this area), including its sub-centres and CHVs (Rs. 3.2 million as salaries and Rs. 1 million for consumables etc..). This would mean that each PHC would get Rs. 140 per capita as against less than Rs. 50 per capita currently. In contrast a district headquarter town with 300,000 population would get Rs. 60 million, and assuming Rs. 300,000 per bed (for instance in Maharashtra the current district hospital expenditure is only Rs. 150,000 per bed) the district hospital too would get much larger resources. To support health administration, monitoring, audit, statistics etc, each unit would have to contribute 5% of its budget. Ofcourse, these figures have been worked out with existing budgetary levels and excluding local government spending which is quite high in larger urban areas. (Duggal,2002)

[30] Such locational restrictions in setting up practice may be viewed as violation of the fundamental right to practice one's profession anywhere. It must be remembered that this right is not absolute and restrictions can be placed in concern for the public good. The suggestion here is not to have compulsion but to restrict through fiscal measures. In fact in the UK under NHS, the local health authorities have the right to prevent setting up of clinics if their area is saturated.

[31] For instance the Delhi Medical Council has taken first steps in improving the registration and information sysetm within the council and some mechanism of public information has been created.

must be compulsorily produced or imported so that they are available to and affordable for all people. Sixth, ESIS, CGHS and other employee based health schemes should be integrated with the general public health system so that there is no discrimination based on employment. Such integration will also result in a more efficient use of resources. ESIS, for instance, is a rich organization sitting on funds collected from employees. Their hospitals and dispensaries are grossly under-utilized and could easily be opened up for public use.

Before any of the above steps can be taken, however, the core content of the health care system must be defined. The core content is the minimum level of care, the core entitlement, which should be guaranteed to all members of society. For example, primary care services[32] should include at least the following:

- A general practitioner for personal health care
- First level referral hospital care and basic specialty services
- Immunization services against all vaccine preventable diseases
- Maternity and reproductive health services for safe contraception, abortion, pregnancy, delivery and postnatal care
- Pharmaceutical services to supply the rational and essential drugs as per accepted standards
- Epidemiological services, including surveillance and control of major diseases, with the aid of continuous public surveys and database management
- Ambulance services
- Health education
- Rehabilitation services for the physically and mentally challenged
- Occupational health services with a clear liability on the employer
- Safe drinking water and sanitation facilities along with protection from hunger and a healthful environment to fulfill obligations of underlying preconditions of health[33]

These components of primary care are the minimum that must be assured, and they must be realized before any programs or policies are initiated. They cannot be divided up and accomplished in stages since they are the core content of the health care system. The key to equity is the existence of a decent minimum level of provision.

It is also essential to specify the minimum standards of the health care resources that must be made available to all people regardless of their social, geographical and financial position. There has been some debate on the standards of personnel requirements (that is, the doctor to population ratio, doctor to nurse ratio, etc.) and of facility requirements (that is, the bed to population ratio, the hospital to population ratio), but no global standards have been formulated. The Bureau of Indian Standards (BIS) has supplied their own recommendations regarding the minimum requirements, suggesting a ratio of one doctor per 3.3 beds and one nurse per 2.7 beds. (BIS 1989, and 1992) Interestingly, many years earlier the Bhore Committee of 1946 had published a list of recommendations as well (which at that time were about half that of the levels in developed countries). They were as follows:

[32] Most of atleast the curative services will of necessity have to be a public-private mix because of the existing baggage of the health system we have but this has to be under an organized and accountable health care system.

[33] These services need not be part of the health department or the national health authority that may be created and may continue to be part of the urban and rural development departments as of present.

- one doctor per 1600 persons
- one nurse per 600 persons
- one health visitor per 5000 persons
- one midwife per 100 births
- one pharmacist per 3 doctors
- one dentist per 4000 persons
- one hospital bed per 175 persons
- one PHC per 10 to 20 thousand people depending on the population density and geographical area covered
- 15% of total government expenditure to be committed to health care, which at that time was about 2% of GDP

Government officials and policy makers usually question using the above norms because they believe that the numbers are excessive for a poor country like India and doubt that they have the resources to create that level of health care provision. That reaction is incorrect. Consider the morbidity rate in India. The daily rate is 2% to 3% of the population, meaning that approximately 20-30 million patients are handled everyday and 7-10 billion every year. Assuming that all 30 million will seek outpatient care and that each GP can handle about 60 patients in a day, a little over 500,000 GPs would need to be equitably distributed across the country, resulting in a ratio of one GP per about 2500 people. Currently, India has over 1,300,000 doctors in all of the systems combined, and if those systems can be integrated through a CME program and the doctors redistributed per standard requirements, GP services can be provided in the ratio of one GP per 700-1000 people.

