A SOCIO-LEGAL ANALYSIS OF ACCESS TO HEALTHCARE IN INDIA WITH SPECIAL REFERENCE TO STATE OF GUJARAT

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in

LAW

By

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Declaration

This thesis is a presentation of my original research work. Whenever contributions of others are involved, every effort is made to indicate it clearly with due reference to the literature and by acknowledging the contribution of others in the same. The work was done under the abled guidance and supervision of Dr. Meenu Chopra, Associate Professor of School of Law, Lovely Professional University, Jalandhar, Punjab. Prior to that the scholar had worked under the guidance of Dr. Jane Eyre Mathew, Dr. Shailesh Hadli and Dr. Irfaan Rasool.

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In my capacity as supervisor of this candidate, I certify that the above declared statements are true the best of my knowledge.

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Certificate

This is to certify that this thesis entitled "A SOCIO-LEGAL ANALYSIS OF ACCESS TO HEALTHCARE IN INDIA WITH SPECIAL REFERENCE TO STATE OF GUJARAT" submitted to School of Law, Lovely Professional University by Ms. Dhanya.S bearing registration number 11719249 for the degree of Doctor of Philosophy in Law is the bonafide record of original work done by the candidate from the academic year August 2017 to December 2021 under my supervision. This study has not previously formed the basis for the award of any degree, diploma, fellowship or any other similar title. We further certify that the entire thesis represents the independent work of Ms. Dhanya.S and all the research work was undertaken by the candidate under my supervision and guidance.

Dr. Meenu Chopra

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ABSTRACT

The roots of the concept of health can be traced in International Law. The International Law started considering health and healthcare as basic human rights with the enactment of Universal Declaration on Human Rights. Subsequently a number of international instruments touched upon the concept of right to health and healthcare. The turning point in the history of the International Health law was the establishment of World health Organisation. World Health organisation aims to achieve "Highest attainable health to all" and it defines health ad "both mental and physical wellbeing". WHO targets the vulnerable sections of the society and working towards providing better health and quality healthcare to them without any discrimination. Another notable step taken by the international community was the application of Human Right Based Approach in Healthcare, this is to bring universality, inequality, accountability, participation etc. in the healthcare system.

Constitution established India as a welfare state, the paramount function of a welfare state is the wellbeing of its citizens. Without proper health, it cannot be achieved. The Constitution implicitly acknowledges healthcare as a fundamental right under article 21. However, there is no express provision under the constitution providing for healthcare as a fundamental right. It was by declaring right to life as "life with dignity" the judiciary has widened the scope of Article 21 and now anything which adversely impacts life with dignity is a violation to article 21. Hence depriving of someone of healthcare can constitute a violation of article 21 as per the judgement of Hon'ble Supreme Court. In addition to Article 21, there are articles like Article 38, 39 (e), 42, 43, 46 of the Constitution also provides for health and healthcare. In India public healthcare is a state subject under List II Entry 6 of the Constitution, hence the states are shouldered with the primary duty of providing quality healthcare to public. However, there are some health-related provisions under concurrent list on which both Central Government and State Governments can legislate. Currently majority of the healthcare policies and programmes are formulated and implemented by central government with the support of state governments and the local governments. In case of healthcare expenditure majority comes from the state.

Though India recognises healthcare as a fundamental right, the sad reality is that access to quality healthcare without discrimination is a dream to many even in this 21st century. Indian healthcare system is still under the curb of many socio-economic evils. Though the

government of India has taken many steps to ensure "healthcare to all", this has become a myth due to some challenges which are still prevalent in the country. As per the reports the major challenges the country is facing are unequal distribution of healthcare units between urban and rural areas, poor quality, unhygienic conditions, poor infrastructure, lack of healthcare professionals and inequality in access based on gender, region and economic capacity. To some extent the reason for all the aforementioned issues are the low expenditure in Healthcare by the Government.

The country is facing the threat of both communicable and non-communicable diseases. Though a number of programmes are put in place to eradicate many diseases, we are still struggling to eliminate leprosy, polio, malaria etc. The other indicators like IMR, MMR, Malnutrition etc. showed an upward trend but still the ratio is high in the country as compared to many other developing nations. The country is contributing the maximum deaths globally due to poor quality healthcare.

In this study the researcher has adopted a multimethod approach to study this multifaceted issue. The broad objective of this study is to evaluate and understand the current status of the healthcare system in India with special reference to the State of Gujarat. The study aims to understand whether there is any need for uniform healthcare legislation to regulate the standard of healthcare provided by both public and private healthcare units in the country. The specific objectives of the study were to analyse and understand the origin and significance of the right-based approach to healthcare and also the position of International law on right to health; to examine the constitutional vision concerning the right to health envisaged under A.21 of the Indian Constitution and analyse the role of the Judiciary in ensuring quality healthcare accessible and available to the people; to examine the magnitudes of inequalities in the healthcare sector on the grounds of Gender, Geography, and economic status with respect to access, quality, affordability, availability of health care in the state of Gujarat (with special reference to Tribal, Rural and Urban Regions); to explore the initiatives taken by the government of India and the Gujarat government in ensuring proper healthcare to the citizens of India and making quality and affordable healthcare system accessible and available to the people without any neglect and discrimination; to compare the healthcare system of India with the best performing selected countries in the public healthcare sector. (Countries are selected based on their performance in public health care based on the Health Index reports of WHO and UNO reports post

2018. The selected countries are Australia, China, France, United States of America, and Myanmar).

For this study the researcher had adopted both doctrinal and empirical study. For the doctrinal study the researcher had reviewed the primary authoritative sources and the secondary sources and for the empirical study survey was carried out. Data were collected from three categories of respondents namely healthcare consumers, healthcare providers and experts using semi-structured questionnaire, unstructured questionnaire and through Interviews and Focus Group discussions.

The study found that as mentioned by many scholars the public healthcare system of India is still under the curb of many socio-economic issues and challenges. With the expanding population and the outbreak of many communicable and non-communicable diseases, the demand for healthcare is increasing day by day. It is high time for India to invest time, money and brain in healthcare to build a healthier population, which in turn contribute to the development of the nation. There is a need for awareness on the government initiatives, the quality of the hospitals should be improved, the government needs to take care of the shortfall in human resources, concentration should be on achieving AAAQ healthcare, more inclusive approach with attention to develop good health is required.

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This research is conceived by the researcher after coming across the news about death of 60 children in Gorakhpur during August 2017 due to lack of oxygen. This incident has spooked the nation and the researcher. This study was undertaken with an aim to understand the idea of "Right to Healthcare", how the same is understood in India and in state of Gujarat. Currently due to the outbreak of the Covid pandemic and in this era of zoonosis, Communicable and non-Communicable diseases, the topic has got a lot of relevance. This is a noble step taken by the researcher to unveil the current scenario of healthcare in India and Gujarat and also find out the best practices from around the world.

At the outset, I am grateful to Lovely Professional University for accepting my candidature and giving me this opportunity to conduct research on the topic of my interest. I am thankful to all the panellist who have monitored my work and guided me in every interval to make my work a quality one.

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ABBREVIATIONS

AAAQ	Availability, Accessibility, Acceptability and Quality
AMA	American Medical Association
ASHA	Accredited Social Health Activists
BCBS	Blue Cross Blue Shield
CEADW	Convention on Elimination of All forms of Discrimination against Women
CHC	Community Healthcare Centre
CRPD	Convention on the Rights of Persons with Disabilities
DPSP	Directive Principles of State Policy
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HRBA	Human Right Based Approach
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICMR	Indian Council for Medical Research
ICMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
IMR	Infant Mortality Rate
INAP	India New born Action Plan
IPD	In Patient Care
MDG's	Millennium Development Goals
MMR	Maternal Mortality Rate

NFHS	National family Health Survey
NHE	National Health Expenditure
NHM	National Health Mission
NHP	National Health Policy
NHRM	National Rural Health Mission
NIECD	National Institute of Cholera and Enteric Diseases
NUHM	National urban Health Mission
OHCHR	Office of the United Nations High Commissioner for Human Rights
OOP	Out of Pocket
OPD	Out Patient Care
PHC	Primary Healthcare Centre
SC	Supreme Court
SDG	Sustainable Development Goal
SDG	Sustainable Development Goals
TB	Tuberculosis
UDHR	Universal Declaration on Human Rights
UK	United Kingdom
UN	United Nations
UNCRC	United Nations Convention on Rights of Child
UNFPA	United Nations Population Fund
UNHCHR	United Nations High Commissioner on Human Rights
UNICEF	United Nations Children's Fund
UOI	Union of India
USA	United States of America
WHO	World Health Organisations

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CHAPTER 1

INTRODUCTION TO THE RESEARCH WORK

"It is my aspiration that health will finally be seen not as a blessing to be wished for, but as a human right to be fought for."

-UN Secretary General, Kofi Annan

1.1 Introduction

Mr Kofi Annan[1] has rightly pointed out that 'health' is everyone's basic right attained by virtue of birth. Availability of affordable, acceptable, accessible and quality health care is the pre-requirement for maintaining the health of the citizens of the country. A healthy population is an asset of any country as they live longer and contribute towards the socio-economic progress of the country. Health is an inevitable part of our life. For the fullest enjoyment of life, health and health care cannot be overlooked.

Indian Constitution provides for the establishment of a welfare State at both the federal level and state level[2]. It is a clear notion that wellbeing of its citizens is the primary obligation of the government in a welfare state. An effective and efficient health care system is essential for every country to provide care for the sick and introduce various measures like policies, programmes and welfare schemes intending to promote wellness and prevent diseases. Along with an effective public health care system, every country needs to nurture a healthier population, this in return will pay back the nation as there is a direct nexus between the economy of the country and the health of its people. A healthier population contributes towards the economic growth of the nation and only with the development of the economy the standard of life of the people can be improved and human development can be boosted. Thus, when the standard of living and human development are being raised there would be a reduction in health problems.

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[1] Kofi Annan served as the seventh Secretary-General of the United Nations from January 1997 to December 2006 and was a Ghanaian diplomat.

[2] A. 38, Constitution of India 1950.

So, by improving the health sector the country can march towards achieving social and economic justice along with development and prosperity.

Whether the recently developed right based approach to health can be said to be an accurate approach? What was the beginning of this development? These are some of the questions which arise in the mind of researchers of health and healthcare during their research. In addition to these questions, there are many other questions a researcher will come across during his literature review. What is right to Health? Whether law of our country guarantees "right to health" including healthcare to its citizens? Whether the "right to health" or healthcare is enforceable? What are the steps taken by the Government and judiciary to recognise health and healthcare as human rights? What are the government initiatives and the steps taken by the judiciary to improve the health sector? What are the best practices and approach of various other best performing and worst performing nations in relation to public healthcare management?

Research is the search for new knowledge or the search to replace or modify the old knowledge. The main aim of any research is find out the ground issues which are impacting the human life and to arrive at solutions to improve the standard of living of the public and contribute to the public good. Through the present research, the researcher is intending to study the concept of the right to health in India with special reference to the status of access to healthcare in the State of Gujarat. The study also intends to cover the healthcare practices in some of the countries around the world to understand the best practices and the drawbacks in the healthcare system around the world. The study aims to identify the instances of inequalities in access to healthcare in the state of Gujarat based on three major variables gender, region, and economy. In other words through this study, the researcher proposes to ascertain the different dimensions of inequalities in access to healthcare confronted by the public in the state of Gujarat, measure the effectiveness and implementation gaps in Central-state legislations and programs, analyse the role of international law and the Indian judiciary in making health a fundamental human right and finally to examine the public health care system of certain developed and developing nations and to compare them with India. The comparative analysis will help the researcher to make some policy

suggestions to the government to overcome the problems that the present health care sector is facing, which might help in improving the same.

1.2 Background of the Study

The roots of the concept of health can be traced in International Law. Gradually the International Law started considering health and healthcare as basic human rights and was reflected in international documents like Universal Declaration on Human Rights. The right-based approach to health is a widely debated notion. What is meant by the right based approach and what was its beginning? In the words of scholars and eminent jurists through the rights-based approach to health, the international community is aiming to employ international legal obligations to the state framework to create a social justice framework and ensure human rights and development. As defined by the "*Office of the High Commissioner for Human Rights (OHCHR), a rights-based approach is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promote and protect human rights*"[3]. By transforming the essential norms, principles and standards in to blueprints for development, this approach supports the international human rights system. One of the reasons for the development of the right based approach to health can be expressed by borrowing the thoughts of Ronald Dwarkin, who said, "*anything which is categorized as a right would attract more importance*"[4]. Can we agree with Dwarkin and say that the reason for the right-based approach to health is to gain more importance to health and health care or should we disagree with him and critically analyse the concept?

Henry Shue, another philosopher equates basic rights to 'minimal subsistence'. Subsistence means to survive, to have access to minimum conveniences to support oneself. Hence "*minimal subsistence' includes unpolluted air and water, adequate food, clothing and shelter, and minimal preventive health care*"[5]. He had emphasised

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[3] Norman E Bowie, "Catholic University Law Review TAKING RIGHTS SERIOUSLY. By Ronald Dworkin" (1977) 26 18 <https://scholarship.law.edu/cgi/viewcontent.cgi?article=2438&context=lawreview>.

[4] Ronald Dworkin, *Taking Rights Seriously* (Harvard University Press 1977).

[5] Michael Payne, "Henry Shue on Basic Rights" (2008) 9 Essays in Philosophy 220.

the point that the right can be recognised only when it is guaranteed against all possible threats[6]. Most of the 'health and human rights studies' have considered health as a basic human right. The basis of human rights law is that when anything is considered as a right, the same should be excluded from any kind of discrimination and inequality. Hence, we can say, to qualify health as a human right, the same should be kept away from any kind of discrimination. One of the advantages of the right-based approach to health is that it establishes that every citizen of that state should have equal access to that right and compels the government to lay down effective measures to ensure quality, availability, accessibility, and affordability of the said right. This means the minimum standards of that right should be made available to the public irrespective of their gender, place, financial condition, etc.

One of the requirements of rights-based approach is that the government initiatives like policies and programmes must have equality as the core element and should concentrate on vulnerable sections of the society. Goal 3 of Agenda 2030, Sustainable Development Goals (SDG) provides for right based approach too[7]. The SDG goal advocates the "fullest enjoyment of health without any discrimination based on race, age, ethnicity or any other status. As per the goal, the countries are expected to take steps to redress any discriminatory law, practice or policy"[8]. Another feature of the rights-based approach as explained by the World Health Organisation is meaningful participation. As per WHO, participation means "*ensuring that national stakeholders including non-state actors such as non-governmental organizations are meaningfully involved in all phases of programming: assessment, analysis, planning, implementation, monitoring and evaluation*" [9].

The watershed event in the history of the right to health was the establishment of the World Health Organisation (hereinafter referred to as WHO) in the year 1946. Ever

[6] Charles Jones, "The Human Right to Subsistence" (2013) 30 Source: Journal of Applied Philosophy 57.
[7] Transforming our world: the 2030 Agenda for Sustainable Development 2015.
[8] United Nations Organisation Department of Economic and Social Affairs, "Transforming Our World: The 2030 Agenda for Sustainable Development | Department of Economic and Social Affairs" <https://sdgs.un.org/2030agenda> accessed May 6, 2021.
[9]WHO, "Human Rights and Health" (*World Health Organisation*, 2017) <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>.

since the adoption of the Constitution of WHO[10] "*highest attainable standard of health to everyone"* is considered as one of the fundamental human rights by the International Community. WHO in its day-to-day activities is striving to achieve this goal by paying special attention to the poorest and most vulnerable sections of the society. This international organisation is actively engaged in increasing the understanding of human rights to health globally. Later many International conventions and instruments considered health and healthcare as a fundamental human right and directed the member states to ensure access to quality healthcare through different policies and programmes.

1.3 Theoretical Framework

What is health? What can be the most suitable definition of health? WHO defined health as "*a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"*[11]. This definition of WHO has been enlarged to include the ability to lead a "*socially and economically productive life*". The next question in any reader's mind can be what is mental well-being? Mental Well-being can be said to be "*a state of well-being in which every individual realizes his or her potential, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to her or his community*"[12]. The above definitions have helped to develop health thinking beyond a limited, biomedical, and pathology-based approach to the more positive domain of well-being. This step has completely expanded the scope of health and also the responsibility of states to provide access and availability of health and healthcare to its citizens[13]. "***Thus, health can be defined as the complete physical, mental and social wellbeing of the total population in a country with the capacity to lead a socially and economically productive life. Health care should be defined as providing health care to the total population of the county irrespective of gender,***

[10] The World Health Organization is a specialized agency of the United Nations that is concerned with international public health. It was established on 07 April 1948 headquartered in Geneva, Switzerland.
[11] Constitution 1948 (The World Health Organization (WHO)).
[12] World Health Organisation, "Mental Health" (*World Health Organization*, 2014) <http://www.who.int/features/factfiles/mental_health/en/> accessed May 12, 2017.
[13] WHO, "About World Health Organisation" (*1948*) <https://www.who.int/about>.

geographical region, and socioeconomic factors and making quality healthcare available, accessible, and affordable to everyone".

The United Nations human rights mechanism also emphasises the importance of carving the path towards increasing accountability for health. Many health-related matters are directly handled by the "UN General Assembly and the Economic and Social Council". In addition to the above UNFPA[14] and UNICEF[15] are working towards achieving universal health coverage. The United Nations Population Fund's in its vision has pointed that "*every person, in every part of the world, of every nationality, every ethnic origin and religion, both believers and non-believers, of every race, sex and sexual orientation...that every person, whether living with HIV or living with disabilities, whether living in safety, displaced or refugee... that every person can enjoy the full range of human rights to which they are entitled, so they can reach their full potential*"[16]. This organisation is working towards achieving reproductive health and maternal healthcare for all.

Various United Nations health right instruments like the "Universal Declaration on Human Rights (UDHR)[17], International Covenant on Economic, Social and Cultural Rights (ICESCR),[18] United Nations Convention on Rights of Child (UNCRC)[19] and Convention on Elimination of All Forms of Discrimination against Women also have

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[14] UNFP, "United Nations Population Fund" (*UNFP*, 1968) <https://www.unfpa.org/about-us> accessed September 12, 2017. United Nations Fund for Population Activities is a UN organization established in 1969. It gives assistance to nations and people through finance and technology transfer. UNFPA is an organisation of United nation working around the world with an aim to improve the availability of essential medicines and reproductive health services, strengthen health systems, and promote international maternal health standards.

[15] UNICEF, "United Nations Children's Fund" (*1946*) <https://www.unicef.org/about-unicef> accessed August 20, 2017. (United Nations Children's Fund is a UN program that provides humanitarian and development assistance to children and mothers in developing countries).

[16] UNICEF (n 15).

[17] Universal Declaration of Human Rights 1948 (United Nation's Organisation). Universal Declaration of Human Rights, G.A. Res. 217(III) A, U.N. Doc. A/RES/2i7(III) (Dec.10,1948). (Art. 25(1): The article affirms that "everyone has a right to a standard of living adequate for the health of himself and his family, including food, clothing, housing, and medical care and necessary social services".

[18] International Covenant on Economic, Social and Cultural Rights 1967. (GA. Res.2200A (XXI) (Dec.16,1966). (Art.12(1), "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". ICESCR has been ratified by 145 countries (as of May 2002).