A Suggested Model[34]

The existing system in India is a perfect example of how to *not* to provide services. The private sector is dominant, and the uncontrolled and unregulated environment leads to a decline in the quality and consistency of services. Converting the existing health care system into a system based on the human rights, however, will require government officials and policy makers to make hard decisions and drastic changes. The following sections outline a suggested model for the system which, of course, will need the support of legislation. More importantly, however, these sections introduce ideas that will need to be considered and debated as a definitive structure for the health care system begins to evolve.

Family Practice

Each family medical practitioner (FMP) will attend to 400-500 families; in dense areas this number may reach as high as 800-1000 families while in less populated areas this number may drop as low as 100-200 families. The FMP will examine patients, make diagnoses, give advice, prescribe drugs, make referrals, and give specific services within his/her framework of skills. For each person enrolled, the FMP will get a fixed amount of money from the local health authority, and he/she will be paid separately for specific services (like minor surgeries, deliveries, home-visits, etc.) he /she renders. The FMP can have the choice of being either an employee of the

[34] The following discussion is an updated version based on work done by the author earlier at the Ministry of Health New Delhi as a fulltime WHO National Consultant in the Planning Division of the Ministry.

national health services who receives a salary and other benefits or an independent practitioner who receives a capitation fee and other service charges.

Epidemiological Services
The FMP will receive work in close collaboration with the epidemiological station (ES) of his/her area. The ES will have one doctor with at least some training in public health and a health team comprised of one public health nurse, several public health workers and a support staff. Each ES will serve 10,000 to 50,000 people in rural areas and even up to 100,000 people in urban areas. There will be approximately one health worker for every 2000 people, and there will be one supervisor for every four health workers. The main tasks of the ES will include epidemiological surveillance, monitoring and database management, and when the occasion arises they will also be in charge of taking preventative measures and providing laboratory services. The health workers will form a survey team and carry out all tasks related to all the preventive programs. Along with the FMPs, the health workers will also facilitate health education.

First Level Referral
A hospital at the 50,000 population level will provide basic specialist consultations and inpatient care only on referral from the FMP or ES, except in case of emergencies. General medicine, general surgery, pediatrics, obstetrics and gynecology, orthopedics, ophthalmology and other basic diagnostic services will be available at this hospital. This hospital will have 2 ambulances, 50 beds, the above mentioned specialists, 6 general duty doctors and 18 nurses (for 3 shifts) and other requisite technical (pharmacists, radiologists, etc.) and support (administrative, statistical, etc.) staff as per recommended standards. The hospital will also maintain a standard set of records.

Pharmaceutical Services
Under the existing system, twenty thousand drug companies and over 60,000 formulations characterize the over Rs. 260 billion drug industry in India.[35] While the WHO lists less than 300 drugs as essential for the provision of a decent level of health care. With this recommended health care system, only the essential drugs required for basic care as named on the WHO essential drug list will be made available through pharmacies contracted by the local health authority. Where pharmacy stores are not available within a 2 km. radial distance from the health facility, the FMP will have the assistance of a pharmacist with stocks of all required medicines. Drugs will be dispensed only with the appropriate prescriptions.

Rehabilitation and Occupational Health Services
Each health district will have a center for rehabilitation services for the physically and mentally challenged. Its services will include occupational and physical therapy.

Licensing, Registration and CME
The local health authority will have the power to issue licenses to new medical practices and hospitals. The licenses will be issued according to the guidelines that are established regarding the geographical distribution of doctors and health centers. The local health authority will also

[35] In addition to this there is a fairly large and expanding ayurvedic and homoeopathy drug industry estimated to be over one-third of mainstream pharmaceuticals

register doctors on behalf of the medical council. Renewal of the registration will be linked with the continuing medical education (CME) programs which doctors will have to periodically complete in order to update their medical knowledge and skills. It will be the responsibility of the local health authority, through a mandate from the medical councils, to ensure that nobody without a license and a valid registration is practicing medicine and that the minimum standards set forth by the core content are maintained.

Managing the Health Care System[36]

Every 3 to 5 units of 50,000 of the population, that is every 150,000-250,000 people, will constitute a health district. The district will be under the control of a local health authority, in the form of a committee, comprised of health practitioners, political leaders, representatives from consumer groups and local citizens. Under the supervision of a secretariat, this committee will monitor the general workings of the system, distribute resources, attend to grievances, provide licensing and registration services to doctors and other health workers, implement CME programs in collaboration with professional associations, and assure that minimum standards of medical practice and hospital services are maintained. The first level hospitals, both state owned and privately contracted, will also be under the supervision of this local health authority. The coordination, monitoring and canalization of funds will be controlled by the National Health Authority. It will, in effect, function as a national regulation agency. It will negotiate fees and schedules with doctors' associations, determine the standards and norms for medical practices and hospital care, and maintain and supervise an evaluation system. Furthermore, it will have the responsibility and authority to pool resources for the health care system using various mechanisms of tax revenues and national insurance funds.

Financing the Health Care System

If a health care system is to ensure equity in access and quality, there should be no direct payment by the patient to the provider for the services procured. The provider should be paid through an independent source so that he/she cannot take advantage of the vulnerable patient. An indirect single payer mechanism has many advantages, including its ability to facilitate regulation.

Tax revenues will remain a major source of finance for the health care system, and efforts will be made to push for a larger share of funds for health care from the state exchequer, but resources will be generated from other areas as well. The agricultural sector, for example, is the largest sector in terms of population, and at least 25%-35% of its workers have the means to contribute to the health care system. Some mechanism, either linked to land revenue or land ownership, will have to be designed to facilitate these contributions. Likewise, successful self-employed professionals should make contributions in a similar manner, perhaps in the form of a profession tax. Hopefully, since there will be no user-charges, people will be more than willing to contribute to social security funding pools. Additionally, taxes on harmful products like alcohol, cigarettes, paan-masalas and guthka should be earmarked for the health sector along with any funds gathered through collection boxes displayed at hospitals. Other countries have used these methods to raise money for their health sector, and it is possible that as time passes fund raising methods more unique to and appropriate for the individual communities will be developed. The

[36] The discussion in this paper is restricted to primary care services but they are not the only component of the core content; higher levels of care are needed as support and these already exist to a fair extent though they need to be reorganized. Thus district level hospitals and metropolitan and teaching hospitals are also part of the core content.

collected funds would be pooled under the NHA, and the goal would be to ensure that at least 50% of the families in India are covered under some statutory contribution scheme.

Creating a Consensus

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 health care discussed above civil society will have to be involved in a very large way and in different ways.

Securing the issue of the right to health a place on the political agenda will be a demanding task. The suggestions below do not outline a plan of action, but rather lay out some of the events that need to take place if the battle for the right to health is going to be a successful one.

- Research and develop a detailed framework for the new health care system.
- Hold national and regional conferences on right to health, piquing the interest of a wide array of social action groups.
- Run campaigns on the national and regional level for the right to health.
- File a public interest litigation on right to health to create a basis for constitutional amendment.
- Demand justiciability of directive principles from government officials.
- Lobby medical professionals to gain support in the medical community for this improved system.
- Lobby political parties to incorporate the right to health in their manifestoes.
- Pressure international bodies like WHO and ICESCR as well as national bodies like NHRC and NCW to do effective monitoring of India's state obligations and demand accountability

This list is not an exhaustive one. The objective is to have widespread dialogue, solid documentation, legal discourse and an ever-rising awareness of the right to health.

IV. Conclusion

It is evident that the failing health care system in India is an issue larger than poor government policy making. Given India's complicated history and current economic situation, the policy approach to health never has worked and most likely never will work. The time has come to shift to a rights-based approach. With constitutional provisions, international laws and active discourse, the opportunity exists to create a consensus on the right to health, and ultimately a universal and comprehensive health care system that fulfills that right. Hopefully, this approach is the start to a new and better life in India.

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Annex A **The Bhore Committee:** The Health Survey and Development Committee under the chairmanship of Sir Joseph Bhore and secretary Dr. KCKE Raja, one of the joint secretaries Dr. K.T. Jungalwala and some of well-known members including Dr. J.B. Grant, Dr. B.C. Roy, Pandit P.N. Sapru and Dr. A.L. Mudaliar spent nearly three years in studying the health situation of the country and formulation of a national healthcare plan. The terms of reference of this committee, popularly referred to as the Bhore Committee, were simple: (a) broad survey of the present position in regard to health conditions and health organization in British India, and (b) recommendations for future development (Bhore, 1946, I.1). In formulating its plan for a National Health Service the Bhore Committee set itself the following objectives:

1. The services should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health;
2. These services should be placed as close to the people as possible, in order to ensure their maximum use by the community, which they are meant to serve;
3. The health organization should provide for the widest possible basis of cooperation between the health personnel and the people;
4. In order to promote the development of the health programme on sound lines the support of the medical and auxiliary professions, such as those of dentists, pharmacists and nurses, is essential; provisions should, therefore, be made for enabling the representatives of these professions to influence the health policy of the country;
5. In view of the complexity of modern medical practice, from the standpoint of diagnosis and treatment, consultant, laboratory and institutional facilities of a varied character, which together constitute "group" practice, should be made available;
6. Special provision will be required for certain sections of the population, e.g. mothers, children, the mentally deficient etc.,
7. No individual should fail to secure adequate medical care, curative and preventive, because of inability to pay for it and
8. The creation and maintenance of as healthy an environment as possible in the homes of the people as well as in all places where they congregate for work, amusement recreation, are essential (Bhore, 1946: II.17).