[19] The Convention on the Rights of the Child 1989 (United Nations Human Rights Office of High Commissioner). (Art. 24(1). ("States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health").

provisions recognising health as a basic human right (CEADW)"[20]. CEADW is one of the important covenants which offered more emphasis on non-discrimination concerning health[21]. "The International Conference on Primary Health Care Alma-Ata Declaration, 1978" was a turning point in the history of public health. It reiterated health as "*a state of complete physical, social and mental wellbeing and not merely the absence of disease or infirmity"*[22] *This declaration reiterated* health as a fundamental human right like the previous international human right documents and emphasised the point "attainment of the highest possible level of health" and declared it as the most important worldwide social goal. In the opinion of Mary Robinson[23], *"The right to health does not mean the right to be healthy, nor does it mean that poor government must put in place expensive health services for which they have no resources. But it does require governments and public authorities to put in place policies and action plans which will lead to available and accessible health care for all in the shortest possible time".*

In the Indian legal system, the reality is that our Constitution, unfortunately, doesn't have a provision on Part III explicitly guaranteeing Fundamental Right to Healthcare. The Indian Constitution has not expressly included health as a fundamental right, but there are indirect and tacit references to the health of the people. The Constitution is very clear about the role the state has to play in developing the health sector and making it accessible to all citizens of the nation irrespective of grounds of gender, place of

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[20] Convention on the Elimination of all forms of Discrimination Against Women 1979. (Art. 11(l)(f) "States Parties shall take all appropriate measures to eliminate discrimination against women in the enjoyment of the right to protection of health and safety in working conditions, including the safeguarding of the function of reproduction").

[21] Convention on the Elimination of all forms of Discrimination Against Women. (Article 12 creates the obligation of states parties to "take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure...access to health care services, including those related to family planning." Article 14 provides "protections for rural women and their special problems, ensuring the right of women to participate in development programs, to have access to adequate health care facilities, to participate in all community activities, to have access to agricultural credit" and to enjoy adequate living conditions").

[22] International Conference on Primary Health Care, Alma-Ata 1978 (World Health Organisation).) (Declaration I "The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector").

[23] Mary Therese Winifred Robinson is the first women to become the seventh President of Ireland. She also served as United Nations High Commissioner for Human Rights from 1997 to 2002.

residence and socio-economic status. The architects of our Constitution through part IV imposed this duty on the state to ensure social and economic justice to the people of India[24]. As per Entry 6, List II of the Constitution the state governments shall make all necessary legislations to regulate the public health sector. By keeping a few health-related subjects in the concurrent list the framers of the Constitution have kept the doors open even for the centre to govern the health sector by making appropriate legislation[25]. "The Preamble to the Constitution gives a wide-ranging direction to the Indian Republic to take measures to attain justice- all social, economic, and political and also ensure equal status and opportunity to the public." Without achieving adequate and accessible health care and wellbeing of the people, attainment of social justice is impossible[26]. Hence the above-mentioned provisions of the Indian Constitution make it very clear that though there is no direct provision in the Constitution of India which makes health a fundamental right it directs the state to take necessary measures to improve the condition of health and healthcare of the people.

The role of the judiciary in making the right to health accessible to all without any discrimination is of great significance. When the right to life is defined to include life with human dignity[27], health is an inevitable part of it. Depriving someone of his health is a deprivation of his/her right to life guaranteed by the Constitution[28]. The apex court through its judgments is trying to give significance to the concept of health and fetch it within the ambit of article 21. The Supreme court in Vincent[29]judgment has emphasised that "*a healthy body is the very foundation of all human activities……maintenance and improvement of public health have to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends on the building of the society of which the Constitution-makers envisaged. Attending to public health is, therefore, is of high priority, perhaps the one at the top*". The similar opinion

[24] Constitution of India. (Art.39, 42 & 47).
[25] Constitution of India. (Entry 6, List II, 7th Schedule).
[26] Durga Das Basu, *Shorter Constitution of India* (Justice AK Patnaik ed, 15th edn, Lexis Nexis 2017).
[27] *Maneka Gandhi vs Union Of India* [1978] 1 SCC 248 SC; *Munn v. Illinois* [1877] U.S 113.; *Francis Coralie v. Delhi* [1980] 2 SCR 1095 SC.; *Confederation of Ex-servicemen Association v UOI* [2006] SC 2945.

[28] Constitution of India. (Art.21).
[29] *Vincent v. Union of India* [1987] 2 SCR 468 SC.

was given by Supreme Court in another judgement by pointing [30] the apex court held that 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 the welfare State……. 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 the violation of his right to life guaranteed under Article 21*".

The hon'ble Apex court in Paschim Benga judgment "*it is the Constitutional obligation of the State to provide adequate medical services to the people. Whatever is necessary for this purpose has to be done. In the context of the Constitutional obligation to provide free legal aid to a poor accused this Court has held that the State cannot avoid its Constitutional obligation that regards on account of financial constraints. The said observations would apply with equal, if not greater, force in the matter of discharge of Constitutional obligation of the State has to be kept in view……..The failure of hospitals to provide timely medical care to needy person violates his right to life guaranteed by A.21*"[31]. The apex court through its landmark judgement in CERC opined that "*right to health is a meaningful part of the right to life, also said the obligation of the state is not only to promote emergency medical services but also to ensure the creation of conditions necessary for good health, including provisions for basic, curative and preventive health services and assurance of healthy living and working conditions".*[32]
In 1996 in another judgment, the apex court following the CERC decision reiterated health as a fundamental right and also held that this right can be claimed against the state and its instrumentalities and also against the private sector.

The government's role in improving the public health care system is of great significance. The public healthcare sector of India has seen an upward trend since 1950.

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[30] *Kirloskar Brothers Ltd. V. Employees State Insurance Corporation* [1996] 2 JT 196 SC.
[31] *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* [1996] 4 SCC 286 SC.
[32] *Consumer Education and Research Centre v. Union of India* [1995] 3 SCC 42 SC.

In 1940 there has been a suggestion to set up Community health workers for every 1000 of the village population by the Sub-committee on National Health, "National Planning Committee of Indian National Congress. Later in 1952 acting on the Bhore committee recommendations, Primary Health Centres were set up to provide "integrated, promotive, and preventive and curative services" to the entire population. PHC's can be called the cornerstone of rural health care. But the studies are showing that though PHC's are established with huge funding assistance and definite goals, they have failed to achieve the objectives due to many reasons. Many Expert Committees were appointed by Government of India, starting with Bhore Committee in 1943[33], had reviewed the healthcare system including the infrastructure and quality-related challenges that prevailed in the country. The recommendations given by various expert committees included steps to prevent and control both transmissible, non-infectious, and emerging diseases. The government of India already have implemented a couple of programmes on curbing the threat caused by these diseases to the healthcare system. During the 1960s the government set up many institutions with an aim to ensure the quality in education and training, and also to support research in the field of the budding health care system of the country. One of such committee contributed to the healthcare system of the country by making some recommendations to progress the same is the Expert Committees on the Public Health System[34] and the National Commission on Macroeconomics and Health[35]. National Five-Year Plans were one of the main initiatives for planning and developing the country which included many programs for improving the health sector. Some other initiatives by Government of India aimed to improve the public healthcare system were National Health Policies[36] and pogrammes

[33] Joseph William Bhore, "Report of the National Health Survey and Development Committee (Bhore Committee Report)," vol One (1946) <https://www.nhp.gov.in/sites/default/files/pdf/Bhore_Committee_Report_VOL-1.pdf>.

[34] JS Bajaj, "Bajaj Committee Report" (1986) <https://www.nhp.gov.in/bajaj-committee-1986_pg>.

[35] Shri P Chidambaram, "The Commission on Macroeconomics and Health" (2005) <https://www.who.int/macrohealth/action/Report of the National Commission.pdf>.

[36] National Institute of Health and Family Welfare (NIHFW), 'Health Policies' (*National Health Portal, Ministry of Health and Family Welfare (MoHFW), Government of India.*) <https://www.nhp.gov.in/health-policies_pg> accessed 11 January 2018. (National Health Policy 1983, National Population Policy (2000), The National Youth Policy (2003), National Health Policy (2002), National Policy for Persons with Disabilities (2006), National Vaccine Policy (April 2011), National Policy for Containment of Antimicrobial Resistance (2011), NHM Policy Planning (2013), Health Research Policy ICMR 2007, National Health Profile 2005 onwards, Home Based New Born Care

such as Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) programme; Rashtriya Bal Swasthya Karyakram (RBSK); The Rashtriya Kishor Swasthya Karyakram; National TB Control Programme; National AIDS Control Organisation; Mission Indradhanush; National Leprosy Eradication Programme; Ending Open Defection Campaign 2014; Health Policy 2015; Clean India Mission 2015; E-Health program; Ayushman Bharat, Pradhan Mantri Amrutam Yojna; the establishment of Jan Oushadhi medical stores, Pradhan Mantri Swasthya Suraksha Yojana (PMSSY).

The international community also were not behind in recognising the importance of healthcare, their initiatives include "Health for All by 2000, Calcutta Declaration on Public Health in Southeast Asia 1999, UN Millennium Development Goals 2000(UNDP 2000), Global Commission on Macroeconomics and Health 2001, revised International Health Regulations 2005, an Asia Pacific Strategy for Emerging Diseases 2005", etc. are the put in place by the government to improve the public health care system.

As a step towards ensuring "Healthcare for All" "highest attainable standard of health" in 2017 the government of India formulated the National Health Policy 2017. It aims at developing the Healthcare system through concerted policy action in all sectors and expands preventive, promotive, curative, palliative, and rehabilitative services provided through the public health sector with a focus on quality [37],[38]. Finally, the Ayushman Bharat health scheme[39] was launched by Central Government in September 2018 to provide health care facilities to over 10 crore families covering urban and rural poor. As a result of these efforts, the country could build a strong healthcare system. Many

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Operational Guidelines 2014, Kangaroo Mother Care & Optimal Feeding of Low Birth Weight Infants 2014, India Newborn Action Plan 2014 (INAP), National Policy For Containment Of Antimicrobial Resistance- 2011, National Policy for Access to Plasma Derived Medicinal Products from Human Plasma for Clinical / Therapeutic Use National Mental Health Policy 2014, National Health Policy, 2017, National AIDS Prevention and Control Policy are some of the health policies initiated by Government of India).

[37]National Health Policy 2017 (National Health Portal, Government fo India). (Available at http://cdsco.nic.in/writereaddata/National-Health-Policy.pdf (accessed on 11/01/2018). Also, visit http://niti.gov.in/writereaddata/files/document_publication/NHS-Strategy-and-Approach-Document-for-consultation.pdf (accessed on 20/11/2018).

[38]Ministry of Health and Family Welfare, Government of India, National Health Policy 2017. Available at http://164.100.158.44/showfile.php?lid=4275 (Last visited on 18/02/2018).

[39] Ayushman Bharat Pradhan Mantri Jan Arogya Yojana 2018. (accessed on 20/11/2018).

national-level programmes intending to counter, control and eliminate various diseases have been set up in the country. Affordable medicines and tools are now available in many regions of the country which are highly effective when used appropriately.

But the demographic and environmental transitions, population explosion, impacts of globalisation, privatisations, and some other human activities are adding to the burden of diseases in India. The first half of the 20th century and the 21st century, starting from 2019-present, had to undergo severe health challenges like communicable diseases.[40] The current pandemic situation has proved beyond doubt that the country is not prepared to face any health emergencies. There have been studies pointing at the prevailing inequalities in access to healthcare based on geography, gender, economic status, etc. Also, there are inequalities in access to health care due to varying economic, social, and political causes.

1.4 Definitions of Some Important Terms

Before starting with other aspects of health and healthcare, it is very important to define certain terms. They are;

1.4.1 Acceptability

According to the UN Economic and Social Council, "*acceptability means health facilities should be respectful of medical ethics and the culture of individuals and communities, as well as attentive to gender and life-cycle requirements*"[41].

1.4.2 Accessibility

According to United Nations, Economic and Social Council "Access to health involve four key elements namely non-discrimination, physical accessibility, economic accessibility, and information accessibility". In other words, it is the duty of all the state

[40] Benjamin Mason Meier and Ashley M Fox, "Development as Health: Employing the Collective Right to Development to Achieve the Goals of the Individual Right to Health" (2008) 30 Human Rights Quarterly 259.

[41] General Comment 14 on The right to the highest attainable standard of health by The United Nations Economic and Social Council. 2000.

to ensure quality health facilities and services available and accessible to everyone without any discrimination. There shouldn't be any disparity in access to healthcare services based on economic status, place of residence, gender etc.[42].

1.4.3 Affordability

Healthcare affordability is an economic concept. The states should ensure that the availability of economically affordable and quality healthcare facilities and services to the people including access to affordable medicines.

1.4.4 Availability

The term availability includes the availability of healthcare units/centres, human resources, medicines, other facilities including infrastructure and availability of other underlying parameters of health like safe water and sanitisation facilities. As per General Comment 14 on The "right to the highest attainable standard of health" by The United Nations Economic and Social Council, "*States should ensure the provision of enough functioning public health and individual health care facilities throughout their territory, as well as safe water and sanitation facilities, trained and fairly-paid medical professionals, and essential medicines*"[43].

1.4.5 Healthcare System

For this study healthcare system can be defined as the institutions/ organisation of people/ resources in a state/country that deliver healthcare services to the public. This includes both treatment and availability of medicines. According to WHO the "*health*

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[42] General Comment 14 on The right to the highest attainable standard of health by The United Nations Economic and Social Council. 2000. (Available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en).

[43] General Comment 14 on The right to the highest attainable standard of health by The United Nations Economic and Social Council.

system comprises all those organizations, institutions and resources that produce actions whose primary purpose is to improve health"[44].

1.4.6 Inequality

Inequality is a widely discussed notion both nationally and internationally. Oxford advanced learners' dictionary defines inequality as the "*status of not being equal especially in status, rights and opportunities"*. In the case of access to healthcare, the equity should be based on need and not based on socio-economic factors. For this study, the researcher defines equality in access to healthcare as getting access to healthcare without any discrimination based on socio-economic factors like gender, economic status or the area of residence and if there are differences in access to healthcare based on the aforementioned factors, that leads to inequality. Non-discrimination and equality are said to be the foundation of the healthcare system and are the vital elements required to address social determinants impacting the fullest enjoyment of the right to health and healthcare[45].

1.4.7 Primary Healthcare

According to World Health Organisation, Primary Health Care (PHC) means "essential Health Care and the same has to be based on some scientifically proven and socially acceptable methods and technology"[46].

1.4.8 Quality

UN Economic and Social Council defines quality healthcare as "health facilities should be scientifically and medically appropriate and of good quality. In other words, there

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[44] World Health Organisation, "The World Health Report 2003" (2003) <https://www.who.int/whr/2003/en/Chapter7.pdf>.
[45] WHO, "Human Rights and Health" (n 9).
[46] World Health Organisation, "Primary Health Care" <https://www.who.int/news-room/fact-sheets/detail/primary-health-care> accessed May 6, 2021.

should be the provision of necessary medicines and equipment, skilled medical professionals, and adequate water and sanitation”[47].

1.4.9 Right to Health

The World Health Organization defines the right to health as “*a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity*”. Thus for this research, the scholar defines health “*as the complete physical, mental and social wellbeing of the total population in a country with the capacity to lead a socially and economically productive life. Health care should be defined as providing health care to the total population of the county irrespective of gender, geographical region, and socioeconomic factors and making quality healthcare available, accessible, and affordable to everyone”*.

1.4.10 Wellbeing

Well-being covers two aspects as per World Health Organisation, physical health and mental health. We can define the term as the state of being healthy both mentally and physically. For this study, the researcher considers only the physical wellness/physical health of the people.

1.5 The Rationale of the Study

The identified area is of utmost social importance as it addresses the problem of inequalities about the penetration and reach of the healthcare system in our county. The system of healthcare in India is still cursed with irrational, grounds of gender, economy & geography even after 70 years of independence. Achieving equality is one of the goals enshrined in the Constitution and is the objective of any welfare state. Inequalities in any sector would adversely affect this objective and hence it is of great national importance.

[47] General Comment 14 on The right to the highest attainable standard of health by The United Nations Economic and Social Council.

The concept of right to health and healthcare is a key subject for a wide arry of international instruments including treaties, conventions etc., and regional treaties. International law has a broader concept of health, it is not merely healthcare but both healthcare and healthy conditions of life. "World Health Organisation" has proclaimed in its preamble as its main objective is to achieve "highest attainable health for everyone". In addition to WHO, UNFPA, UNICEF, etc. are also working towards improving health and healthcare and attaining global health, hence the topic has some international importance too.

Why should I focus on healthcare amongst other competing priorities? This was the main dilemma the researchers had in mind while choosing this topic for study. As per the Principles and Guidelines for Human Rights approach to poverty Reduction Strategies, ill-health contributes to impoverishment, reduces productivity, lowers educational achievements, and limits opportunities. Because poverty and health are interrelated concepts, poverty leads to malnutrition and thereby ill-health similarly health expenses push people to the grab of poverty. We can say that ill health and poverty are contributory to each other[48]. Good health is the key to create the abilities that the impoverished need to defeat poverty and gain economic security and other human development. Good health is not the outcome but a way of achieving development[49].

Few judgments of Hon'ble Supreme Court, the recent reports of infant Mortality at Maharashtra, UP[50], and Gujarat[51] due to lack of infrastructure, the new step was taken by the Karnataka Government to regulate the Private health care system is few reasons

[48] Principles and Guidelines for a Human Rights Approach to Poverty Reduction Strategies 2006 (Office of the United Nations High Commissioner for Human Rights) 49. (Available at http://www.ohchr.org/Documents/Publications/PovertyStrategiesen.pdf, Accessed on 13/01/2018).
[49] Principles and Guidelines for a Human Rights Approach to Poverty Reduction Strategies.
[50] Haider Naqvi and Rajesh Kumar Singh, "49 Infants Die in Farrukhabad Hospital, Probe Blames Lack of Oxygen" *Hindustan Times* (farrukhabad, UP, September 5, 2017) <https://www.hindustantimes.com/india-news/49-infants-die-in-up-s-farrukhabad-hospital-probe-blames-lack-of-oxygen-dm-and-senior-doctors-transferred/story-JGNxpubfXzCRnluVVUE79I.html>.
[51] Haider Naqvi and Rajesh Kumar Singh, 49 infants die in Farrukhabad hospital, probe blames lack of oxygen, Hindustan Times, Sep. 05, 2017, (Available at https://www.hindustantimes.com/india-news/49-infants-die-in-up-s-farrukhabad-hospital-probe-blames-lack-of-oxygen-dm-and-senior-doctors-transferred/story-JGNxpubfXzCRnluVVUE79I.html (Accessed on 13/01/2018). Also, check http://www.dailymail.co.uk/news/article-4786116/Outrage-mounts-dozens-infant-deaths-India-hospital.html).

which motivated the researcher to choose this Right to Health as the topic for the study. The news about IMR's appeared to be very alarming as even after 70 years of independence, our country is facing a very high infant mortality rate. The people are not assured of their right to health. There is no Universal health coverage in actual practice. The Karnataka government's new law to regulate private hospitals is thought-provoking. Can a state government regulate the private hospitals and make the medical practitioners liable for their negligence? Can there be legislation fixing the fee to be charged by the private medical practitioners? Do we require central legislation to this effect to strike down the malpractices and control the negligence issues? In India despite the progress in access to healthcare, disproportions based on gender, economic ability and geographical area of residence continue to persist. Such discrimination and the challenges of the epidemic and other non-epidemic diseases faced by the Indian population may be due to the lack of quality, availability, and accessibility of the health care system and the unethical practices by hospitals and medical professionals. In this research study, the researcher aims to find out answers to many questions by conducting a combination of Doctrinal and empirical research. The empirical study to be carried out in the different regions of the state of Gujarat, and by which the researcher aims to understand the different facets of health and healthcare problems the public is facing currently, their impacts on individuals, families and the development of the country, the influence of executed policies on the public health sector, the role of the judiciary in recognising the right to health, etc. I would like to agree with Laurie Garrett's while concluding my introduction part, in her book she pointed that the 'central government in India has surrendered its responsibility to maintain the health of billions to the states and more concentrating on developing nuclear weapons. States with little resources and inefficient and corrupt bureaucrats are least bothered about public health. They are concentrating on clinical services than preventing the cause of infectious and other diseases[52]. Through her book, this foreign researcher and author are trying to show us what is the actual position of health in our country. Thus, the growth of public health is the need of the hour. India must give more attention to its public health sector mainly

[52] Laurie Garrett, *Betrayal of Trust: The Collapse of Global Public Health* (Hyperion 2000).

to the causes than the other factors and they should also strive to make health and healthcare available, accessible, and affordable to everyone without any discrimination.