The Bhore Committee further recognized the vast rural-urban disparities in the existing health services and hence based its plan with specifically the rural population in mind. Its plan was for the district as a unit. "Two requirements of the district health scheme are that the peripheral units of the (health) organization should be brought as close to the people as possible and that the service rendered should be sufficiently comprehensive to satisfy modern standards of health administration" (Bhore, 1946: II.22).

The district health scheme, also called the three million plan, which represented an average district's population, was to be organized in a 3-tier system "in an ascending scale of efficiency from the point of view of staffing and equipment. At the periphery will be the primary unit, the smallest of these three types. A certain number of these primary units will be brought under a secondary unit, which will perform the dual function of providing a more efficient type of health service at its headquarters and of supervising the work of these primary units. The headquarters of the district will be provided with an organization which will include, within its scope, all the facilities that are necessary for modern medical practice as well as the supervisory staff who will be responsible for the health administration of the district in its various specialized types of service" (Ibid, II.22).

This health organization would provide integrated health services - curative, preventive and promotive - to the entire population. "The health organization is expected to produce a reasonably satisfactory service for rural and urban communities alike. It is based mainly on a system of hospitals of varying size and of differing technical efficiency. The institutions will play the dual role of providing medical relief and of taking an active part in the preventive campaign" (Ibid. II.30).

What would be the structure of this national health plan? Stated in terms of a ratio to a standard unit of population the minimum requirement recommended by the Bhore Committee was:

- 567 hospital beds per 100,000 population
- 62.3 doctors per 100,000 population
- 150.8 nurses per 100,000 population (Bhore, 1946: III.3-4)

What existed at that time (1942) in India was:

- 24 beds per 100,000 population
- 15.87 doctors per 100,000 population
- 2.32 nurses per 100,000 population (Bhore, 1946: I.13)

In contrast what existed in the UK in 1942 was:

- 714 beds per 100,000 population
- 100 doctors per 100,000 population
- 333 nurses per 100,000 population (Ibid)

We may conclude from the above that the health care facilities that existed in India at the time of the Bhore Committee were embarrassingly inadequate. In fact, most of these were in urban areas and largely in enclaves of the British Civil administration and Cantonments (Jeffery, 1988: 98). What the Bhore Committee recommended was not excessive when we look at the ratio of facilities already existing in the UK even prior to the setting up of its National Health Service.

The Bhore Plan

The organizational structure of the National Health Scheme as envisaged by the Bhore Committee is given below in some detail (Bhore, 1946: II.17-34, III.3-4).

Primary Unit: Every 10,000 to 20,000 population (depending on density from one area to another) should have a 75 bedded hospital served by six medical officers including medical, surgical and obstetrical and gynecological specialists. Six public health nurses, 2 sanitary inspectors, 2 health assistants and 6 midwives to provide domiciliary treatment should support this medical staff. At the hospital there should be a complement of 20 nurses, 3 hospital social workers, 8 ward attendants, 3 compounders and other non-medical workers.

Two medical officers along with the public health nurses should engage in providing preventive health services and curative treatment at homes of patients. The sanitary inspectors and health assistants should aid the medical team in preventive and promotive work. Preferably at least 3 of the 6 doctors should be women.

Of the 75 beds, 25 should cater to medical problems, 10 for surgical, 10 for obstetrical and gynaecological, 20 for infectious diseases, 6 for malaria and 4 for tuberculosis. This primary unit should have adequate ambulatory support to link it to the secondary unit when the need arises for secondary level care.

Each province should have the autonomy to organize its primary units in the way it deemed most suitable for its population but there was to be no compromise on quality and accessibility. Hence, a highly dense province like Bengal may have a primary unit for every 20,000 population but a province like Sind (now in Pakistan) or Central Provinces (now Madhya Pradesh) which have a highly dispersed population may have a primary unit for every 10,000 or even less population unit. The deciding factor should be easy access for that unit of population.

Secondary Unit: About 30 primary units or less should be under a secondary unit. The secondary unit should be a 650 bed hospital having all the major specialties with a staff of 140 doctors, 180 nurses and 178 other staff including 15 hospital social workers, 50 ward attendants and 25 compounders.

The secondary unit besides being a first level referral hospital would supervise both the preventive and curative work of the primary units. The 650 beds of the secondary unit hospital should be distributed as follows :

Medical:		150
Surgical:		200
Ob. & GY.:	100	
Infectious diseases:		20
Malaria:		10
Tuberculosis:	120	
Pediatrics:	50	
TOTAL		650

District Hospital: Every district centre should have a 2500 beds hospital providing largely tertiary care with 269 doctors, 625 nurses, 50 hospital social workers and 723 other workers. The hospital should have 300 medical beds, 350 surgical beds, 300 Ob. & Gy. beds, 540 tuberculosis beds, 250 pediatric beds, 300 leprosy beds, 40 infectious diseases beds, 20 malaria beds and 400 beds for mental diseases. This distribution was based on the epidemiological profile the Committee had constructed based on their enquiry. A large number of these district hospitals would have medical colleges attached to them. However, each of the 3 levels should have functions related to medical education, and training including internship and refresher courses.

In addition to this basic infrastructure the Committee recommended a wide range of other health programs, keeping in mind the special problems that India faced due to its economic and political conditions, which would provide support and strength to this health organization. Certain diseases were singled out for special inputs that would be needed to control and/or eradicate them. They were singled out because they constituted a major problem then. And most of them 54 years later still constitute a major problem in the country. These diseases were malaria, tuberculosis, small pox, cholera, plague, leprosy, venereal diseases, hookworm disease, filariasis, guinea-worm disease, cancer, mental diseases and mental deficiency and diseases of the eye and blindness. For all these diseases the Committee found that facilities are grossly inadequate and need urgent attention - proper sanitation and other public health measures are the key to eradicate or control such diseases (Bhore, 1946: I.88-132). After a thorough review of the prevalence of these diseases a detailed plan to deal with them had been outlined. This plan was to be executed as a part and parcel of the general health services (Bhore, 1946, II.147-212). The Committee also made special recommendation in the area of environmental hygiene, public health engineering, housing, health education, health services for mothers and children, health services for school children, industrial health service, the population problem, medical education and research and vital statistics.

All this shows that the Bhore Committee plan was not only well studied and argued but also comprehensive and suited to the Indian situation. The Committee categorically states, "we are satisfied that our requirements can only be met satisfactorily by the development and maintenance of a state Health Service" (Ibid, II.13). It recommended

that all services provided by the health organization should be free to the population without distinction and it should be financed through tax revenues (Ibid, II.14). It further recommended that the health service should be a salaried service with whole-time doctors who should be prohibited from private practice (Ibid, II.15).

The Bhore Committee ends its report on a clear note of urgency for implementation of the plan in its full form. "The existing state of public health in the country is so unsatisfactory that any attempt to improve the present position must necessarily involve administrative measures of such magnitude as may well seem to be out of all proportion to what has been conceived and accomplished in the past. This seems to us inevitable, especially because health administration has so far received from governments but a fraction of the attention that it deserves in comparison with other branches of governmental activity. We believe that we have only been fulfilling the duty imposed on us by the Government of India in putting forward this health programme, which can in no way be considered as extravagant either in relation to the standards of health administration already reached in many other countries or in relation to the minimum requirements of any scheme which is intended to demonstrate an appreciable improvement in the health of the community. For reasons already set out, we also believe that the execution of the scheme should not be beyond the financial capacity of governments.

"We desire to stress the organic unity of the component parts of the programme we have put forward. Large-scale provision for the training of health personnel forms an essential part of the scheme, because the organization of a trained army of fighters is the first requisite for the successful prosecution of the campaign against diseases. Side by side with such training of personnel, we have provided for the establishment of a health organization which will bring remedial and preventive services within the reach of the people, particularly of that vast sections of the community which lies scattered over the rural areas and which has, in the past, been largely neglected from the point of view of health protection on modern lines. Considerations based on inadequacy of funds and insufficiency of trained workers have naturally necessitated the suggestion that the new organization should first be established over a limited area in each district and later extended as and when funds and trained personnel become increasingly available. Even with such limitations the proposed health service is intended to fulfill, from the beginning and in an increasing measure as it expands, certain requirements, which are now generally accepted as essential characteristics of modern health administration. These are that curative and preventive work should dovetail into each other and that, in the provision of such a combined service to the people, institutional and domiciliary treatment facilities should be so integrated as to provide the maximum benefit to the community. There should also be provision in the health organization for such consultant and laboratory services as are necessary to facilitate correct diagnosis and treatment. Our proposals incorporate these requirements of a satisfactory health service.

"We have drawn attention to these aspects of the health programme because we feel that it is highly desirable that the plan should be accepted and executed in its entirety. We would strongly deprecate any attempt, on the plea of lack of funds, to isolate specific parts of the scheme and to give effect to them without taking into consideration the interrelationships of the component parts of the programme. Our conception of the process of the development of the national health services is that it will be a cooperative effort in which the Centre, acting with imagination and sympathy, will assist and guide a coordinated advance in the provinces. We therefore look forward to a pooling of resources and personnel, as far as circumstances permit, in the joint task that lies before the governments" (Ibid. II.516-517).