1.6 Literature Review

The literature review is an integral part and the basis of any research. It was only after doing an extensive review of literature the researcher had selected this topic for study. Similarly, the review had helped the researcher to understand the current status, issues and challenges of healthcare in India and the status of healthcare in some of the selected foreign nations. It has helped the researcher to build the foundation of the research and based on the same the researcher was able to understand the shortfalls of studies in this area and formulated the objectives.

Healthcare is a precondition for enjoying the fundamental "right to health" guaranteed by our Constitution. Health, in general, is a complicated concept as it is interconnected with many other external factors. Health is dependent on food, nutrition, pollution-free environment, safe and hygienic living conditions, accessible quality healthcare and so on. As mentioned in chapter 1 healthy population is the asset of a country and it will contribute towards the Gross Domestic Product (GDP) of the country and nation-building. With an objective to study the status of healthcare in India with special reference to the state of Gujarat, the researcher has conducted an extensive literature review to understand the current status of healthcare in the countries around the world, India and specifically the state of Gujarat.

The researcher has classified the literature to the below-mentioned themes;

- International Law, Human Right Based Approach and Right to Health and Healthcare
- Role of Indian Legislature and Judiciary in Recognizing Health and Healthcare as a Human Right
- Status of Healthcare in selected countries of the world
- Healthcare: Current Scenario in India
- Status of Healthcare in Gujarat

- Discussion on Identified Gap

1.6.1 Right Based Approach and Right to Healthcare

UN Common country programme has adopted the human right based approach as the key programming principle concerning guiding UN common country programmes. Before 1997 the UN organizations followed the 'basic needs approach', and in the same, they identified the basic requirements of the beneficiaries and the policies and programmes were made to address the same[53]. Whereas in case of HRBA, the duty bearers develop their capacity to encourage the right holders to claim their rights. secondly to strengthen the capacity of duty-bearers who have the obligation to respect, protect, promote, and fulfil human rights[54].

Hence, we can say that one of the aims of HRBA is the elimination of all forms of discrimination and equality in access to quality and affordable healthcare to the public irrespective of their gender, race, caste, place of residence, economic capacity etc. HRBA to health provides that the policies and programmes concerning health are to be guided by human rights standards and principles. Hence policymakers play a vital role in HRBA and are expected to make policies that are in accordance with human rights standards[55]. The turning point in the International Health Law had been the establishment of the "**World Health Organization"** (hereinafter referred to as WHO). WHO is a United Nations Agency founded in 1948 with an intention to connect nations to promote health and healthcare and also to give special assistance to the vulnerable sections of society[56]. WHO is engaged in the expansion of Universal Health Coverage; it assists countries in case of health emergencies and promotes healthier life across the world. Achieving the highest attainable standard of health is declared as the motto of WHO.

Some of the major work of WHO are shown in the below table;

"Activities Of World Health Organisation	
I.	**For Universal Health Coverage**
a)	Focus On Primary Health Care to Improve Access to Quality Essential Services
b)	Work Towards Sustainable Financing and Financial Protection
c)	Improve Access to Essential Medicines and Health Products
d)	Train The Health Workforce and Advise on Labour Policies
e)	Support People's Participation in National Health Policies
f)	Improve Monitoring, Data and Information.
II.	**For Health Emergencies**
a)	Prepare For Emergencies by Identifying, Mitigating and Managing Risks
b)	Prevent Emergencies and Support the Development of Tools Necessary During Outbreaks
c)	Detect And Respond to Acute Health Emergencies
d)	Support Delivery of Essential Health Services in Fragile Settings.
III.	**For Health and Well-Being**
a)	Address Social Determinants
b)	Promote Inter-Sectoral Approaches for Health
c)	Prioritize Health in All Policies and Healthy Settings.
IV.	**Other Activities Addresses**
a)	Human Capital Across the Life-Course
b)	Non-Communicable Diseases Prevention
c)	Mental Health Promotion
d)	Climate Change in Small Island Developing States
e)	Antimicrobial Resistance
f)	Elimination And Eradication of High-Impact Communicable Diseases".

Table 1: Major Activities of WHO[57]

[53]United Nations Population Fund, "The Human Rights-Based Approach" <https://www.unfpa.org/human-rights-based-approach> accessed September 14, 2021.

[54] "Why a Human Rights-Based Approach?" <http://www.universalhumanrightsindex.org> accessed September 13, 2021.

[55] Human Rights Office of the High Commissioner United Nations and others, "Summary Reflection Guide on a Human Rights-Based Approach to Health for Health Workers" 2.

[56] WHO, "World Health Organization" (1948) <https://www.who.int/about> accessed September 14, 2021.

[57] WHO, "About World Health Organisation" (n 13).

The motto of WHO is "*the enjoyment of highest attainable standard of health to all*" and this agency of UN defines health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*"[58].

The next development in relation to the right to health in international law was the remarkable address of health as a fundamental human right by the "**Universal Declaration on Human Rights"** (hereinafter referred to as UDHR). UDHR under Article 25 explicitly provided that "*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control"*[59]. In this article, UDHR has adopted the theory of minimal subsistence and emphasized the need for making basic rights accessible to the public.

Later on, in 1966 in the "**International Covenant on Economic, Social and Cultural Rights** (ICESCR)" under Article 12 has recognized it as a human right and provided that *"The States Parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*. The Covenant also had given the root map to achieve the same, that includes the state parties shall incorporate provisions for reduction of stillbirth rate in their healthcare policies; improvement of environmental and industrial hygiene; Prevention, control and treatment of communicable and non-communicable diseases and enhancement in access to healthcare[60]. Likewise, the General Comment 14 of the Committee on Economic, Social and Cultural Rights (CESCR) has imposed a duty on the member states to implement provisions to make quality healthcare accessible and available to all at an affordable rate. This document reiterated the fact that the "highest attainable standard of health" is everyone's right and is essential to lead a life with dignity[61].

[58] Constitution of World Health Organisation 1946.
[59] Universal Declaration of Human Rights.
[60] International Covenant on Economic, Social and Cultural Rights 1966.
[61] General comment No. 14: The right to the highest attainable standard of Health 2000.

The international Law had a gender-specific approach in "**Convention on Elimination of All Forms of Discrimination against Women"** (hereinafter referred to as CEDAW). Under Article 12 CEDAW provides for eliminating discrimination based on gender and ensuring equal access to healthcare for women[62]. The article has an extended provision addressing the requirement of appropriate services to be provided to women during gestation, detention and the first six weeks after delivery, as well as adequate nutrition during the period of pregnancy and lactation. The next step of the international community towards attaining the "highest attainable standard of health" was the Alma Ata declaration also called the International Conference on Primary healthcare. This is a milestone in the steps taken by international law in the 21st century in the direction of healthcare. This conference recognized primary healthcare as the key to achieving "health for all". The conference deliberated on the rights and duties of people to participate in decision making and implementation of healthcare[63].

All the above mentioned are the primary authoritative sources of International Law emphasizing the importance of recognizing health and healthcare as basic human rights. There are some secondary sources also available in which philosophers and scholars have expressed their views on HRBA and also on healthcare. One of the important views is given by Ronald Dwarkin requires a discussion here. In his book titled "**Taking Rights Seriously"**, Dwarkin deliberates on due process, both in law and politics. His theory of politics has got its roots in his theory of law and critique of legal positivism. He conceives law in terms of a "right to equality". According to him "*anything which is categorized as a right would attract more importance"*. For him the principle of legal process is to view our relations with others in terms of justice, hence he advocates that the basis of the political process should be the promotion of the general welfare[64]. **Henry Shue** another scholar also had a similar view and he equated basic rights with 'minimal subsistence', which means the minimum requirements to lead a dignified life[65].

[62] Convention on the Elimination of all forms of Discrimination Against Women.

[63] WHO, "Declaration of Alma-Ata" (1978) <https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata> accessed September 14, 2021.

[64] Dworkin (n 4).

[65] Payne (n 5).

In his work "**The Human Right to Health"** Jonathan Wolff conducts an enquiry into the ethical issues involving healthcare practices. In the first chapter Wolff points out that the thinkers and scholars say that there is human right to health but deceased life expectancy and recurring illnesses reported around the world shows that it is a myth or the same is not accessible to public. In words of the author "*providing essential medical care and keeping people free from disease by providing nutrition, clean water, sanitization and decent working and housing conditions are the basis of healthcare*". The author says that it is impossible to attain universal human right to health in the current conditions of the world. The study explains to the readers that health is a complex concept and is dependent on many factors like climate, clean environment, access to healthcare, access to medicines, access to food etc. For him each early deaths happening in the world is due to the wrong decisions by a group of people –decision about policies on basic needs, pricing of medicines, national priorities etc. According to Wolff, the starting point of human right activism is monitoring hence the national governments should pay more attention towards data collection, independent monitoring and evaluation of interventions[66].

In his article **"Interpreting the International Right to Health in a Human Rights-Based Approach to Health"** the author Paul Hunt tries to find out answers for two things namely the methodology adopted by the legal spectrum in interpreting the right to health enshrined in International Law and the relation between right to health and the recently adopted HRBA. After analyzing the scholarly articles on right to health and the development of International Law with reference to the same the author expresses his thoughts on the topic. The author examines evidence showing a rights-based approach to health minimises the international right to health. He examines the extent to which the international right to health includes characteristics that are not shared by other rights in a rights-based approach to health. Because of the significance of these distinguishing characteristics, the author then investigates legal approach for the interpretation. Following a critique of John Tobin's methodology for interpreting the

[66]Jonathan Wolff, *The Human Right to Health* (2012) <https://www.google.co.in/books/edition/The_Human_Right_to_Health_Norton_Global/zcg_cM-vLgQC?hl=en&gbpv=1&printsec=frontcover> accessed September 16, 2021.

international right to health, he proposes that the while remaining within the boundary set by the Vienna Convention on Law of Treaties, the human rights treaties allow for various methods of treaty interpretation. He contends that, as part of a rights-based approach to health, the international right to health should be construed using these diverse methodologies of treaty interpretation. He emphasises in the conclusion of the article that the current movement in human rights and health is from theory to practise, and from broad to specific.[67].

The article titled **"Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences"** is a work in which the authors are discussing the importance of right based approach to development and its vivid aspects. Here the authors Morten Broberg & Hans Otto Sano have acknowledged the support being provided by development cooperations and the non-governmental actors of developing countries towards the right based approach. This paper has addressed the approach, its application, and the central agents and principal components of the same. Participation and inclusion, non-discrimination and equality, and accountability, according to the authors, are three human rights concepts that play a critical role in its implementation. The study demonstrates that, in terms of execution, the strategy is linked to empowerment processes, advocacy forms, and the use of legal instruments to defend groups of impoverished people who are discriminated against. The authors conclude that both "human rights-based approach" and a poverty-oriented approach to development have a role to play, as the former opens up new possibilities for assisting vulnerable populations, while the latter seeks to enhance their standard of life by reducing poverty.[68]

[67]Paul Hunt, "Interpreting the International Right to Health in a Human Rights-Based Approach to Health" [2016] Health and Human rights journal<https://www.hhrjournal.org/2016/12/interpreting-the-international-right-to-health-in-a-human-rights-based-approach-to-health/> accessed September 15, 2021.

[68] Morten Broberg and Hans Otto Sano, "Strengths and Weaknesses in a Human Rights-Based Approach to International Development – An Analysis of a Rights-Based Approach to Development Assistance Based on Practical Experiences" (2018) 22 International Journal of Human Rights 664 <https://doi.org/10.1080/13642987.2017.1408591>.

Another approach suggested by authors of "Development as Health: Employing the Collective Right to Development to Achieve the Goals of the Individual Right to Health" is that through development processes that strengthen public health systems, the human right to development can be used as a tool to address underlying determinants of ill-health. The study examines evidence of public health deterioration, drawing connections between poverty and illness as well as development and public health institutions. The paper also looks at current public health responses to globalisation, analysing how the individual human right to health, as part of a rights-based approach to development, has failed to prevent the harmful consequences of neoliberal development, and discussing the rise of a collective right to development, chronicling its evolution in human rights jurisprudence and interdisciplinary research. The authors conclude by emphasising the need of utilising the right to development to ensure that development policies help states achieve the highest possible standard of health by tackling underlying health determinants and strengthening national public health systems.[69]

However, it has been found that there is steady improvement in the healthcare system across the world where ever HRBA to healthcare has been adopted. In India though it is not free from issues and challenges, there are remarkable improvement in the healthcare due to the adoption of HRBA to healthcare.

1.6.2 Initiatives towards Recognizing Health and Healthcare as a Human Right by Judiciary and Legislature of India

In India due to the support of the government and judiciary health and healthcare have reached a long way. After independence India witnessed a systematic approach to healthcare. The initiatives of government and judiciary are remarkable. However, due to the complex nature of the topic and also due to the challenges thrown by external factors, the country is still struggling to achieve the goals fixed by SDG. "**The Constitution of India"** doesn't have specific provisions on right to healthcare, however, the Constitution under many other provisions recognizes public healthcare as one of the duties of the government. The realm of Article 21 is widened with the

[69] Mason Meier and Fox (n 41).

judgement of Maneka Gandhi in 1976, and later on life is defined as life with dignity. This had opened the flood gates for several related rights which are necessary to lead a dignified life to be part of A. 21. The Article provides for the "Right to life and personal liberty". As per the provision, "No person shall be deprived of his right to life and personal liberty except according to the procedure established by law"[70], which means the article prohibits the deprivation of the right to life, both directly or indirectly, except based on a procedure established by law.

Later in "**Francis Coralie Mullin**" Judgement, Hon'ble Justice P. Bhagavati pointed that A. 21 *"embodies a Constitutional value of supreme importance in a democratic society"*, it is the *"the procedural Magna Carta protective of life and liberty"* added Hon'ble Justice Krishna Iyer[71]. In **"Kharag Singh"** the Hon'ble court observed that "*By the term 'life' as here used, something more is meant than mere animal existence. The inhibition against its deprivation extends to all those limbs and faculties by which life is enjoyed. The provision equally prohibits the mutilation of the body by amputation of an armoured leg or the pulling out of an eye, or the destruction of any other organ of the body through which the soul communicates with the outer world[72]".* Subsequently in several judgements like Sunil Batra[73], Bandhua Mukti Morcha[74], Peoples Union for Democratic Rights[75] etc., the court emphasised on the importance of the concept life with dignity and upheld the judgement in Maneka Gandhi.

The Constitution under part IV imposes certain duties to the state namely under **Article 39 (e)**, the Constitution says *"The State shall, in particular, direct its policy towards securing that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength"[76]*. Likewise **Article 42** provides for

[70] Article 21, The Constitution of India 1950.
[71] *Francis Coralie Mullin Vs Administrator, Union Territory of Delhi* [1981] 2 SCR 516 SC.
[72] *Kharak Singh v State of Uttar Pradesh* [1964] 1 SCR 332 SC.
[73] *Sunil Batra v Delhi Administration* [1980] 2 SCR 557 SC.
[74] *Bandhua Mukti Morcha vs UOI* [1984] 2 SCR 67 SC.
[75] *People'S Union for Democratic Reforms . vs Union Of India & Others* [1983] 1 SCR 456.
[76] Article 39 (e); The Constitution of Indi 1950.

"Just and human conditions of work and maternity relief to workers"[77] and under **Article 47** the Constitution reads as *"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"*[78]. Under **List II**, the Constitution empowers the state governments to make all necessary legislations to regulate the public health sector[79]. Also, the framers of the Constitution have kept certain health-related subjects in the concurrent list and kept the doors open even for the centre to govern the health sector by making appropriate legislation[80].

Post independent India witnessed a new phase of organised healthcare approach by enacting new legislations, modifying colonial legislations and also following the precedents set by the higher judiciary of the country. The initiatives taken by the **judiciary** in making quality healthcare accessible and available to the public at an affordable rate is praiseworthy. The Hon'ble Supreme Court while interpreting Article 21 in various judgements made it beyond doubt that "right to life guaranteed under A 21 includes right to health and medical care. In "**State of Punjab v. M.S. Chawla",** the apex court held **"***It is now settled law that right to health is an integral to right to life. Government has Constitutional obligation to provide the health facilities"*[81]. In "**Consumer Education and Research Centre v. Union of India"** the court expressed the workers right to health is an integral part of Article 21. The court cited Article 38[82],

[77] Article 42; The Constitution of Indi1950.
[78] Article 47; The Constitution of India 1950.
[79] Entry 6, List II; The Constitution of India 1950.
[80] Entry 26, list II; The Constitution of India 1950.
[81] *State of Punjab v M.S Chawla* [1996] 113 PLR 499 SC.
[82] A 38 provides for "State to secure a social order for the promotion of welfare of the people"

39(e)[83], 42[84], 43[85], 46[86] to support the decision[87]. Another notable decision which acknowledged health as a fundamental right was "**Paschim Banga Khet Mazdoor Samity v. State of West Bengal".** In this judgement the apex court held that "*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*"[88].

As mentioned above, the **Government of India** also played a vital role in improving the healthcare system. The government has been working towards achieving highest attainable standard of health and to make it available to public since independence. Some of the legislations enacted by the government of India to ensure quality healthcare accessible, acceptable and available at an affordable rate are as follows;

Legislations governing the qualification, practice and conduct of medical professionals aims to ensure that the staff working in the public healthcare sector is having enough qualification and are authorised to perform the technical duties. Some of such legislations are "The Medical Council Act 1956[89]; Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002[90]; Indian Medical

[83] A 39 (e) states that "the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength"
[84] A 42 provides for "The State shall make provision for securing just and humane conditions of work and for maternity relief."
[85] A 43- "The State shall endeavour to secure, by suitable legislation or economic organisation or in any other way, to all workers, agricultural, industrial or otherwise, work, a living wage, conditions of work ensuring a decent standard of life and full enjoyment of leisure and social and cultural opportunities and, in particular, the State shall endeavour to promote cottage industries on an individual or co-operative basis in rural areas".
[86] A 46- "The State shall promote with special care the educational and economic interests of the weaker sections of the people, and, in particular, of the Scheduled Castes and the Scheduled Tribes, and shall protect them from social injustice and all forms of exploitation".
[87] *Consumer Education and Research Centre v. Union of India* [1995] 3 SCC 42 SC.
[88] *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* [1996] 4 SCC 286 SC.
[89] The Indian Medical Council Act, 1956.
[90] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 (Published in Part III, Section 4 of the Gazette of India, dated 6th April, 2002) MEDICAL COUNCIL OF INDIA NOTIFICATION 2002.

Council (Professional Conduct, Etiquette and Ethics) (Amendment Regulations) 2020[91]; The Indian Medical Degrees Act, 1916[92]; Indian Nursing Council Act 1947[93]; The Pharmacy Act, 1948[94]; The Dentist Act, 1948[95] etc". All these legislations provide for the establishment of councils for regulating the qualification of the respective medical staff. Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 defines the essential professional conduct which is expected from a medical practitioner, the act has provisions defining the duties, roles and responsibilities to be played by a medical practitioner and also prohibition on certain acts which are not to be performed while practising the profession.

Legislations on Quality of Healthcare services and facilities: In India, there is no uniform law to regulate the quality of healthcare services and facilities whereas there are various legislations indirectly governing the same. Some of the important legislations are as follows; "All India Institute of Medical Sciences Act, 1956; The Post Graduate Institute of Medical Education and Research, Chandigarh Act, 1966[96]; Bureau of Indian Standards Act 1986 and Rules, 1987[97]; National Institute of Pharmaceutical Education and Research Act, 1998[98]; The Clinical Establishments (Registration and Regulation) Act, 2010[99]". All these legislations were enacted to establish the institutions of National importance and also to monitor and maintain the standard of medical education in India.