This above review provides not only a brief summary of the Bhore committee report but it also lends a contrast to the present level of development of health care services. If the concern of our health policy is universal access to health care with equity, then the above discussion is very relevant even today.

Annex B A review of court cases related to health issues shows that very little has been battled over the general right ot health and healthcare. The largest chunk of cases refer to negligence in medical practice and liability related cases under Law of Torts and the Consumer Protection Act. Supreme Court cases dealing with violation of human rights on health matters have generally used Article 21 - the right to life, as most such cases have been in situations of emergency or extreme distress. And often in the latter the cases are workplace related for the health and safety of workers or their right to medical care. Our search generated only one case where for the general population the right to a functioning primary health centre was obligated by the court (Mahendra Pratap v/s Orissa State). Also there have been a number of cases pertaining to environmental health, like pollution of rivers, air etc.. which violate

preconditions for good health. Below we have extracted selected cases that have used the rights perspective on health related matters:

Access to Healthcare

1. Mahendra Pratap Singh v/s Orissa State : Constitution of India, 1950 - Articles 226 and 227 - Writ of mandamus - Scope of - Prayer is made for issuance direction to take effective measures to run Primary Health Centre at Pachhikote. Held, Keeping in view the entire gamut of facts, considering the public oriented geneson's ad on a conspectus of prevalent scenario direction issued that the Grama Panchayat would comply the formalities by end of December and the Secretary - Health would depute a responsible office to visit the building meant for hospital and thereafter make suitable arrangement for running the P.H.C. Result - Writ application disposed of. **OJC Nos. 6359 of 1995 Date of Judgment : 29/07/1996** (source JUDIS Orissa). *This is probably on the only case in which a judge on right to health for a general population has been given.*

Access to Healthcare by Workers and Right to a Healthy Work environment

1. Bandhua Mukti Morcha v/s Union of India: Constitution of India.-Article 32(1)-Mode of interpreting Article 32 and Article 21 Right to life meaning right to live with dignity as in Francis Mullen v/s Union of India. The petitioner, an organisation dedicated to the cause f release of bonded labourers in the country, addressed a letter to Hon'ble Bhagwati, J. alleging: (1) that there were a large number of labourers from different parts of the country who were working in some of the stone quarries situate in district Faridabad, State of Haryana under "inhuman and intolerable conditions; (2) that a large number of them were bonded labourers; (3) that the provisions of the Constitution and various social welfare laws passed for the benefit of the said workmen were not being implemented in regard to these labourers. The petitioner also mentioned in the letter the names of the stone quarries and particulars of labourers who were working as bonded labourers and prayed that a writ be issued for proper implementation of the various provisions of the social welfare legislations, such as, Mines Act, 1952 Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979, Contract Labour (Regulation and Abolition) Act, 1970, Bonded Labour System (Abolition) Act, 1976, Minimum Wages Act, Workmen's Compensation Act, Payment of Wages Act, Employees State Insurance Act, Maternity Benefits Act etc. applicable to these labourers working in the said stone quarries with a view to ending the misery, suffering and helplessness of "these victims of the most inhuman exploitation." The Court treated the letter as a writ petition and appointed a commission to inquire into the allegations made by the petitioner. The commission while confirming he allegations of the petitioner, pointed out in its report that (i) the whole atmosphere in the alleged stone quarries was full of dust and it was difficult for any one to breathe; (ii) some of the workmen were not allowed to leave the stone quarries and were providing forced labour; (iii) there was no facility of providing pure water to drink and the labourers were compelled to drink dirty water from a nullah; (iv) the labourers were not having proper shelter but were living in jhuggies with stones piled one upon the other as walls and straw covering the top which was too low to stand and which did not afford any protection against sun and rain; (v) some of the labourers were suffering from chronic diseases; (vi) no compensation was being paid to labourers who were injured due to accidents arising in the course of employment; (vii) there were no facilities for medical treatment or schooling. At the direction of the Court, a socio-legal investigation was also carried out and it suggested measures for improving the conditions of the mine workers. HELD: The State Government's objection as to the maintainability of the writ petition under Article 32 of the Constitution by the petitioners is reprehensible. If any citizen brings before the Court a complaint that a large number of peasants or workers are bonded serfs or are being subjected to exploitation by a few mine lessees or contractors or employers or are being denied the benefits of social welfare laws, the State Government, which is, under our constitutional scheme, charged with the mission of bringing about a new socioeconomic order where there will be social and economic justice for every one equality of status and opportunity for all, would welcome an inquiry by the court, so that if it is found that there are in fact bonded labourers or even if the workers are not bonded in the strict sense of the term as defined in the Bonded Labour System (Abolition) Act 1976 but they are made to provide forced labour or are consigned to a life of utter deprivation and degradation, such a situation can be set right by the State Government. Even if the State Government is on its own inquiry satisfied that the workmen are not bonded and are not compelled to provide forced labour and are living and working in decent conditions with all the basic necessities of life provided to them, the State Government should not baulk an inquiry by the court when a complaint is brought by a citizen,

but it should be anxious to satisfy the court and through the court, the people of the country, that it is discharging its constitutional obligation fairly and adequately and the workmen are being ensured social and economic justice**. Date of Judgement: 16/12/83** (Source: JUDIS, Supreme Court of India). *This case might highlight the plight of the stone quarry workers and their bonded status but such is working environment of over half the population of the country.*

2. Paschim Banga Khet Mazdoor Samity v/s State of West Bengal: Constitution of India Article 21 and Directive Principles. The Constitution envisages the establishment of a welfare state at the federal level as well as at the state level. In a welfare state the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. The Government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. 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 violation of his right to life guaranteed under Article 21. In the present case there was breach of the said right of Hakim Seikh guaranteed under Article 21 when he was denied treatment at the various Government hospitals which were approached even though his condition was very serious at that time and he was in need of immediate medical attention. Since the said denial of the right of Hakim Seikh guaranteed under Article 21 was by officers of the State in hospitals run by the State the State cannot avoid its responsibility for such denial of the constitutional right of Hakim Seikh. In respect of deprivation of the constitutional rights guaranteed under Part III of the Constitution the position is well settled that adequate compensation can be awarded by the court for such violation by way of redress in proceedings under Articles 32 and 226 of the Constitution. [See : Rudal Sah v. State of Bihar, 1983 (3) SCR 508 Nilabati Behara v. State of Orissa. 1993 (2) SCC 746: Consumer Education and Research Centre v. Union of India, 1995 (3) SCC 42]. Hakim Seikh should, therefore, be suitably compensated for the breach of his right guaranteed under Article 21 of the Constitution. Having regard to the facts and circumstances of the case, we fix the amount of such compensation at Rs. 25,000/-. A sum of Rs. 15,000/- was directed to be paid to Hakim Seikh as interim compensation under the orders of this Court dated April 22, 1994. The balance amount should be paid by respondent No. 1 to Hakim Seikh within one month. **Date of Judgement: 06/05/96** (Source JUDIS, Supreme Court of India). *This case reflects the right to health care in an emergency situation and state hospitals are duty bound to attend immediately to such patients and cannot refuse medical aid.*

3. CERC v/s Union of India: Constitution of India Articles 21, 38, 39(e), 41, 43, 48-A. This was public interest case filed by Consumer Education and Research Centre on behalf of workers in asbestos mines and industries. The contention was that the employer, the Union government, was obliged to provide protection against work hazards in such work which causes asbestosis as well as carcinoma of the lungs. Using the above provisions of the constitution the Court stated that the employer should have provided protective measures to prevent workers from getting affected by occupational disease. Justice Ramaswamy held that the right to health and medical care to protect the workers health and vigour while in service or post-retirement is a fundamental right of a worker under Article 21 read in conjunction with provisions of Directive principles to make the life of the workman meaningful and purposeful with dignity of person. He further stated that all agencies whether the state or private industry is enjoined to take all such action which will promote health, strength and vigour of the workman during the period of employment and leisure and health even after retirement as basic essentials to live life with health and happiness. (Source: 1995(3) SCC p 42, as quoted in Toebes, 1998). *Another worker's health related judgment specifying the workers right to health and security.*

4. CESC v/s Subhash Chandra Bose: Constitution of India Article 21 and 39 (e), UDHR Article 25 and and ICESCR Article 7(b).This case concerned a litigation between the Calcutta Electricity Supply Corporation and its electrical contractor over who carried responsibility for the workers social security - health and occupational hazards. The contractor claimed that its employees had been employed under the responsibility of CESC and that the employers were covered by the Electricity Act, which included the liability of providing social security. The Supreme Court dismissed the claim, that the immediate employer (contractor) had to be held responsible. In a dissenting opinion Justice Ramaswamy invoked international human rights conventions and Article 39 of the Directive Principles of the constitution which provides for protection of the health and strength of workers. He cited Article 21 stating that the

right to livelihood springs from the right to life as set forth in Article 21. He claimed that medical facilities were part of social security and that the right to health is a fundamental right to workmen. (Source: 1992(1) SCC, p 441 as quoted in Toebes, 1998) *This is perhaps one rare case with regard to health which has invoked the international human rights provisions for right to health and healthcare. But it must be noted that the judgment focused only on this right for the worker and not any citizen.*

There are many more such cases and if needed some more can be added. The above seem to suffice as illustrations to support the discussion in the paper.