Legislations on Disease Control and Medical Care: Disease control and care are one of the important aspects of the right to healthcare. Epidemics needs to be controlled in order to prevent its spread. Similarly, there have to be legislations governing do's and don'ts of certain aspects of healthcare too. The given legislations are some of the tools enacted in India to deal with disease control and medical care - "Epidemic Diseases Act, 1897; Indian Aircraft Act and Rules, 1934 &1954; Indian Port Health Rules, 1955;

[91] Indian Medical Council (Professional Conduct, Etiquette and Ethics) (Amendment Regulations) 2020.
[92] Indian Medical Degrees Act, 1916.
[93] Indian Nursing Council Act 1947.
[94] The Pharmacy Act, 1948.
[95] The Dentist Act, 1948 (16 OF 1948).
[96] The Post Graduate Institute of Medical Education and Research, Chandigarh Act, 1966.
[97] The Bureau of Indian Standards Act, 1986.
[98] National Institute of Pharmaceutical Education and Research Act, 1998.
[99] The Clinical Establishments (Registration and Regulation) Act 2010.

Medical Termination of Pregnancy Act, 1971 &1975; The Mental Health Act, 1987; Transplantation of Human Organs Act and Rules, 1994, 1995 & 2002; Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act and Rules, 1994, 1996, 2002, 2003" etc.

In addition to the aforementioned legislations, the Government of India at every interval appointed different commissions to study the effectiveness of public healthcare and suggest improvements. Which include the Bhore Committee appointed by Indian National congress during 1943-1946; "Mudaliar Committee (1961) appointed by the Government of India to review the progress made in the health sector after implementing the recommendations by Bhore Committee; Chaddah committee (1964); Mukerjee committee 1965; Jungalwalla Committee 1967; Kartar Singh Committee 1973; Shrivastav Committee 1975; Shivaraman Committee; Bajaj Committee 1986; Krishnan Committee 1992 etc. The government also had implemented various specific policies to deal with different aspects of healthcare. Some of them are National Health Policy 1983, National Population Policy (2000), The National Youth Policy (2003), National Health Policy (2002), National Policy for Persons with Disabilities (2006), National Vaccine Policy (April 2011), National Policy for Containment of Antimicrobial Resistance (2011), NHM Policy Planning (2013), Health Research Policy ICMR 2007, National Health Profile 2005 onwards, Home Based New Born Care Operational Guidelines 2014, Kangaroo Mother Care & Optimal Feeding of Low Birth Weight Infants 2014, India New born Action Plan 2014 (INAP), National Policy For Containment Of Antimicrobial Resistance- 2011, National Policy for Access to Plasma Derived Medicinal Products from Human Plasma for Clinical / Therapeutic Use National Mental Health Policy 2014, National Health Policy, 2017, National AIDS Prevention and Control Policy" etc.

Currently there are many programmes, schemes and policies implemented by both central government and state governments in place intending to fill the gap in access to healthcare based on many barriers. However, these initiatives could not achieve the end goal as the Indian society and the healthcare are very complex concepts.

1.6.3 Healthcare in selected countries of the world

In different countries the healthcare system is different. The public healthcare spent, quality, infrastructure, technology and other resources all differs from country to country. Some of the developed countries have achieved Universal Health Coverage and have a better system with quality, accessibility, acceptability and affordability in place where as other developing and low-income countries are still struggling with every aspect of healthcare. In the present study the researcher had reviewed some of the scholarly articles and books on healthcare system of some countries to understand the status of healthcare in those regions.

The article titled "**What is a human rights-based approach to health and does it matter?**" is a work showing healthcare status of South and Southern Africa. Through this research, the author aimed to examine South and Southern Africa's research and policy development activities, as well as how the health crisis links with concerns of social justice and human rights. The author opens the article by emphasizing the importance of the right based approach to health. According to him '*right-based approach to health is essential to deal with the inequalities persisting in healthcare globally'*. He strongly points out that the inequalities in health and economic development are pervading the development trajectory of the countries globally. He proposes the right-based approach to health as a remedy because of this. According to the study, states desire and ability to meet Constitutional commitments relating to the right to health are influenced by different perceptions of what human rights encompass. According to the research, new methods to health policy formulation are needed that draw on the agency of disadvantaged groups, link local conflicts to global contexts, and clearly incorporate rights frameworks into public health planning. The author finishes the piece by stating that new thinking in the interaction between civil society and governments is critical. He advocated a human rights framework that respects the state's and its parties' and shared interests in attaining the right to health, as well as the interests of users, communities, and civil society. In his words, there should be a shift in the general approach of penalizing the individual health professionals and shouldering them with all accountability in case of issues to collectively working towards achieving

this goal of the right to healthcare. These are the solutions put forwarded by the author to the violations of human right to health [100].

"The Quality of Medical Advice in Low-Income Countries" is a study of quality of healthcare in four middle- and low-income countries namely India, Indonesia, Tanzania, and Paraguay. The authors give comprehensive evidence in this study to demonstrate that isolated instances indicate common patterns. The study discovered that, as assessed by what doctors know, the quality of treatment in low-income nations is very low, and that the problem of low competence is exacerbated by low effort, with doctors providing lower standards of care for their patients than they know how to offer. The study was based on case studies conducted in the selected countries and also by applying observation method. By this study the authors are highlighting another challenge in the healthcare sector i.e., the attitude of the medical practitioners. The study concluded that traditional measures of health-care quality in low-income countries, which are based on physical infrastructure and sometimes the availability of specific drugs, are woefully inadequate; however, vignettes and direct observation can be used to assess the quality of medical advice. The study concluded that poor quality is caused by a combination of low competence and low effort on the part of medical professionals. [101].

"The Right to Health a Multi-Country Study of Law, Policy and Practice" is an interdisciplinary study which analyses the relation between of human rights law, health law, and public health. The writers of this book examine how states at the national level implement the internationally proclaimed human "right to health." Scholars from more than 10 nations were brought together for this study, with each examining the right to health in their own country or region. They're all focused on a topic that's essential to their country, such as health inequality, the Millennium Development Goals, or healthcare privatization. The authors through this book have revealed to the world the

[100] Leslie London, "What Is a Human Rights-Based Approach to Health and Does It Matter?" (2008) 10 Health and Human Rights Journal 65 <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2469/2013/07/6-London.pdf>.
[101] Jishnu Das, Jeffrey Hammer and Kenneth Leonard, "The Quality of Medical Advice in Low-Income Countries," vol 22 (2008).

realities in right to healthcare prevailed in Africa, Asia, Arab World, America and some parts of Europe. The book in detail discussed the complex web of challenges coming in way of right to healthcare and preventing it from achieving the benchmarks set by MDGs. The work acknowledged that the ratification of many international documents providing for right to health and healthcare and the implementation of HRBA has brought great changes in the system of healthcare in the above-mentioned countries. The book was helpful to understand the perceptions of authors about the healthcare system of their respective countries[102].

Laurie Garrett in her book "**The book 'Betrayal of Trust: The Collapse of Global Public Health"** claims that "public health is a public good". The government and international agencies, according to the author, have a responsibility to safeguard communities from contagious diseases and environmental hazards, as well as to provide disadvantaged people with access to medical care. The "betrayal of trust" is a critique of public health failings and vulnerabilities in a number of countries. The inability of national and international level institutions to fulfil these tasks has resulted in the collapse of global public health, as the title of the book suggests**.** She uses examples of epidemic control failures in developing nations, the collapse of public health in the former Soviet Union, and the deterioration of public health infrastructure in the United States to demonstrate her point. Garrett chronicles the disintegration of public health in the former Soviet Union, which has seen resurgent diphtheria, the advent of multi-drug-resistant tuberculosis, and exploding HIV and hepatitis epidemics attributable to intravenous drug addiction. According to the author punitive, authoritarian, and outdated disease control methods were used in the former Soviet regime. Under communist rule, infant and adult mortality rates rose, and the fall of communism resulted in the implosion of an already anarchic system, lowering adult life expectancy even further. Russia's current economic crises and disarray provide little chance for reform, and the country's illness issues constitute a threat to the rest of Europe. Garrett correctly underlines increasing challenges to public health as a result of globalisation,

[102] Obiajulu Nnamuchi Brigit Toebes, Milan M. Markovic, Rhonda Ferguson, *The Right to Health: A Multi-Country Study of Law, Policy and Practice* (TMC Asser Press 2014) <https://www.google.co.in/books/edition/The_Right_to_Health/HzNwBAAAQBAJ?hl=en&gbpv=1&printsec=frontcover> accessed September 16, 2021.

in which air travel and food importation from developing countries enhance the spread of infectious diseases. At a time when the infrastructure for disease surveillance and control is eroding, emerging illnesses such as HIV, the development of antibiotic-resistant bacteria and foodborne outbreaks, and the risks of biologic warfare and bioterrorism pose international problems.[103].

1.6.4 Access to Healthcare an Indian Scenario

To study and understand the present status of healthcare scenario in India, it was essential for the researcher to review all the available studies in to the healthcare system of the country. For the same the researcher had considered the journal articles, books and reports of governmental and non-governmental organizations on various aspects of healthcare.

In an observational study titled "**Gender differences in healthcare-seeking during common illnesses in a rural community of West Bengal, India"** researchers looked at gender differences in seeking medical help and managing diarrhea, acute respiratory infections, and fever at home among 530 children under the age of five in a rural community in West Bengal, India. The data were examined using both bivariate and multivariate approaches, and the methodology used was empirical. The research was carried out in a cluster of four villages 10 kilometers from Kolkata (Calcutta), which serve as the National Institute of Cholera and Enteric Diseases (NICED) of India's test site. There are 1,500 families in the area, with a total population of 7,000 people. This research uncovered the widespread discrimination against female children seeking medical care. The author cited an Indian survey to demonstrate that there are significant regional variances across the country, with Orissa, Haryana, and Punjab being the worst affected. The author also cited data from several nutritional and ethnographic research conducted in various parts of India, which revealed gender inequality. This practice is reported to be widespread in North India's plains, but not in the rest of the country. Preferential feeding for girls is not widespread in the hills of northern India. Outside medical help was sought in 32.6 percent of boys' episodes versus 22.4 percent of girls'

[103] Garrett L, Betrayal of Trust: The Collapse of Global Public Health (Hachette Books 2015).

episodes. Hospital statistics from across India found that the number of boys and girls admitted to the hospital for treatment was more evenly distributed in the north. Such a gender divide was uncommon in the South. The quality of care provided differed as well. Boys were more frequently referred to qualified doctors from nearby metropolitan facilities than girls. For both boys and girls, there were differences in the time it took to seek therapy and the amount of money spent on it.[104].

"**Politics of Rural Health in India**" is a work of Shri D. Banerji aimed where the author looks at the public healthcare history of the country. Through this article, the author tries to highlight some of the serious shortfalls in the formulation of the National Rural Health Mission (NRHM). The limited political commitment to improving rural health services has confined it to the National Rural Health Mission (NRHM) which is primarily concerned with addressing some minor concerns that have hampered the development of rural health care. While the UPA bemoaned the fact that India is among the world's bottom five countries in terms of government health spending. The proportion of GDP spent on healthcare was just 0.9% in 2005, it failed to examine the politics of the constant drop in the percentage over time. The same considerations have led to a glossing over of the fact that, while public health expenditure accounts for 70-90 percent of overall health expenditure in wealthy European countries, it accounts for only approximately 20% in India. The government's moves towards globalization further accelerated this trend towards the commodification of medical services. He had appreciated NRHM for attempting to take a 'bottom-up approach to development. He went on to criticize the implementation gap in the programmes by giving special mention to Community Health care Centers for not fulfilling the minimal grades set up by Indian Public Health Standards (IPHS) of task group III[105].

"**Health Care Case Law in India"** is a work has deliberations on Constitutional recognition and judicial pronouncements on matters of right to health in India. These precedents lay the groundwork for the right to health care and can be used to support

[104] Aparna Pandey and others, "Gender Differences in Healthcare-Seeking during Common Illnesses in a Rural Community of West Bengal, India" (2003) 20 Journal of Health Population and Nutrition 306.
[105] D Banerji, "Politics of Rural Health in India." (2005) 40 Economic and Political Weekly 3253 <http://www.jstor.org/stable/4416927>.

future public interest litigation in a variety of areas. The goal has also been to simplify the laws and make information more accessible to the general public, so that the judgements may be utilized to effectively demand the right to health care. Although knowledge of these decisions does not guarantee that they will be implemented quickly, it is critical for future action and the development of future legal and non-legal measures aimed at realizing the right to health. While concluding the authors have suggested shift of subject health from DPSP to Part III of the Constitution; enacting a National Healthcare Act to maintain uniformity in the healthcare system; Pooling of financial resources and redistribution of all resources and participation by the public as solution for some of the challenges the healthcare sector of India is undergoing now[106].

In a 2010 study titled "**Analyzing Catastrophic OOP Health Expenditure in India: Concepts, Determinants and Policy Implications"**, the author had studied the Out of Pocket (here in after referred to as OOP) health expenditure and its impacts on the consumption pattern and how the poor are deprived of their requirements due to OOP. The study analysed the community's preferences, income level and the factors that led to OOP health expenditure. The variables of the study were the OOP health expenditure and household's spending on different consumption items. The study found that the vulnerable sections of the society including the poor and the Scheduled Caste are more likely to incur catastrophic health expenditure than others. Education also plays a role in the same, as in educated house holds the OOP expenditure on health is less as compared to others. The study highlights that economic well-being and education are the key factors which reduce the probability of catastrophic spending on healthcare. Households with literate female and female head showed less probability of catastrophic spending on health[107].

The author of "Catastrophic Payments and Impoverishment Due to Out-of-Pocket Health Spending: The Effects of Recent Health Sector Reforms in India" investigated the healthcare expenditure of India and sixteen states in the country. It has been found

[106] Mihir Desai and Kamayani Bali Mahabal, *Health Care Case Law in India: A Reader* (2007) <http://books.google.com/books?id=sLXwSAAACAAJ&pgis=1%5Cnhttp://www.cehat.org/go/uploads/Hhr/caselaws.pdf>.
[107] Rama Pal, "Analysing Catastrophic Oop Health Expenditure in India: Concepts, Determinants and Policy Implications" [2011] SSRN Electronic Journal.

by the study that there was commendable increase in the Out-of-Pocket expenditure in India and the selected states during 1990's and early 2000's. The author has carried out a detailed analysis of magnitude and distribution of OOP payments relative to total household consumption expenditure across economic classes; the extent of catastrophic Healthcare expenditure due to OOP payments; and the changes in the magnitude and depth of impoverishment because of OOP payments were all examined by the author . In this work using the National Sample Survey on Consumption Expenditure conducted in 1993–94 and 2004–05 the author assesses catastrophic payments and impoverishment owing to out-of-pocket Healthcare costs. The study's findings indicate that lower and middle-income categories of people are more likely to be impoverished. The study suggested that a broad-based risk pooling and pre-payment measure (balancing sick and healthy) would be a better financing strategy because it would limit out-of-pocket spending, increase financial protection, reduce the risk of impoverishment, and ensure that the poorest of the poor receive Healthcare. Alternatively, by subsidizing pharmaceuticals for low-income households (from lower-middle-class to those living below the poverty line) and increasing both public and private-sector health-care spending, this can be avoided. [108]

The KPMG Report on "**Healthcare: The Neglected GDP Driver"** acknowledges that as the healthcare industry is multifaceted and complex, it is challenging to realize its full potential and deliver high-quality services. The goal of the report is to help people see investment in citizens' health as an investment in the nation's economic prosperity, rather than as a social expense. The study's recommendations echoed the findings of many of the previously mentioned studies, stating that appropriate investments in healthcare delivery and education are expected to increase employment rates and have a positive impact on the country's GDP, and that the onus of bringing the sector into the spotlight as a GDP driver now rests with the government. Finally in conclusion the report described that the health of the public is an important agenda for the nation as it

[108]Soumitra Ghosh, "Catastrophic Payments and Impoverishment Due to Out-of-Pocket Health Spending" (2011) 46 Economic and Political Weekly 63.

is directly connected with better productivity. Hence the nation should invest more on health and healthcare of the public[109].

Another KPMG analysis, titled **"Healthcare in India: Current State and Key Imperatives",** attempted to capture not only the current state of Indian healthcare and identify difficulties afflicting the system, but also to analyses initiatives outlined in the draught National Health Policy (NHP)2015. The document also intends to identify holes in the NHP 2015 draught that have yet to be addressed, as well as make recommendations for how to fill them. This will most likely allow India to realize its goal of universal health care. To show India's public spending is low as compared to other BRICS countries, the report referred to data produced by World Bank.

"Healthcare in India: Current State and Key Imperatives					
Health Indicators	**India**	**Brazil**	**Russia**	**China**	**South Africa**
GDP Spending on Healthcare	4.0%	9.3%	6.3%	5.4%	8.8%
Private Health Expenditure (% of GDP)	66.9%	53.6%	39.0%	44.0%	52.1%
Public Health Expenditure (% of GDP)	33.1%	46.4%	61.0%	56.0%	47.9%
Life Expectancy at Birth in 2012	66	74	70	75	56
IMR per 1000 live births in 2013	41	12	9	11	33
MMR per 100000 live births in 2013	190	69	24	32	140"

(Table 2: Source: KPMG Report 2015[110])

The report highlighted scarcity of beds, human resources, increasing affordability issues, disconnect with higher level of care in the primary and territory healthcare units, lack of quality etc as the main gaps in the healthcare system of India. The report concluded by giving some recommendations like; aallocation of higher budget to

[109]KPMG-FICCI, "Healthcare: The Neglected GDP Driver" (2015) <https://www.kpmg.com/IN/en/IssuesAndInsights/ArticlesPublications/Documents/Healthcare the neglected GDP driver - 2015.pdf>.
[110] KPMG-FICCI (n 110).

national healthcare expenditure; strengthening primary healthcare centers with quality infrastructure, qualified doctors, and access to drugs; integrating primary care with higher levels of care; strengthening of the low cost drug delivery program; establishing and upgrading the existing healthcare education institutes along with the launch of community healthcare programs and establishing a robust healthcare funding program for improving the current healthcare system[111].

"India: Health of the Nation States" is a collaborative work by the experts and stakeholders from over 100 institutions across India "Indian Council of Medical Research, the Public Health Foundation of India, the Institute for Health Metrics and Evaluation", to assess and understand the disease burden at the state level. By employing an exhaustive process, they identified all the data sources and inputs accessible to estimate disease burden in each state and union territory of India, and attempts were made to obtain this data for the purposes of this study. The major findings of the study are; (i) In spite of the improvement in the health status there exist inequalities between states; (ii) With reference to the changing disease profile huge differences between states exist; (iii) Though there is overall reduction in infectious and communicable diseases, but it is still high in some states and (iv) there is raising burden of communicable diseases recorded in all states[112]. The study has pointed at the disparities prevailing in different regions of the country, this highlights the need for a uniform system.

"Right to health a Constitutional mandate in India" is a doctrinal study in which the author started with the definition of some of the important terms in health and healthcare. The study portrays healthcare as one of the important elements of right to health. Relying on the right based approach to health, the author highlights the need for participation of public and non-governmental organizations in implementation of the

[111] KPMG, "Healthcare in India: Current State and Key Imperatives (Review of National Health Policy Draft 2015)" <https://assets.kpmg/content/dam/kpmg/in/pdf/2016/09/AHPI-Healthcare-India.pdf> accessed May 26, 2021.
[112] Institute for Health Metrics Indian Council of Medical Research, Public Health Foundation of India, "India: Health of the Nation's States" (2017).

healthcare policies. While concluding his study the author foresees transfer of health form DPSP to fundamental rights part like education[113].

The work titled “Strategies for Ensuring Quality Healthcare in India: Experiences from the Field” is a study examines whether the growing health industry is contributing to the quality services or good outcome. For the same the researcher has selected the utilization of the maternity services at both public and private facilities in the Banda district in Uttar Pradesh. The study found various issues with respect to infrastructure of the healthcare units, management of human resources, reliability of the process, and monitoring of the system. The author concluded the article by stating that a thorough understanding of the grass root level issues and challenges are essential to guarantee adequate delivery of the healthcare services. India requires major investment and upgrading of quality standards; receptivity to and rapid adoption of innovations can help India achieve its lofty objective of providing high-quality Healthcare more quickly. Regulations are needed, including a re-evaluation of existing policies and programmes to see what works and what needs to be reworked; interventions into quality promotion, such as the “Indian Public Health Standards 2008, National Quality Assurance Standards”, and others; uniform regulation, implementation, monitoring, and accreditation, as well as research into and attempts to address region-specific challenges. for the purpose of focusing and assessing fundamental policy issues, international targets, and standards might serve as a credible guide etc.[114]

The study, titled **“An Empirical Analysis of Trends and Opportunities in Healthcare Services: A Case Study of India”,** looked at the private sector and health services in India, as well as the growth of per capita healthcare spending. The study also looked into some of India's most important healthcare market. In India's healthcare sector has numerous trends. At the same time as the study focused on three major areas in relation to healthcare (i) 12th Five-Year Plan (2012–17) and health services in India

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[113] Md Baharul and Islam Asst Professor, “Right to Health a Constitutional Mandate in India” (2017) 3 Ijariie 2627 <www.ijariie.com> accessed September 15, 2021.
[114] K Madan Gopal, “Strategies for Ensuring Quality Health Care in India: Experiences From the Field” (2019) 44 Indian journal of community medicine: official publication of Indian Association of Preventive & Social Medicine 1 <https://doi.org/10.1016/S2214-109X>.

(ii) as well as the growth drivers of the Indian healthcare sector, and (iii) medical tourism. The Indian policy support and opportunities in the Indian healthcare sector is another topic explored by the study. The study depicted that the Indian healthcare sector has tremendous potential for creating employment opportunities and solving the problem of the Indian economy; Abundant revenue can be generated through the health services provided to foreigners and accordingly the problem of balance of payment difficulties can be easily tackled by availing foreign currency; Indian healthcare sector by adopting medical tourism may come out from the problem of healthcare backwardness and an image of the country at the global level can be easily improved by availing the world-class facilities to the masses; As the government of India is regularly providing the financial support to the healthcare sector, by which standard of living and life expectance of the people can be easily improved[115].

"Right to Health and Healthcare: Constitutional Directives and Judicial Pronouncements" is a doctrinal study conducted by the author to understand the Constitutional vision of right to health and healthcare in India and also the judicial activism in relation to the subject. After analyzing the Constitutional provisions specially Article 21 and some of the articles from Directive Principles of State Policy and the decision of the Hon'ble Supreme Court on various cases the author depicts the development of health and healthcare to a fundamental right. He points at the change of trend of the higher judiciary as in the initial judgements the court approach was to give directions to government to improve the healthcare conditions and now the court started treating it as an integral part of article 21[116].

1.6.5 Status of Healthcare in Gujarat

Gujarat is known for its economic growth and is one among the fastest growing states in India. However, the state is no exception to the challenges majority of the Indian

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[115] Gaikar Vilas B, "An Empirical Analysis Of Trends And Opportunities In The Healthcare Services: A Case Study Of India" (2020) XIV Journal of Economic & Social Development 141 <https://www.researchgate.net/publication/340528943_AN_EMPIRICAL_ANALYSIS_OF_TRENDS_AND_OPPORTUNITIES_IN_THE_HEALTHCARE_SERVICES_A_CASE_STUDY_OF_INDIA>.

[116] Dr Amit Patil, "Right to Health and Healthcare" (2020) 8 ndian Journal of Applied Research 141 <https://www.researchgate.net/publication/339017511_13_Right_to_Health_and_Healthcare/citation/download>.

states are undergoing in relation to healthcare development. The Controller and Auditor General of India in the report slammed Government of Gujarat on the ground of reported shortage of healthcare staff, inadequate infrastructure and lack of essential medicines.[117] Referring to the outbreak of swine flu and Zika virus in 2017 and the reported deaths as a result of the same the CAG criticized the government for its lack of interest in public healthcare.[118]

"Gujarat: Economically upfront, but far behind in health" by Oommen C. Kurian tried to analyses how the economic growth in Gujarat is impacting its healthcare. The study found a mixed response. The study by referring to NHFS data of few years' points that there has been improvement in cases of IMR and MMR in Gujarat over the years and Gujarat has relatively lower proportion of out-of-pocket spending on healthcare. But immunization has always been a concern for Gujarat, it is one among the states having very low immunization coverage. Gujarat has increased cases of tuberculosis (TB) too.

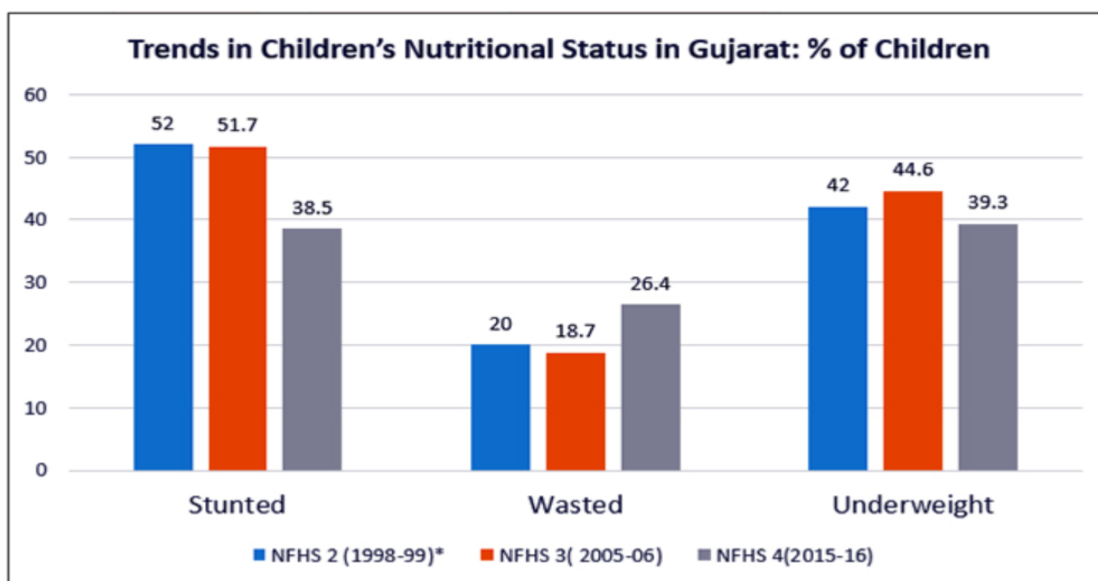

Figure 1-Source: orfonline.org

[117]CAG, "Report of the Controller and Auditor General of India 2018" (2018) <https://cag.gov.in/cag_old/sites/default/files/audit_report_files/Report No. 6 of 2020_Civil_English_signed.pdf>.

[118] Bridge India, "Briefing: Public Health in Gujarat" (*2018*) <https://www.bridgeindia.org.uk/briefing-public-health-in-gujarat/> accessed September 16, 2021.

Similarly, another concern for Gujarat is malnutrition, stunting and wasting in children. The author has explained the same by relying on the NFHS data (shown Below). Hence the author suggests urgent steps towards improving the prevalent situation[119].

The study titled "**Hospital Efficiency: An Empirical Analysis of District Hospitals and Grant-in-aid Hospitals in Gujarat"** was conducted by the authors to examine the emergency clinic effectiveness of District Hospitals and grant in-help Hospitals in Gujarat. The review endeavors to give an outline of the overall status of the medical care administrations given by emergency clinics in Gujarat as far as their specialized and allocative effectiveness is concerned. To analyze the same the step taken by the author was to check out the condition of medical care administrations given by both District hospital and grant in aid hospital. The inspiration driving addressing the effectiveness issue is to give an exact examination of the public authority's arrangement to give grant to nonprofit organizations to guarantee access to public healthcare in the state. The study has taken into consideration whether grant-in-aid hospitals are relatively more efficient than public hospitals. As per the study below given tables shows the healthcare infrastructure of Gujarat as per 1999 data and number of health professionals in Gujarat in 1998 respectively.

Table 3: Public and Private Healthcare Units in Gujarat during 1999

	Number	Per 100000 Population	Beds	Per 100000 Population
Primary Care (Government)				
Sub-Centres	7274	15.15		
PHCs	993	2.07		
Urban FW Centres	106	0.22		
Post-partum units	89	0.19		
Dispensaries	63	0.13		
Mobile units	16	0.03		
Secondary and tertiary (Government)				
Government Hospitals	288	0.89	23625	49.20
General Hospitals – District	25	0.05	5536	11.53
Government Hospitals (Class I and II)	26	0.05	2011	4.19
Community Health Centres	223	0.46	7344	15.30
Mental Hospitals	4	0.01	683	1.42
Specialty Hospitals (Dental and others)	2	0.00	120	0.25
Teaching Hospitals	8	0.02	7931	16.52
ESIS Facilities				
Dispensaries	124		1445	
Hospitals	11			
Private sector (including NGOs)				
Grant-in-aid Institutions (NGOs)	140	0.29	4736	9.87
Hospitals	2152	4.48	32131	76.81
Dispensaries	6824	14.21	9176	19.12
Total			71113	148.15

[119] Oommen C. Kurian, "Gujarat: Economically Upfront, but Far Behind in Health" (*ORF Online*, 2017) <https://www.orfonline.org/expert-speak/gujarat-economically-upfront-far-behind-health/> accessed September 16, 2021.

Table 4: Number of Healthcare Professionals in Gujarat during 1998

Category of Health Personnel	Number
Allopathic Doctors	17738
Government facilities	4265
Non-governmental organisations	5139
Practising privately	8334
Ayurvedic Doctors (Registered)	21033
Homeopath (4619) and Unani (234) (all registered)	4853
Registered Dentists (1 dentist per 39955 population)	1320
Total Doctors (1 doctor per 1068 population)	44944
Registered General Nurses (1 nurse per 3475 population)	13553
Registered ANM (1 ANM per 7776 population)	6057

Source: Basic Health Statistics, Gujarat 1998

The annual medical and public health expenditure of the Gujarat government is Rs. 0.23 billion, according to the report (year 1999-00). The state spends around a quarter of this on hospitals and pharmacies. During the same period, Gujarat had roughly 139 grant-in-aid health facilities with a total bed capacity of 4736, with the government allocating around Rs. 250 million to all of these institutions. The study's final findings revealed that grant-in-aid institutions have a greater overall efficiency level than government hospitals.[120]. However, the above-mentioned status has changed in case of healthcare infrastructure, the state has strengthened the healthcare system by creating more hospitals and appointing more staff. Still the state has been criticized by the researchers on the ground that the development of healthcare sector is not in conformity with the economic development of the state. The recent studies are showing that there exists a huge shortage of healthcare professionals in the state and the same has been reflected in the initial days of Covid pandemic.

"Healthcare Sector Efficiency in Gujarat (India): An Exploratory Study Using Data Envelopment Analysis" by Brijesh C. Purohit is a review directed to break down the productivity of medical care framework in the sub state level at territory of Gujarat utilizing the area level information for 2012-13. The consequences of the review

[120] Ramesh Bhat, Bharat Bhushan Verma and Elan Reuben, "Hospital Efficiency: An Empirical Analysis of District Hospitals and Grant-in-Aid Hospitals in Gujarat" (2001) 3 Journal of Health Management 167.

relating to region level wellbeing framework proficiency in Gujarat State show that a portion of the regions have low productivity in use of sources of info like specialists, beds and responsibility per wellbeing establishments. There are likewise different regions, which need a greater amount of these data sources, which might upgrade their yield and productivity. It was recommended that the effectiveness in Valsad needs an improvement considerably more than different areas, though regions like Ahmadabad and Surat need a greater amount of both clinical labor and offices. Indeed, even if there should arise an occurrence of Vadodara and Rajkot, the positioning as far as the greater part of clinical labor and offices is low and hence these regions may likewise be benefitted by extra information sources. Subsequently, there is a blend of both failure and deficiency of data sources, which is reflected in our outcomes[121].

In a recent study titled "**An Empirical Study on Availability of Rural Health Care Services in Zarol Village as Per the Indian Public Health Standards"** is a review on accessibility of Health care in Zarol town based on the Indian Public Health Standards. For the study the researcher has considered 80 respondents. The data were collected using semi-structured questionnaire and interview method. Information was gathered through organized shut finished survey utilizing non-likelihood comfort examining strategy through specifically meeting the respondents. The Service Quality Dimensions were utilized to gauge the Service Quality Assurance of Public Health care administrations. Exploration result uncovers that implies score of significant help quality measurements is generally high showing more elevated level of patient's fulfillment from PHC of Zarol. The level of patient satisfaction in relation to work force quality and wellbeing estimated a low score. The patient satisfaction was high in case of the Infrastructure, Clinical care, administrative procedures, Image, trustworthiness, social responsibility are relatively high indicating a higher level of patient's satisfaction

[121] Brijesh C Purohit, "Healthcare Sector Efficiency in Gujarat (India): An Exploratory Study Using Data Envelopment Analysis" (2016) 4 Healthcare in Low-resource Settings <https://www.pagepressjournals.org/index.php/hls/article/view/5525/5885> accessed September 15, 2021.

from PHC's of Zarol. The lowest level of patient satisfaction is reflected in the personnel quality and safety measures. [122]

Brijesh C. Puerohit's book, **"Inequality in Indian Health Care",** examines significant facets of inequity in India's healthcare industry, including access, finance, financial risk protection, gender, service delivery, and utilization. It also goes over numerous ways to define inequity in each of these areas, as well as different indices for each dimension of imbalance, such as financing, utilization, region, health outcomes, caste and class, and gender. The book examines fifteen main Indian states as well as chosen case studies at the district level, including both theoretical and empirical topics . The book gives a comprehensive perspective of both economic development and policy changes in general based on the quantitative and qualitative studies. The book not only provides crucial data and insights for politicians and academics, but it also suggests further policy reforms that might help to alleviate India's present healthcare disparities. As a result, it is an invaluable resource for health economics graduate students, as well as academics and policymakers.[123].

1.7 Identified Research Gap

The initial analysis and discussion above show that healthcare is a recognised human right both internationally and also at the national level. In India, though the Constitution does not recognise healthcare as a fundamental right in express terms, it has many indirect provisions pointing at the importance of healthcare and impliedly the law recognises health and healthcare as an integral part of the right to life. The Indian judiciary has over and again emphasised this point by saying that depriving a person of his healthcare means deprivation of his right to life. The apex court has also established that it is the duty of the state to provide accessible, affordable and quality healthcare to its public. The steps taken by the judiciary, Government of India and State governments

[122] Anupam Mitra and Shivangi Shukla, "An Empirical Study on Availability of Health Care Services in Zarol Village as per the Indian Public Health Standards" (2019) 10 Independent Journal of Management & Production 216 <http://www.ijmp.jor.br/index.php/ijmp/article/view/817> accessed September 15, 2021.

[123] Brijesh C Purohit, *Inequity in Indian Health Care* (Springer 2017).

are appreciable as they have succeeded in creating a foundation of healthcare system, which no doubt needs to be improved and made accessible to public.

The review of literature has found that there exist a number of studies conducted by academicians and experts of healthcare and law to varied aspects of public healthcare including the determinants of health, efficiency of public healthcare system, comparative study of public and private healthcare system etc. However there has been a very few studies covering the socio-legal aspects of healthcare with special reference to right to health and inequalities based on gender, place of residence and economic ability. And a very few studies have discussed the legal framework on Right to health and healthcare both international and national level.

In the review of literature, some studies have discussed the importance of public healthcare, determinants of health, the issues and challenges the Indian healthcare system is undergoing etc. Some studies have covered the challenges thrown by the pandemic as well. However, a very few studies have covered the inequalities in access to healthcare based on the three parameters namely gender, Income and Geographical area of residence. There is no comprehensive study which tried to analyse the Constitutional vision of right to healthcare along with the international law aspects, evaluation of current status of healthcare in India, role played by Judiciary and Government of India in ensuring access to healthcare to all. In addition to that th this work the researcher has also studied the healthcare scenario in Gujarat through an empirical study.

Gujarat has always been criticised for its poor healthcare infrastructure and quality. The same was proved beyond doubt during the pandemic. As per the reports, the pandemic caused several deaths in Gujarat due to the ventilator failure. The studies have shown quality-related issues, poor infrastructure, low human resources, lack of hygiene etc. The state has been criticised for having large number of malnutrition cases. Gujarat is one of the top states which is contributing maximum cases of stunting, wasting and malnutrition in Children. In the review it has been found that Gujarat is far behind its peers when it comes to the budgetary allocation for health care services. It has been

reducing over the years, from 5.59% of the total state budget in 2015-16, to 5.06% in 2017-18. The studies have reported discrepancies in the report produced by Gujarat Government and the NFHS data with respect to malnutrition. The study by ORF online reported high number of maternal and new-born deaths were attributed to “vacant posts of Gynaecologists and Paediatricians, and lack of life saving equipment and beds in the maternity ward”. Underutilisation of allotted fund also were reported by the studies. One of the reasons which is clear from the discussion for all the above-mentioned challenge is unavailability and accessibility of healthcare units and resources.

In the process of review of literature, it has been found that there are very few studies conducted in to state of Gujarat in relation to Right to Healthcare. The researcher couldn’t find any study addressing the ‘socio-legal aspects of Access to healthcare in state of Gujarat’. Some of the studies have discussed the issues and challenges in relation to the key indicators of health where as there is a gap when it comes to access to healthcare and inequalities based on gender, geography and economic status. After the review the researcher has understood that none of the studies have tried to understand the healthcare in urban, rural and tribal areas of Gujarat. Similarly, there is lack of evaluation research to understand the success ratio of government initiatives too.

In the present study, before starting with the field survey of Gujarat, the researcher felt the need to understand the Constitutional vision of healthcare in India, the stand of judiciary towards healthcare and also the steps taken by Indian government to recognise healthcare as a fundamental right. Therefore, the researcher proposed a study into the healthcare sector of Gujarat aiming to study the inequalities prevailing in the state based on three main criteria’s namely; gender, geography and economic condition and also the impact assessment of selected governmental initiatives.

CHAPTER 2
DESIGN AND RESEARCH METHODOLOGY

2.1 Introduction to the Chapter

Access to healthcare is a complex issue many states of India is undergoing. Inequalities in access to healthcare based on different parameters like gender, geographical region and economic ability are some of the challenges the healthcare sector is undergoing. In addition to that, there are issues concerning quality, acceptability and affordability of medical care and medicines. The lack of a uniform system or uniform legislation to regulate healthcare in India including both public and private healthcare sectors has widened the gap and lead to disparities based on geographical area/region. Now we can see the healthcare system of Kerala is different from Assam, in some states the system is performing well whereas some states are still cursed with the aforementioned challenges.

This study is an attempt made by the researcher to understand the present status of healthcare in India by giving special reference to the state of Gujarat. The study also has tried to understand the present status and success metrics of the government policies and programmes implemented in Gujarat intending to control, and eradicate both communicable and non-communicable diseases and also to make healthcare accessible and affordable to the public. The dimensions of disparity in access to healthcare based on gender, geographical area and economic status also were considered by the study. A Multi-method approach was adopted by the researcher to study this topic as the topic demands both doctrinal and empirical research.