Annex C The WHO constitution states the following Principles: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger. Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development. The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health. Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people. Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.- WHO Constitution

"Everyone has the right to a standard of living adequate for ... health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of ... sickness, disability.... Motherhood and childhood are entitled to special care and assistance...." --Universal Declaration of Human Rights, Article 25

"States Parties shall ... ensure to [women] ... access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.... States Parties shall ... eliminate discrimination against women in ... health care ... to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning....; ensure ... appropriate services in connection with pregnancy.... States Parties shall ... ensure ... that [women in rural areas] ... have access to adequate health care facilities, including information counselling and services in family planning...." --Convention on the Elimination of All Forms of Discrimination Against Women, Articles 10, 12, and 14

"States Parties undertake to ... eliminate racial discrimination ... and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, ... the right to public health, medical care, social security and social services...." --Convention on the Elimination of All Forms of Racial Discrimination, Article 5

"States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health...." --Convention on the Rights of the Child, Article 24

In the 1977 World Health Assembly member states pledged a commitment towards a health for all strategy, ".. the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.." (AL Taylor –Making the World Health Organisation Work : A legal framework for universal access to the conditions for Health, American Journal of Law and Medicine, Vol 18 No. 4, 1992, 302). At the International conference which followed in 1978 at Alma Ata this was converted into the famous primary health care declaration whereby Governments would be responsible to the people to assure primary health care for all by the year 2000. Primary health care is "essential health care which is to be universally accessible to individuals and families in the community in ways acceptable to them, through their full participation at a cost the community can afford" (WHO, Primary Health Care, 1978, p. 3) – Alma Ata Declaration on Health For All by 2000

"Health and development are intimately interconnected. Both insufficient development leading to poverty and inappropriate development ... can result in severe environmental health problems.... The primary health needs of the world's population ... are integral to the achievement of the goals of sustainable development and primary environmental care.... Major goals ... By the year 2000 ... eliminate guinea worm disease...; eradicate polio;... By 1995 ... reduce measles deaths by 95 per cent...; ensure universal access to safe drinking water and ... sanitary measures of excreta disposal...; By the year 2000 [reduce] the number of deaths from childhood diarrhoea ... by 50 to 70 per cent..." -- Agenda 21,Chapter 6, paras. 1 and 12

"Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care.... The role of women as primary custodians of family health should be recognized and supported. Access to basic health care, expanded health education, the availability of simple cost-effective remedies ... should be provided...." --Cairo Programme of Action, Principle 8 and para. 8.6

"We commit ourselves to promoting and attaining the goals of universal and equitable access to ... the highest attainable standard of physical and mental health, and the access of all to primary health care, making particular efforts to rectify inequalities relating to social conditions and without distinction as to race, national origin, gender, age or disability...." --Copenhagen Declaration, Commitment 6

"The explicit recognition ... of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.... We are determined to ... ensure equal access to and equal treatment of women and men in ... health care and enhance women's sexual and reproductive health as well as Health." --Beijing Declaration, paras. 17 and 30

"Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life.... Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology.... To attain optimal health, ... equality, including the sharing of family responsibilities, development and peace are necessary conditions." --Beijing Platform for Action, para. 89

"Strategic objective ... Increase women's access throughout the life cycles to appropriate, affordable and quality health care, information and related services.... Actions to be taken: ... Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation...; Provide more accessible, available and affordable primary health care services of high quality, including sexual and reproductive health care...; Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to health services...; reduce maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015;... make reproductive health care accessible ... to all ... no later than ... 2015...; take specific measures for closing the gender gaps in morbidity and mortality where girls are disadvantaged, while achieving ... by the year 2000, the reduction of mortality rates of infants and children under five ... by one third of the 1990 level...; by the year 2015 an infant morality rate below 35 per 1,000 live births.... Ensure the availability of and universal access to safe drinking water and sanitation...." --Beijing Platform for Action, para. 106

"Human health and quality of life are at the centre of the effort to develop sustainable human settlements. We ... commit ourselves to ... the goals of universal and equal access to ... the highest attainable standard of physical, mental and environmental health, and the equal access of all to primary health care, making particular efforts to rectify inequalities relating to social and economic conditions ..., without distinction as to race, national origin, gender, age, or disability. Good health throughout the life-span of every man and woman, good health for every child ... are fundamental to ensuring that people of all ages are able to ... participate fully in the social, economic and political processes of human settlements .... Sustainable human settlements depend on ... policies ... to provide access to food and nutrition, safe drinking water, sanitation, and universal access to the widest range of primary health-care services...; to eradicate major diseases that take a heavy toll of human lives, particularly childhood diseases; to create safe places to work and live; and to protect the environment.... Measures to prevent ill health and disease are as important as the availability of appropriate medical treatment and care. It is therefore essential to take a holistic approach to health, whereby both prevention and care are placed within the context of environmental policy...." --Habitat Agenda, paras. 36 and 128

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