2.2 Objectives of Research

The broad objective of this study is to evaluate and understand the current status of the healthcare system in India with special reference to the State of Gujarat. The study aims to understand whether there is any need for uniform healthcare legislation to regulate

the standard of healthcare provided by both public and private healthcare units in the country.

1) To analyse and understand the origin and significance of the right-based approach to healthcare and also the position of International law on right to health.
2) To examine the Constitutional vision concerning the right to health envisaged under A.21 of the Indian Constitution and analyse the role of the Judiciary in ensuring quality healthcare accessible and available to the people.

3) To examine the magnitudes of inequalities in the healthcare sector on the grounds of Gender, Geography, and economic status with respect to access, quality, affordability, availability of health care in the state of Gujarat (with special reference to Tribal, Rural and Urban Regions).

4) To explore the initiatives taken by the government of India and the Gujarat government in ensuring proper healthcare to the citizens of India and making quality and affordable healthcare system accessible and available to the people without any neglect and discrimination.

5) To compare the healthcare system of India with the best performing selected countries in the public healthcare sector. (Countries are selected based on their performance in public health care based on the Health Index reports of WHO and UNO reports post 2018. The selected countries are Australia, China, France, United States of America, and Myanmar).

2.3 Hypotheses

1) Disparities in access, quality, and availability of healthcare exist based on socio-economic status, Gender, and Geographical region in the state of Gujarat.

2) The lack of quality, availability, affordability and accessibility of the health care system, Poor implementation of national-state policies and programs, and lack of unique legislation are the main cause behind the poor development in the healthcare sector in the state of Gujarat.

2.4 Research Questions

1) Can health and healthcare be considered human rights? What is the rights-based approach to health?

2) Does India guarantee the fundamental right to health? What is the Constitutional vision of the right to health? What is the role of the Judiciary in making quality health care accessible and available to the people?

3) Do inequalities based on gender (between male and female), geography (between rural, urban semi-urban, coastal and tribal regions), and Economic status (between the poor and better-off) exist?

4) What are the initiatives taken by the government of India and the Gujarat government in ensuring proper health to the citizens of India and making a quality healthcare system accessible, available and acceptable to the people without any neglect and discrimination? Did a particular program or any governmental action had narrow down or widened the health inequalities?

5) What are the different steps taken by the best-performing countries in their public health sector?

2.5 Research Methodology

The researcher by this proposed study aims to conduct a detailed study of the impact of socio-economic status, gender, and geographical region on access to healthcare, by analysing their merits and shortcomings, discuss them in detail and further offer recommendations for improved practice in the future.

Answering all the above questions requires a combination of both doctrinal and empirical study due to the complex nature of the topic chosen. Thus, the present proposed research is a blend of doctrinal and empirical research methods. For studying objectives 1, 2, and 5 the researcher has adopted doctrinal study and for 3 & 4 empirical research study as the questions calls for it.

The Design for this study is explanatory and evaluative in nature. The researcher has tried to analyse the 'what', 'how' and 'why' aspects of the research questions and tried to provide with a well-researched model with detailed explanations on the problems studied hence exploratory. One of the aspects of the study is to analyse and understand the effectiveness of government initiatives such as certain identified programmes and policies, hence evaluation research.

The researcher has deployed a mix methodology means both quantitative and qualitative techniques in this study. For target group I and II namely the healthcare consumers and healthcare providers respectively, survey method was adopted using questionnaire with both closed ended and open-ended questions, hence the data collected is a mixture of both qualitative and quantitative. For third category of respondents, i.e., the experts an in-depth interview and focus group discussions were conducted and hence the data is qualitative in nature.

2.5.1 Research Methodology for Research Questions 1,2 &5 (Doctrinal Study)

a) **Research Design for Objective/Research Question 1**: "*To analyze and understand the origin and significance of the right-based approach to healthcare and also the position of International law on right to health",* the researcher has adopted the doctrinal research method. The doctrinal legal research is research into legal concepts and principles, statutes, rules, etc. It is concerned with the analysis of

the legal doctrine and how it has been developed and applied and is pure theoretical research. Here the researcher firstly looked into the primary authoritative sources like international agreements, covenants, treaties, etc. to understand the stand of international law on right to health. Secondly, the researcher reviewed secondary sources like the reports and other publications of international organizations like WHO, UNFPA, etc., and the programs and policies by international organizations to understand the concept of the right to health under International Organizations.

b) **Research Design for Objective/Research Question 2**: The second question of the proposed research study aims "*to examine the Constitutional vision concerning the right to health envisaged under A.21 of the Indian Constitution and analyze the role of the Judiciary in ensuring quality healthcare accessible and available to the people*". To find out an answer for the same, the researcher had again adopted the doctrinal research method. The only possible way to find an answer to the aforementioned question is to study the Indian Constitution and the judgments delivered by the higher Judiciary in the proposed area. Hence the researcher had reviewed the sources like the Indian Constitution, commentaries on the Indian Constitution, judgments by the higher judiciary in India on the matters of healthcare, articles, books, internet materials, news, etc. on Constitutional law on the proposed topic.

c) **Research Design for Objective/Research Question 5:** Research question 5 demands a comparative research study with a few countries of the world. Comparative Analysis will give the researchers an opportunity to explore the practices in other countries and understand the similarities and differences, identify the best practices and the worst practices. In this present study the researcher has looked in to the healthcare system of few selected countries with an intention to understand the status of healthcare in the selected countries, the government initiatives like policies, programmes and the legislations implemented to make quality healthcare accessible and available to all at affordable rates, what are the mistakes committed by the concerned states in making health accessible to all

without discrimination. This analysis will enable us to learn from the good practices and the common mistakes.

The countries are selected based on their ranking by the World Health Organization and the United Nations for their performance in the healthcare system. Thus, the identified countries are Australia, China, France, the USA, and Myanmar. The research method adopted here is a doctrinal study. The purpose of considering this objective in the study is to compare India's Healthcare system with the healthcare system of the best performing and poorest performing countries of the world. The selection of countries is made based on the reports of the United Nations Health Index and the Reports of WHO. In this study, the researcher looked into the laws governing the health care system of the identified countries, their policies, and programs, GDP spent on the health sector, and also the different studies and reports on the area of health and health care in all the above-mentioned countries.

2.5.2 Research Method for Research Questions 3 & 4 And Hypotheses 1 & 2 (Empirical Study)

The research question 3 and 4 and the Hypotheses 1 & 2 both has the same variables and they require an empirical study. Research question 3 aims to understand the status of inequalities in access to healthcare in the State of Gujarat based on three different criteria's namely Gender, Geography, and Economic status. The researcher had surveyed different regions of the state of Gujarat to understand whether healthcare is equally accessible to all irrespective of their gender, locality of residence, and financial condition or there exists discrimination based on Gender (Male and Female), Geography i.e., rural, urban and tribal area and economic status mean disparities between rich and poor.

To test the Hypotheses, the study demands a quantitative analysis and one part of Research questions 3 & 4 requires a qualitative analysis too. Hence the researcher had adopted a mixed methodology to study Research question 3 & 4 comprising of both Qualitative and Quantitative analysis.

A. Framework for Quantitative Study of Hypothesis 1&2 / Research Question 3 & 4

The hypothesis to be tested for this study are;

Hypothesis 1: Disparities in access, quality, and availability of healthcare exist based on socio-economic status, Gender, and Geographical region in the state of Gujarat.

Hypothesis 2: The lack of quality, availability, affordability, and accessibility of the health care system, Poor implementation of national-state policies and programs, and lack of unique legislation are the main cause behind the poor development in the healthcare sector in the state of Gujarat.

By testing hypotheses 1 & 2 or by studying question 3 and 4, the researcher aims to arrive at some generalizable findings, hence has adopted the quantitative method to understand the inequalities in access to healthcare based on gender, geography, and economic status in mainly three districts of Gujarat namely Ahmedabad, Gandhinagar, and Panchmahal.

As an initial step the researcher has carried out an elementary research by reviewing the already existing studies on the same objective in the form of books, articles, reports, news, other internet resources, etc., The review covered works done on the topics of inequalities in access to health and healthcare, the impact of government policies on the healthcare sector issues the current health sector of India is undergoing and all other things related to the topic with an intension to build a foundation for the proposed study. The subsequent step was field study and data collection.

The major ingredients of the proposed research study are;

1. Universe and Sample Units for Quantitative Study

Access to healthcare and the quality of healthcare services largely depends on the number of hospitals, doctors, nurses, and other ancillary facilities in a particular area.

Quantitative indicators alone are not good indicators of the quality of services. Nevertheless, it gives a fairly good idea about the accessibility of health care services. Thus, to ascertain the answer for the research questions 3 & 4[124] the researcher has conducted an empirical study of the healthcare system in the state of Gujarat. The universe of this study is the healthcare consumers in state of Gujarat and the healthcare providers of public and private healthcare units of state of Gujarat.

To ascertain the data, the first step that the researcher did was to identify a suitable set of respondents from whom the required data set can be collected. For the same the researcher had conducted research to understand the number of public and private healthcare units in Gujarat state. For the same the researcher had relayed on the data provided by the website of Department of Health and Family welfare, Government of Gujarat. It was found that at the inception of this study in 2017, Gujarat had 33 districts[125] which includes urban, rural, and tribal populations and these regions had 1474 Primary Healthcare Centres[126], 363 Community Healthcare Centres[127], 23 district hospitals[128] and many Private hospitals[129].

The researcher here adopted the Stratified Sampling Technique and classified the universe in to three main categories namely Urban Gujarat, Rural Gujarat and Tribal Gujarat. From these three categories one districts representing the aforementioned population was selected using Simple Random Technique. The selected districts are Ahmedabad, Gandhinagar and Panchmahal representing urban, rural and tribal population respectively. Healthcare consumers from these regions were approached for

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[124] Research question 3 is 'Do inequalities based on gender (between male and female), geography (between rural, urban and tribal regions) and Economic status (between the poor and better-off) exist? And research question 4 is What are the initiatives taken by the government of India and the Gujarat government in ensuring proper health to the citizens of India and making a quality healthcare system accessible, available and acceptable to the people without any neglect and discrimination? Did a particular program or any governmental action had narrow down or widened the health inequalities?
125 Census of 2011.
[126] National Health Mission, State Health Society, Health and Family Welfare department, https://nhm.gujarat.gov.in/(Accessed on 20/02/2018).
[127] *Ibid.*
[128] *Ibid.*
[129] The researcher is considering only 159 private hospitals as per the list of Health and Family Welfare department- Mukhyamantri Amrutham website lists details available at http://www.magujarat.com/DistrictwisePrivateHospital.html (last accessed on.

collecting data. From each district 120 respondents were identified and data were collected by the researcher.

The next step was to identify public and private healthcare units from the above-identified districts to collect data from the second category of respondents. From each selected district of Gujarat one district hospital, two Primary Healthcare Centre's, two Community Healthcare Centre's, and one Private Hospital are chosen using a simple random sampling method for the purpose of collecting data.

2. Targeted Respondents for Data Collection

For the purpose of quantitative analysis, the researcher has identified two categories of respondents namely;

Category 1: Healthcare consumers: - For this study the researcher aims to collect data from the healthcare consumers/patients visiting the primary healthcare units, community healthcare units, district hospitals, and the private hospitals of the above-mentioned selected sample units.

3. Sample Design for Quantitative Study

As a first step, the researcher classified the state of Gujarat into 3 strata's namely Urban Gujarat, Rural Gujarat, and Tribal Gujarat. From each stratum, one district each is selected using Simple Random Technique for data collection. The selected sample units are Ahmedabad district representing urban Gujarat, Gandhinagar district representing rural Gujarat and Panchmahal district representing Tribal Population.

a) **Urban Gujarat: Ahmedabad** is the largest city in Gujarat and the seventh-largest urban area with a population of 7,045,314. Ahmedabad consists of 11 talukas 506 villages and 14 municipal towns with an area of 8,107 km². The district has one district hospital, 07 Community Healthcare Centers, and 77 Urban Healthcare

Centers. Ahmedabad Municipal Corporation has divided the district in to different zones and there are 10 Urban Healthcare Centers in Central Zone, 11 in East Zone, seven in North West Zone, 14 in North Zone, 5 in South West Zone, 15 in South Zone and 15 in West Zone. Similarly, each zone has a Community Healthcare Centre[130].

For this study the researcher has collected data from the first target group i.e., the healthcare consumers by visiting the selected healthcare units and households. For second category of respondents i.e., the healthcare providers mainly the Doctors, Nurses, Hospital staff and the management team, the researcher using Simple Random Technique chose two Primary Healthcare Centers, one Community Healthcare Centre, the District Civil Hospital and a multi-specialty private hospital situated near to the Civil Hospital for the study. From each unit based on availability and convenience, the researcher had selected 20 respondents for data collection.

b) **Rural Gujarat: Gandhinagar** is the capital of the state of Gujarat situated in the northern part of Gujarat. It has an area of 2,163 km² with a population of 195,891. Gandhinagar consists of 4 talukas, 15 municipal towns, and 252 villages. The public healthcare sector of Gandhinagar has one district hospital 08 Community Healthcare Centers and 31 Primary Healthcare Centers (majorly situated in villages). For the present research study, the researcher has selected the Gandhinagar district hospital, one Community Healthcare Centre, two Primary Healthcare Centre's and a private hospital using Simple Random Sampling Technique.

The first category of respondents is the healthcare consumers or the in and outpatients of the selected healthcare units and the households in rural areas of Gandhinagar district. The researcher has collected 120 data from the households in this region and also from the patients visiting the aforementioned healthcare units.

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[130]Ahmedabad Municipal Corporation, "Urban Health Centers" <https://ahmedabadcity.gov.in/portal/jsp/Static_pages/citizen_Urban Health centres.jsp#List> accessed September 7, 2021.

Like Ahmedabad, the researcher has collected data from 20 healthcare providers based on availability and convenience from the selected sample units.

c) **Tribal Gujarat: Panchmahal** is one of the tribal regions of Gujarat situated in eastern parts of the state. It is one among the country's most back work district. Panchmahal has population of 2,390,776 as per 2011 Census. The healthcare sector of Panchmahal district includes one District Hospital, 12 Community Healthcare Centers, and 6 Primary Healthcare Centers (situated in tribal villages). The researcher using the Simple random sampling technique has identified the district hospital, a Community Healthcare Centre and two Primary Healthcare Centre's, and a private hospital for the research study. This sample will cover the tribal population in this region. Again, here the researcher shall collect data from 120 patients and 20 healthcare providers.

Table 5: Details of sample units selected for data collection as part of the Quantitative Study for Category I Respondents

District	District /Civil Hospital	Community Health Centre	Primary Health Centre	Private Hospital	Sample Size and other details
Ahmedabad	District Civil Hospital, Ahmedabad	One CHC	Two PHC	One Private Hospital	The researcher had collected data from both inpatients and out patients of the selected Primary Healthcare Centre's, Community Healthcare Centre, district hospital, and private hospital and also from different household of the urban areas of Ahmedabad.

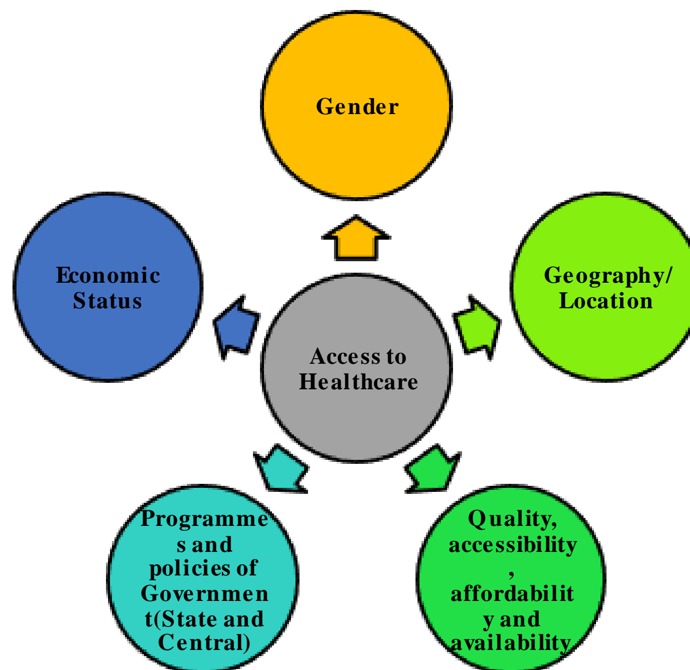
Gandhinagar	District Civil Hospital, Gandhinagar	One CHC	Two PHC's	One Private Hospital	The researcher had collected data from both inpatient and out patients of the selected Primary Healthcare Centre's, Community Healthcare Centre, district hospital, and private hospital and also from different household of the urban areas of Ahmedabad.
Panchmahal	District General hospital, Panchmahal	District Civil Hospital, Panchmahal	One CHC	Two PHC's	The researcher had collected data from both inpatient and out patients of the selected Primary Healthcare Centre's, Community Healthcare Centre, district hospital, and private hospital and also from different household of the urban areas of Ahmedabad.
	Total				**363 Healthcare Consumers and 60 Healthcare Providers**

4. The sample size for Quantitative Analysis

The first category of respondents is the healthcare consumers representing Urban, Rural and Tribal population residing in the above-mentioned districts. The proposed sample size is 120 from each identified district. The researcher had collected 20 samples each form each selected units and 40 samples from house hold in the identified districts representing the identifies stratums. Thus, the total collected sample is 120(Respondents)*3 (Districts)=360.

5. Key Variables

Secondly, there needs to be clarity on the key variables in the analysis. The variables to be tested in the present proposed research are;



(Figure 2: Key variables of Study)

(i) The inequalities in access to healthcare are based on gender, geography, and economic status. Inequality is the dependent variable and gender [Male and Female], geographical region (Tribal, Rural, Urban, Semi-urban and coastal) and economic status [People below poverty line (BPL) and above poverty line (APL)] are the selected independent variables influencing the healthcare system in the proposed study.

(ii) Another set of variables are quality, accessibility, availability, and affordability and its impacts on the healthcare system in the state of Gujarat.

(iii) The relation between the programs and policies of the government (Both State and Central) and the rate of development of the health sector in India is the next chosen set of variables.

(iv) Finally, the relation between the programs and policies of the governments of selected countries and their impact on the rate of development of the health sector in those countries.

6. Data Collection Techniques

The next step is to define the data collection techniques.

For Category, I Respondents (Healthcare Consumers): -A semi-structured questionnaire was used to collect data from healthcare consumers. The questionnaire consisted of 35 questions out of which 30 were dichotomous and multiple-choice questions, and three were open-ended questions. The researcher had collected the data using questionnaires by directly approaching them in the healthcare units and households.

7. Data Analysis

Finally, the researcher to analyse the collected data requires a set of quantitative methods, and statistical tools for measuring inequality, the progressivity of health care, the impact of governmental programs. Here the researcher had adopted the descriptive/inferential statistical methods to measure the selected variables. And the tool used for analysis were Excel.

B. Framework for Qualitative Analysis

The researcher had adopted qualitative analysis also for the below questions as the number of respondents are less and it also involves opinions of experts.

[**Research Question 3**: Do inequalities based on gender (between male and female), geography (between rural, urban semi-urban, coastal and tribal regions) and Economic status (between the poor and better-off) exist?

Research Question 4: What are the initiatives taken by the government of India and the Gujarat government in ensuring proper health to the citizens of India and making a quality healthcare system accessible, available, and acceptable to the people without any neglect and discrimination? Did a particular program or any governmental action had narrow down or widened the health inequalities?]

As mentioned above, one part of the research question 3 & 4 requires a qualitative analysis also to understand and record the opinions of the healthcare providers and experts on the issues and challenges the current healthcare system of the State of Gujarat is undergoing, the initiatives taken by the government to curb such challenges, their success ratio and also the possible solutions to mitigate and control such challenges. The researcher had used open ended questionnaires, in-depth interviews and Focus Group Discussions to collect data from the two categories of respondents.

I. Sample Frame for Respondent Category II (Healthcare Providers)

For the study the identified second category, healthcare providers include Doctors, Members of Hospital management, nurses, and other staff of the hospital.
The nature of the research questions demands data collection from the healthcare providers too as they are one of the key stakeholders of the healthcare system. For the purpose of this study the term healthcare provider includes Doctors, Hospital Management, Nurses, and other staff of the selected sample units.

The identified universe for the proposed research study is the public and private healthcare units in the state of Gujarat. To draw a sample from the same the researcher selected three sample units namely Ahmedabad District, Gandhinagar district, and Panchmahal district. Subsequent to that from each selected unit the researcher has

selected two Primary Healthcare Centre's, one Community Healthcare Centre, one District Hospital, and one Private Hospital using a simple random sampling technique.

The technique adopted to collect data is a questionnaire or interviews. The researcher has decided to record the response of 5 health care providers from each category of healthcare systems from all three districts. So, the total number of respondents would be 4(categories of public healthcare units) X 3 (selected districts) X 5 healthcare providers=60.

Table 6: Details of sample units selected for data collection as part of the Quantitative Study for category II Respondents

District	District/Civil Hospital	Community Health Centre	Primary Health Centre	Private Hospital	Sample Size and other details
Ahmedabad	District Civil Hospital, Ahmedabad	One CHC	Two PHC	One Private Hospital	The researcher had collected data from healthcare providers including Doctors, Nurses, members of Hospital Management, and other staff from each unit. Thus, the total data collected from the second category of respondents from Gandhinagar district is 20.
Gandhinagar	District Civil Hospital, Gandhinagar	One CHC	Two PHC's	One Private Hospital	The total data collected from healthcare providers of Gandhinagar district is 20.

Panchmahal	District General hospital, Panchmahal	District Civil Hospital, Panchmahal	One CHC	Two PHC's	From the District Panchmahal too, the researcher has collected data from 20 healthcare providers i.e., Primary Healthcare Centre, Community Healthcare Centre, District hospital and Private hospital
			Total		**60 Healthcare Consumers**

1. **Sample Size for Category II Respondents**

Category II: The second category of respondents are the healthcare providers including Doctors, nurses, staff, and other members of hospital management. The researcher had collected data from 5 respondents from each category of the healthcare units from all three districts. So, the total number of respondents would be 3 (Ahmedabad+ Gandhinagar+ Panchmahal) **X** 4 (PHC + CHC + District Hospital + Private Hospital) **X** 5 healthcare providers =60.

2. **Tool for Data Collection from Category II Respondents**

For collecting data from category II respondents, the researcher had used a Questionnaire with open ended questions. The questionnaire consisted of 15 questions.

3. **Data Analysis**

Since the collected data is qualitative in nature, the researcher shall interpret then in a narrative way. The technique to be used is content analysis.

II. Sample Frame for Study of Category III Respondents

For qualitative analysis of the Research Question 3 & 4, the researcher has selected the experts and other stakeholders of the healthcare sector. Here the researcher aims to collect data using an in-depth interview method. The identified category includes two

health law experts from the academicians, researchers, and advocates, one person representing the Ministry of Health and Family Welfare of the government of Gujarat or Parliament, one draftsman each from the draft department of State of Gujarat as well as the Government of India, two representatives of the Gujarat Medical Council/Ahmedabad Medical Association, two members of Association of Physicians of Ahmedabad and two from among the NGO's working on the public healthcare sector[131]. This would make the sample size 10.

The third category of respondents includes healthcare experts from the state of Gujarat. The identified experts are;

Table 7: Selected Respondents for Qualitative analysis

Sr. No	Respondent	Justification for Selection
1.	Public healthcare experts	Both the selected faculties have done many grass root level researches to understand the issues and challenges the healthcare sector of Gujarat is undergoing.
2.	Academicians having Sociology, Economics, Law and Public Healthcare background	An established professor having done many works in the field of Women and Healthcare and other healthcare-related matters.
3.	Healthcare Experts	As they are working in the field of improving access to healthcare, the reason for including them in the qualitative study helped to get more insights into the problems and possible and required solutions.
4.	Representatives of Civil Society/NGO	Helped in understanding the grassroot level problems

131 All the identified category to be included in the research depending upon the availability of respondents.

5.	Bureaucrats / officers of the Government	This is another NGO working on the same cause. Interaction with them will give more insights into the problems and possible and required solutions.
6.	Legal Practitioners/Advocates	Helped in understanding the legal aspects involving right to healthcare.
Total		**10 Respondents**

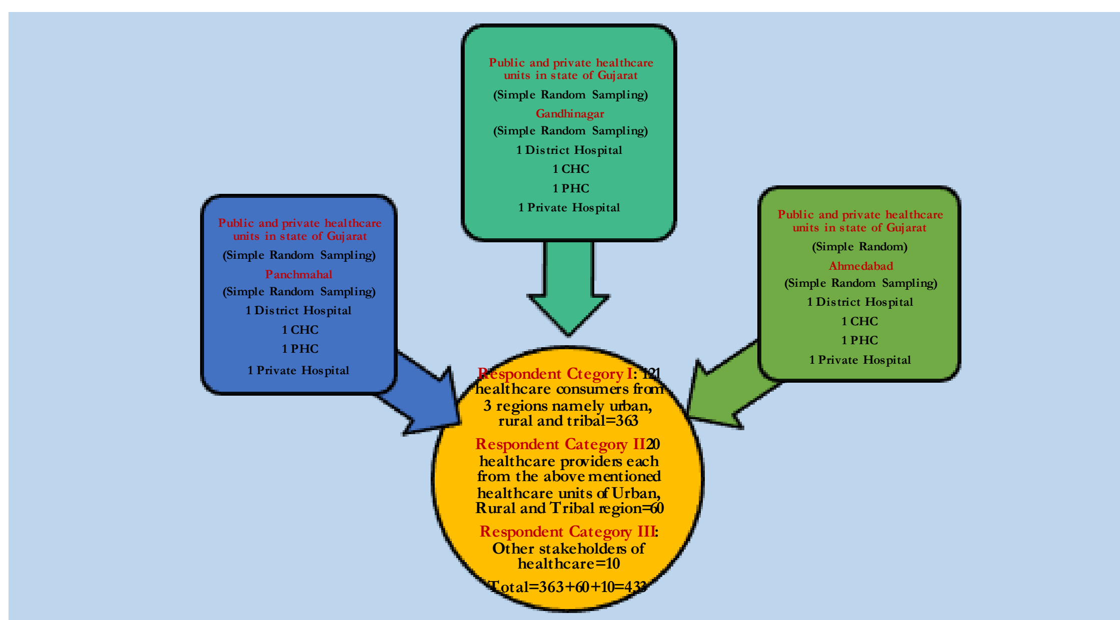
1. Data Collection Technique

The tool used for data collection from the experts is in-depth interviews and Focus Group Discussions (FGD). The researcher had used an in-depth interview guide with 12 open-ended questions to gather information from some of the experts and the same 12 open-ended questions were discussed in the FGD too.

2. Data Analysis

The researcher had used content analysis to interpret the data collected from the experts.

2.5.3 Figure 3: Total Sample of the Study



2.5.4 Limitations of the Study

The researcher has to restrict the study only to three districts of Gujarat due to the prevailing pandemic issues and restrictions on movement. The Covid situation has hampered the research as the nature of the research is empirical and the same requires visits to hospitals and households for data collection.

Similarly, the health emergency forced the researcher to restrict the study only to the urban, rural and tribal regions of the state, the researcher couldn't consider the semi-urban and coastal regions for the study.

Due to the paucity of time and the challenges thrown by the pandemic, the researcher could concentrate only on few aspects of healthcare namely quality, accessibility, Inequalities in access, and the evaluation of certain schemes by the central government and state government. Many other aspects of healthcare like the affordability of medicines, impact of the covid -19 emergency on healthcare etc and many schemes of Central and State government are not considered for the study.

CHAPTER 3

FINDINGS AND DISCUSSION

RIGHT TO HEALTHCARE: EVOLUTION, DEVELOPMENT AND INDIAN SCENARIO

3.1 Introduction

India has a massive healthcare system with a lot of disparities issues and challenges. Indian public healthcare system provides free inpatient and outpatient healthcare to the public. India has a decentralized approach with respect to the healthcare system. As deliberated in the previous chapters in India the healthcare is a state subject under list II of the Indian Constitution. India's public healthcare is known for lack of quality, poor human resources or non-availability of doctors and staff, and poor infrastructure. This is evident from the incidents[132] reported in 2017 where many children died due to lack of oxygen[133]. Due to the same majority of the households in India prefer to get treatment from private hospitals. In 2018 the Government of India launched the National Health Protection Scheme Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana[134] to support the economically weaker sections of the society.

Even after continuous efforts of the government, the healthcare system of India is still under the curb of evils like inequalities in access, non-availability of staff and medicine, non-accessibility, poor quality, etc. In this chapter, the researcher had analyzed two different concepts namely the approach of international law to the right to healthcare and the Indian approach. The chapter analyses how the concept of healthcare absorbed the color of right and what is the role played by the Government of India and the Indian Judiciary in recognizing it as a fundamental right. The chapter

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[132]"Gorakhpur Tragedy: 60 Children Die in Baba Raghav Das Medical College in a Week amid Oxygen Supply Disruption" *Hindustan Times* (2017) <https://www.hindustantimes.com/india-news/up-30-dead-in-48-hours-due-to-disruption-of-oxygen-supply-in-gorakhpur-hospital/story-TwMrMJxhAZzIkn3pXcZEMN.html> accessed September 30, 2021.

[133]"UP: 49 Infant Deaths in 30 Days at Farrukhabad Hospital; CMO and DM Removed" *India News* (2017) <https://www.indiatoday.in/india/story/farrukhabad-ram-manohar-lohia-hospital-infant-deaths-lack-of-oxygen-medicines-newborns-1037365-2017-09-04> accessed September 30, 2021.

[134] National Health Authority, "About Pradhan Mantri Jan Arogya Yojana (PM-JAY) | Official Website Ayushman Bharat Pradhan Mantri Jan Arogya Yojana" <https://pmjay.gov.in/about/pmjay> accessed September 30, 2021.

in detail analyses the International Instruments on healthcare, the legislations by the Government of India governing health and healthcare, the programmes and policies put forth by the government to improve the quality of healthcare and make it easily accessible to the public, and the expert committee reports on healthcare. This chapter analyses objectives 1[135] and 2[136] mentioned in chapter 3.

3.2 Right Based Approach to Healthcare

The very foundation of freedom, justice, and peace in the world is the equal and inalienable rights of human beings. United Nations reform efforts initiated in 1997 relies on the principle of Human Rights-Based Approach (HRBA), it is one of the key principles guiding UN common country programmes. Later in 2003 with an aim to adopt a common understanding of the Human Rights Based Approach, the UN agencies came together[137]. In addition to the UN Programme of Reform 1997, the World Summit 2005 and The Accra Agenda for Action 2008 also has emphasized the importance of integrating human right based approach into national policies of the member states. Prior to that UN had Right Vs. Needs Approach. Under this approach basic needs of beneficiaries are identified and either concentrated on improving the service delivery or advocated for the same. Whereas HRBA has a different approach, here people are recognized as key actors not beneficiaries[138]. HRBA system pushes the duty bearers to meet their obligation and on the other hand encourages the right holders to claim the same. The key focus area of this approach is the weaker sections of the society like marginalized, excluded etc. The approach here is that identification of human rights by programmes; rather than recipients of services, people are the key actors in their development and is ensured through participation; regular monitoring

[135]To analyse and understand the origin and significance of the right-based approach to healthcare and also the position of international law on right to health.

[136]To examine the Constitutional vision concerning the right to health envisaged under A.21 of the Indian Constitution and analyse the role of the Judiciary in ensuring quality healthcare accessible and available to the people.

[137] Sofia Gruskin, Dina Bogecho and Laura Ferguson, "Rights-Based Approaches to Health Policies and Programs: Articulations, Ambiguities, and Assessment" (2010) 31 Journal of Public Health Policy 129 <http://dx.doi.org/10.1057/jphp.2010.7>.

[138] Health and Human Rights Resource Guide, "The Approach to Human Rights" <https://www.hhrguide.org/153-2/> accessed November 17, 2021.

and evaluation of the process and outcome of the programmes; equal access without any discrimination is the key principle; identification of root problems etc.[139]

During the last two decades the international community with the cooperation of nation states has come to a common understanding that is Human Right Based Approach to Public Health. This approach of watching Public Health through the lenses of Human Right will enable the nations to understand the problem, identify the disadvantaged, design and execute the programmes and monitor and evaluate the process and outcome. The basis of this approach is participation, accountability, non-discrimination, empowerment, linkages to rights and sustainability. This practice establishes rights and corresponding state obligations under International Law. This approach aims to eliminate the inequalities, discriminatory practices and the unjust power relations which come in the way of sustainable development of the healthcare sector.

Realization and integration of right to health in national policies is the first step advocated by the international community for the sustainable development of the health sector. The right to health is already recognized by many of the core international instruments like "The International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC)". The interpretation of "General Comment 14 by Committee on Economic, Social and Cultural rights" demonstrated that right to health is a multifaceted concept and cannot be dealt with in isolation. It includes timely and appropriate healthcare and other underlying determinants essential to ensure good health like potable water, food, sanitation, shelter, pollution free environment to live, education etc.[140] The "General Comment 14 describes AAAQ-Availability, Accessibility, Acceptability and Quality" as the four elements essential to ensure healthcare for all.

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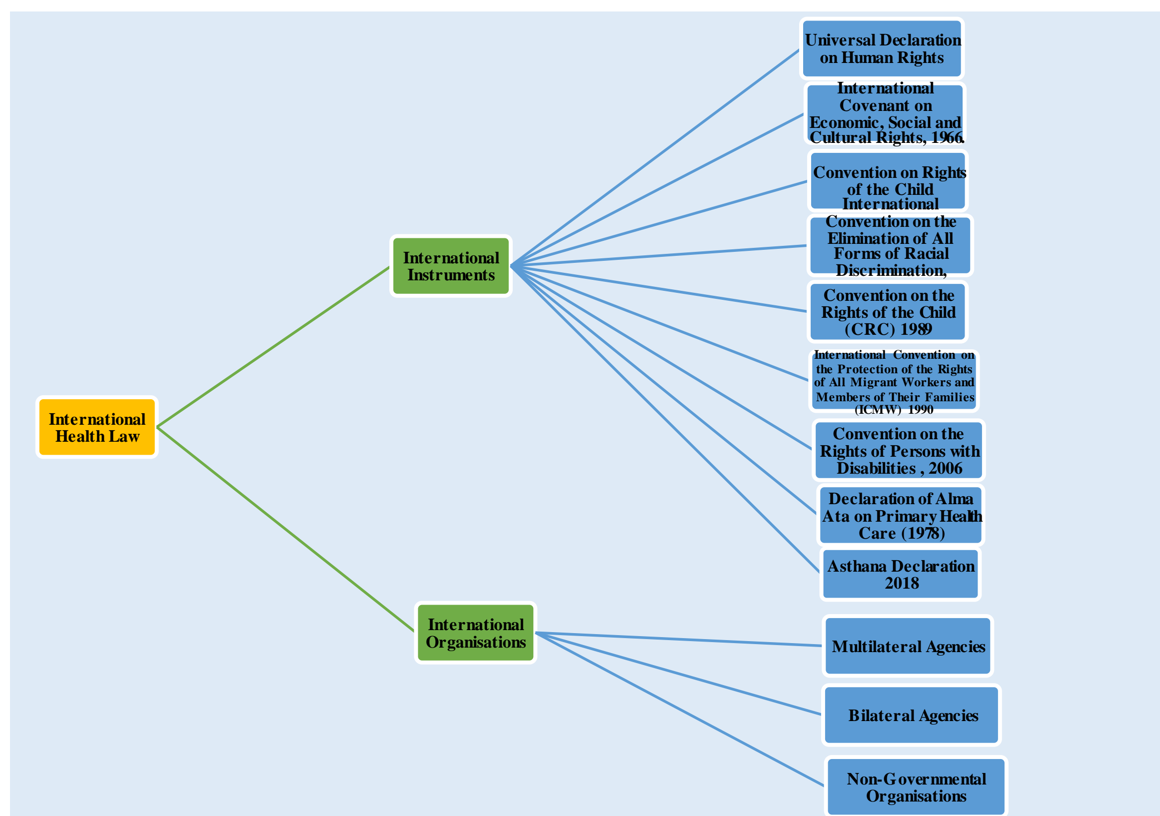
[139] UNFP (n 14).

[140] General comment No. 14: The right to the highest attainable standard of Health.

3.3 International Law and Healthcare

Health Law is an emerging field of Public International Law. Protection of health has become a pressing social need with the Covid Pandemic and is one of the major challenges the whole globe is undergoing now, hence it requires an important space in international law. The origin of the right-based approach to health marks its roots in International Law. "Right to highest attainable standard of health" is the slogan of International Law. International Health Law brings together international standard-setting instruments under human rights law; rules, regulations and norms adopted under the World Health Organization and overlapping branches of Public International Law.



(Figure 4: International Law and Healthcare)

As mentioned in the above paragraphs, international law is the starting point of the right based approach to health. It was Universal Declaration on Human Rights for the first time provided for medical care and health. Later on, many International human

right treaties have addressed this much neglected issue. In addition to the international instruments, there are many international organizations working towards improving the access to healthcare globally. They can be classified in to multilateral organizations, bilateral organizations and non-governmental organizations.

3.3.1 International Instruments on Healthcare

1) Universal Declaration on Human Rights (UDHR)

UDHR is a revolutionary document on human rights adopted by UN General Assembly in 1948. The United Nations General Assembly adopted it as Resolution 217 during its third session on December 10, 1948, in the Palais de Chaillot in Paris, France. There were 48 votes in favour, none against, eight abstentions, and two no votes among the 58 members of the United Nations at the time. The document provided for the rights and freedoms of human beings. The "Universal Declaration of Human Rights (UDHR)" binds states to acknowledge all people as "born free and equal in dignity and rights, regardless of their nationality, place of residence, gender, national or ethnic origin, colour, religion, language, or any other status". Under Article 25 UDHR emphasises on the importance of protection of health and healthcare.

> According to the article 25(1) "*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control*".
>
> And 25(2) states that "*Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection*"[141].

The first part of the article has two different aspects primarily it talks about the right to health and well-being of the people and secondly it highlights the criteria's necessary to lead a healthy life which include medical care too. The second part of the article is focusing on protection of health of vulnerable group like women and children.

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[141] Universal Declaration on Human Rights 1948 1948.

2) International Covenant on Economic Social and Cultural Rights (ICESCR) 1966

ICESCR is a multilateral treaty adopted by UN General Assembly in 1966. Around 171 countries have signed the covenant as per the data of 2020. "The main aim of the covenant is to work towards the granting of economic, social, and cultural rights (ESCR) to the Non-Self-Governing and Trust Territories and individuals, including labour rights and the right to health, the right to education, and the right to an adequate standard of living". The covenant under Article 12 provides for right to health and healthcare. The article reads as.

> 1. *"The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
> 2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
>
> a) *The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
> b) *The improvement of all aspects of environmental and industrial hygiene;*
> c) *The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
> d) *The creation of conditions which would assure to all medical service and medical attention in the event of sickness"*[142].

This covenant went one step ahead the Universal Declaration and specifically included both physical and mental health in its ambit. The Article also talks about the need for working towards reduction of still birth rate, IMR and healthy development of the children by the member states. The Covenant seek the member countries to maintain environmental and industrial hygiene. The member states are also directed to work towards prevention and control of epidemic and endemic and maintain occupational health. Finally, the covenant directs the member countries to prepare the nations to deal with all medical emergencies.

[142] International Covenant on Economic, Social and Cultural Rights.

3) International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) 1965

The International Convention on the Elimination of All Forms of Racial Discrimination (hereinafter ICERD) is the cornerstone of the international regime for racial discrimination protection and enforcement. In 1965, "the International Convention for the Elimination of All Forms of Racial Discrimination" came in to force, and it became effective in 1969. It is still the most important international human rights document for defining and banning racial discrimination in both private and public life. Article 5 of the document has included healthcare as its part under the Economic, Social and cultural rights. Article 5 reads as follows;

> "*In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:*
>
> *[...] (e) Economic, social and cultural rights, in particular:*
>
> *[...] (iv) The right to public health, medical care, social security and social services; [...]".*

4) Convention on the Elimination of All Forms of Discrimination Against Women, (CEDAW) 1979

CEDAW is a gender specific instrument of UN intending to ensure equality and prevent all kinds of discrimination against women. The instrument defines discrimination as "any distinction, exclusion, or restriction made on the basis of sex that has the effect or purpose of impairing or nullifying the recognition, enjoyment, or exercise by women, irrespective of their marital status, of human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field, on the basis of equality of men and women". The Convention directs the state parties who are members of the convention

(i) to undertake all necessary measures to eliminate discrimination against women in all its forms.

(ii) to alleviate discrimination based on gender and incorporate principles of equality in their legal system

(iii) to establish effective adjudicatory and monitory mechanisms to guarantee protection of women against discrimination

The instrument in Article 12 specifically provides for healthcare oif women. The article reads as;

> *12 (1). "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning".*
>
> *(2.) "Notwithstanding the provisions of paragraph, I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation"*[143]*.*

5) Convention on the Rights of the Child (CRC) 1989

CRC is a document provides for the protection of rights of children. It has a inclusive approach to health and healthcare of the Children. It emphasises on health promotion, curative, rehabilitative, palliative services and timely and appropriate prevention of diseases in children. In addition, the text addresses the right of children to reach their full potential and live in situations that allow them to achieve the maximum level of health possible through the implementation of programmes that address the underlying determinants of health.

Article 24 of the convention reads as *"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. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.*

> *2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:*

a. To diminish infant and child mortality;
b. To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
c. To combat disease and malnutrition, including within the framework of primary health care, though, inter alia, the application of readily available technology

[143] Convention on the Elimination of All Forms of Discrimination against Women 1979.

and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

d. *To ensure appropriate pre-natal and post-natal health care for mothers;*
e. *To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;*
f. *To develop preventive health care, guidance for parents and family planning education and services.*

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries".

6) International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICMW) 1990

ICMW, 1990 is an international Convention implemented with an aim to protect the rights of Migrant Workers which includes right to health too. The covenant under Article 28 provided for the right to receive medical care by migrant and his/her family in case of emergency. Under Article 43 the covenant guarantees equality in access to healthcare and equal treatment with other nationals of the state in case of access to healthcare to migrants and their family. This has been a great step by the international law which is difficult to even locate in national laws when there is migration from one state to the other[144]. The provisions on healthcare under the covenant reads as follows;

"Article 28: Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.

Article 43(1): 1. Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to:

[144] MK Zhurunova, "Protection of the Rights of Migrant Workers in the EAEU" [2020] Law and State 105.

(e) Access to social and health services, provided that the requirements for participation in the respective schemes are met;

Article 45(1): 1. Members of the families of migrant workers shall, in the State of employment, enjoy equality of treatment with nationals of that State in relation to:

(c) Access to social and health services, provided that requirements for participation in the respective schemes are met".[145]

Healthcare of migrants has got a lot of significance with 244 million international migrants around the world. An accessible healthcare system without any discrimination to migrants and refugees are essential to achieve the vision of 2030 Agenda and the SDG which calls for 'leave no one behind'. The illegal or undocumented migrants living in various countries are out of healthcare system[146]. Some of the countries have implemented specific policies intending to protect irregular migrants, however there is no uniform system around the world and also the legal entitlements have failed to guarantee access[147].

7) Convention on the Rights of Persons with Disabilities (CRPD) 2006

CRPD is the first convention aiming to protect the rights of specific category 'persons with Disability' developed by UN. Convention provides for inclusive approach in healthcare. The convention emphasises on non-discriminatory practices in access to healthcare. The provisions of healthcare under the convention reads as follows;

"*Article 25: States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:*

(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons,

[145] International Convention on the Protection of the Rights of All Migrant Workers 1990.
[146] Kolitha Wickramage and others, "Migration and Health: A Global Public Health Research Priority" (2018) 18 BMC Public Health 1 <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-5932-5> accessed November 27, 2021.
[147] World Health Organisation, "Health of Refugees and Migrants" (2018).

including in the area of sexual and reproductive health and population-based public health programmes;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people's own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability"[148].

8) Declaration of Alma Ata on Primary Health Care (1978)

Alma Ata Declaration on Primary healthcare is considered to be another watershed event in the history of healthcare. The declaration reaffirmed the definition of health given by WHO and declared it as a fundamental human right. It discusses the need for elimination of inequality in access to healthcare based on developed and developing countries and within the countries. The convention advocates the need for people's participation in the planning and implementation of healthcare. The main objective of this declaration is attainment of "Healthcare for All by 2020" and this concept has its origin in definition of health given in the Constitution of WHO. Unfortunately, this target was not achieved by the declaration and even after 20 years the disparities based

[148] Convention on the Rights of Persons with Disabilities.

on various factors still exist in the healthcare system of majority of the nation states so as in case of India too.

> *"VI. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*
>
> *VIII. All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally"*[149].

9) Declaration of Astana on Primary Health Care (2018)

This declaration is a continuation of the Alma Ata Declaration 1978 which unfortunately had failed to achieve the formulated goals. This new declaration on primary healthcare is signed by 120 countries. This declaration focuses on disease prevention and health promotion more specifically preventive, promotive, curative, rehabilitative services and palliative care. The declaration also concentrates on non-communicable diseases, mental health and health impacts of climate change[150].

> *"I. We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind. Convening on the fortieth anniversary of the Declaration of Alma-Ata, we reaffirm our commitment to all its values and principles, in particular to justice and solidarity, and we underline the importance of health for peace, security and socioeconomic development, and their interdependence.*
>
> *IV. We reaffirm the primary role and responsibility of Governments at all levels in promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health.*

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[149] Alma Ata Primary Healthcare Conference 1978.

[150] Gijs Walraven, "The 2018 Astana Declaration on Primary Health Care, Is It Useful?" (2019) 9 Journal of Global Health 10313 </pmc/articles/PMC6445497/> accessed November 18, 2021.

VI. We support the involvement of individuals, families, communities and civil society through their participation in the development and implementation of policies and plans that have an impact on health. (...) We will protect and promote solidarity, ethics and human rights. (...)

VII. (...) In implementing this Declaration, countries and stakeholders will work together in a spirit of partnership and effective development cooperation, sharing knowledge and good practices while fully respecting national sovereignty and human rights"[151].

The studies have proved beyond doubt that though there are specific instruments on on protection of human rights including the health and healthcare of the public, majority of the member states couldn't include them in the national legislations and in case of the countries where equal access to healthcare has been addressed by the legislation, the legal entitlements in reality are not guaranteeing the access.

3.3.2 International Organizations and Healthcare

There are multiple international agencies and institutions striving to shape global health policies and fund, implement such policies and evaluate the effectiveness of such programs. They are generally categorized multilateral organizations, bilateral organizations, and non-governmental organizations (NGOs).

1) Multilateral Agencies

Multilateral agencies get funding from multiple governments and non-governmental sources and is distributed among many different countries. The prominent multilateral organizations are all part of the United Nations which include the World Health Organization, World Bank, UNICEF, UNFPA etc. Among all WHO is the main organization actively working on improving health and healthcare globally.

a) World Health Organization

World Health Organization is one of the United Nations agencies founded in 1948 to promote health around the globe[152]. It leads the global efforts to implement

[151] "Astana Declaration on Primary Healthcare" (2018) <https://www.who.int/teams/primary-health-care/conference/declaration> accessed November 18, 2021.
[152] WHO, "About World Health Organisation" (n 13).

Universal Health Coverage. This organization of UN is working closely with all 194 member states. The activities of WHO are rooted in the concept "right to health and well-being for all" as outlined in the Constitution of WHO. 'Right to Health' founds its origins in the Constitution of World Health Organisation. World Health Organisation's Constitution through its preamble *"... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*[153]. World Health Organisation for the first time expanded the scope of healthcare beyond mere physical wellbeing and included mental health too. As per WHO it is the capacity of a person to lead a productive life in the society, for the same he requires both mental and physical well-being. Healthcare is an integral part of health.

"Advocating for universal healthcare, monitoring public health hazards, coordinating responses to health emergencies, and promoting health and well-being are all part of the WHO's mission". It assists countries with technical aid, establishes worldwide health standards, and gathers data on global health concerns[154]. WHO's approach to government health policy has two goals: "first, to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches, and second, to promote a healthier environment, intensify primary prevention, and influence public policies in all sectors so as to increase health equity"[155].

The WHO has played a leading role in several public health achievements, most notably the eradication of smallpox, the near-eradication of polio, and the development of an Ebola vaccine. Its current priorities include communicable diseases, particularly HIV/AIDS, Ebola, COVID-19, malaria and tuberculosis; non-

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[153] Constitution of World Health Organisation.
[154] WHO, "What We Do- World Health Organization" (2017) <https://www.who.int/about/what-we-do> accessed September 14, 2021.
[155] Joan Benach and others, "A Conceptual Framework for Action On the Social Determinants Of Health" (2010).

communicable diseases such as heart disease and cancer; healthy diet, nutrition, and food security; occupational health; and substance abuse.

b) World Bank

World Bank is a leading institution for investments in health and development. This multilateral agency plays a critical role in shaping global health policy. World Bank is supporting the countries to alleviate poverty, improving education, healthcare, agriculture, environment and natural resources and also for the infrastructure development by providing loans, credits and grants to the under developed and developing nations. This organisation is supporting countries to achieve the goal of Universal health coverage and to develop a quality affordable healthcare system accessible to all, regardless of their ability to pay[156].

In 2015 World Bank hosted a multi-stakeholder partnership intending to reduce the maternal and Child Mortality burden called The Global Financing Facility for Women, Children and Adolescents (GFF). Since its inception, the partner countries have made commendable progress. In addition to this World Banks contribution to support mental health-related activities are also commendable. This organisation is supporting countries in eradication of communicable and non-communicable diseases as well. World Bank aim is to support countries to build healthier, more equitable societies, as well as to improve their financial performance and country competitiveness[157].

Other activities of the World Bank include research in global, regional, and country-level and knowledge generation, financial investments, technical assistance, and global convenings. Aiming to achieve the Sustainable Development Goal 3.8 "to achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe,

[156] The World Bank, "Public Health and World Bank Operations (Health, Nutrition, and Population Series)."
[157]World Bank, "Health Overview: Development News, Research, Data" <https://www.worldbank.org/en/topic/health/overview#1> accessed May 29, 2022.

effective, quality, and affordable essential medicines and vaccines for all" World Bank concentrates on four major areas namely;

(i) Firstly, its World Bank supports the countries to build affordable, quality primary healthcare by funding for the same.
(ii) Secondly, it promotes private sector participation as it is impossible for the public sector alone to meet the unmet coverage and financing needs. It is working towards unlocking new models for health financing and delivery.
(iii) Thirdly, World Bank supports countries to develop the other determinants of health; work towards improving education, broadening social services, and creating jobs.
(iv) Fourthly, this organisation is helping nation-states to catalyse domestic resources to build sustainable national health systems[158].

c) United Nations Children's Fund

United Nations established UNICEF post second world war in 1946 to provide emergency food and health care to children in affected countries. Currently UNICEF supports the development of children in 190 countries. UNICEF delivers medical supplies and healthcare services to the countries aiming to support child health. In addition to the direct intervention in healthcare it also works towards enhancing the education, advocacy for children's rights, health related research, and disaster relief[159].

This multilateral organisation is focusing on major health concerns like HIV and AIDs, maternal and child nutrition, excessive maternal mortality, increasing vaccination rates, among other areas of importance such as gender equality, and child survival and development. UNICEF believes that to achieve the sustainable goal 3.8, there has to be a global shift from treating diseases to strengthening the healthcare system. The major activities of UNICEF include;

[158] Bank (n 158).
[159] "What We Do | UNICEF" <https://www.unicef.org/what-we-do> accessed May 29, 2022.

i. **Support to improve maternal, new born and child care:** UNICEF works to end preventable maternal, new born and child deaths and stillbirths by scaling up quality essential maternal and new born care services, sustaining immunization programmes, and supporting preventive, promotive and curative services for pneumonia, diarrhoea, malaria and other child health conditions[160].

ii. **Health and Well-being of Children including Adolescents:** UNICEF is committed to helping children and adolescents build a solid foundation for adulthood. They support the national health plans on adolescent health and well-being, improve age-specific health services for children and adolescents, and help countries combat non-communicable diseases including mental ill-health, prevent injuries and better support children with developmental delays and disabilities.

iii. **Health System Strengthening:** UNICEF supports primary health care, especially at the community level, to help achieve universal health coverage. We work to strengthen health systems to deliver integrated services for children, adolescents and women of reproductive age – focusing on health; nutrition; early childhood development; HIV and AIDS; and water, sanitation and hygiene. Our work also promotes overall health and well-being by focusing on education, child protection and social inclusion.

iv. **Health in emergencies and humanitarian settings:** One of the notable works by UNICEF is its support to the places affected by conflicts, natural disasters, migration, urbanization, and political and economic instability. UNICEF supports such regions through direct responses to emergencies and help them to develop resilient health systems[161].

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[160] Mark Young and others, "World Health Organization/United Nations Children's Fund Joint Statement on Integrated Community Case Management: An Equity-Focused Strategy to Improve Access to Essential Treatment Services for Children" (2012) 87 Am. J. Trop. Med. Hyg 6 <www.CCMCentral.com.>.

[161] UNICEF (n 15).

d) United Nations Population Fund (UNFPA)

UNFPA is known as the United Nations sexual and reproductive health agency. It declares that every pregnancy is wanted and strives for the realization of reproductive rights. UNFPA offers support to women in more than 150 countries. It also supports voluntary family planning, and comprehensive sexuality education. The main functions of UNFPA include promotion of universal access to quality sexual and reproductive healthcare; eradication of preventable maternal mortalities and alleviation of gender-based violence and harmful practices like child marriage, Female Genital Mutilation etc[162].

e) UNAIDS: Created in 1996 UNAIDS works towards eradication of HIV /AIDS. This organisation is a collaboration of various UN agencies and activities of UNAIDS is spread across 80 nations. The collaborated 11 organisations include UNHCR (United Nations High Commissioner for Refugees), UNICEF (United Nations Children's Fund, World Bank, UNESCO (United Nations Educational, Scientific and Cultural Organization), UN Women (United Nations Entity for Gender Equality and the Empowerment of Women), UNDP (United Nations Development Programme), UNFPA (United Nations Populations Fund), WHO (World Health Organisation), World Food Programme, UNODC (United Nations Office on Drugs and Crime), ILO (International Labour Organisation). This joint initiative is coordinated by the secretariat of UNAIDS situated in Geneva[163].

HIV/AIDS interventions including treatment, counselling and testing, social safety nets, health sector strengthening, prevention, training, and technical support with financial support are the major contributions by UNAIDS. All these services are rendered with the collaboration and support of all the 11 partner organizations as well as donations.

[162] UNFP (n 14).
[163] "About UNAIDS | UNAIDS" <https://www.unaids.org/en/whoweare/about> accessed May 29, 2022.

2) Bilateral Agencies

A bilateral organization is an organisation that is based in single country and provides assistance to developing countries. It can be a governmental or non-governmental organisation. There are many such organisations functioning to improve the healthcare in the developing and under developed regions.

a) **United States Agency for International Development:** USAID is one of the largest bilateral agencies involved in global health efforts. In 1961, Congress started with U.S. foreign assistance programs. It became the first U.S. foreign assistance organization whose primary emphasis was on long-range economic and social development assistance. It strives to end extreme global poverty while assisting resilient, democratic societies to realize their potential. USAID's commitment to improving global health includes confronting global health challenges through improving the quality, availability, and use of essential health services. USAID provides funding for and supports global health initiatives in areas such as emerging pandemic threats, family planning, HIV and AIDS, health systems strengthening, malaria, maternal and child health, neglected tropical diseases, nutrition, and tuberculosis (TB).

b) **Centres for Disease Control and Prevention (CDC):** This is another organisation based at USA. CDC is part of the U.S. Department of Health and Human Services. In USA, CDC is responsible for implementing public health initiatives. This agency of USA is working to achieve protection of public health and safety by concentrating on prevention of diseases worldwide. The major focus area of CDC includes infectious disease, foodborne pathogens, environmental health, occupational safety and health, health promotion, injury prevention and educational activities designed to improve the health of United States citizens. It also conducts research and give suggestions to the countries on strengthening the healthcare system.

3) Non-governmental Organizations

In addition to the government organisations, there are a number of non-governmental organisations working towards strengthening the healthcare system of the poor nations.

a) **Doctors Without Borders / Médecins Sans Frontières:** Médecins Sans Frontières is a non-governmental organisation striving to support countries that are having emergency medical aids. This organisation assists the countries affected by conflict, epidemics, disasters, or lack of access to care.

b) **CARE International (Cooperative for Assistance and Relief Everywhere):** It is a humanitarian organization with a mission to fight global poverty. The organization places special emphasis on working with and empowering women as a way to help whole families and communities escape poverty. The organization's programs focus on emergency response, advocacy, education, maternal health, HIV and AIDS, and food security, among other issues.

   In India CARE till the end of 1980 focused on providing food to children between the age group of 6-11 and later on it extended the support to ICDS programmes. Currently CARE is supporting Government of India in Integrated Nutrition and Health Project; Better Health and Nutrition Project; Anaemia Control Project; Improving Women’s Health Project; Improved Health Care for Adolescent Girl’s Project; Child Survival Project; Improving Women’s Reproductive Health and Family Spacing Project and Konkan Integrated Development Project etc

c) **Population Services International:** Population Services International (PSI) is a non-profit organization that takes a business approach to save lives by breaking the traditional development model and addressing the most challenging health problems by using proven business practices such as marketing and franchising. PSI helps build strong health systems in the private and public sector by using the expertise of over 8,900 local staff located in more than 65 countries globally. Other programmes of PSI include programs targeting malaria, child survival, HIV, and reproductive health.

d) **The International Red Cross and Red Crescent Movement**: It is a global humanitarian network of 80 million people. This organisation helps those facing disaster, conflict and health and social problems. It consists of the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies and the 192 National Red Cross and Red Crescent Societies.

3.4 Protection of Right to Healthcare in India

Healthcare in India is protected under the Constitution and various legislations. The responsibility of state towards public healthcare has its roots in

1. International Law;
2. Constitutional obligation;
3. Obligation based on human right approach;
4. Legal obligation arising out of legislations;
5. Obligation arising out of judicial pronouncements considering healthcare as part of Article 21 and;
6. Obligation as a welfare state[164].

3.4.1 Obligation of India to Protect Healthcare under International law

The country being a member to many international conventions and treaties which recognised public healthcare as a human right is bound to abide by its obligations under international law by virtue of Article 52 read with entries 12,13 and 14 of Central list 7th schedule of the Constitution. The human right to health and the state responsibility to protect the same under international law has already been discussed above under 4.3. “The Universal Declaration of Human Right” is the first ever document considered medical care as a human right[165]. Later the “International Covenant on Civil and Political Rights” under Article 6, “International Covenant on Economic, Social and Cultural Rights”[166]under Article 12 recognised “right of everyone to enjoy highest attainable standard of physical and mental health” as a fundamental human right. These

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[164]Sujata Pawar, “State Responsibility for Ensuring Health Care: Assam Leads the Way!” [2011] Practical Lawyer <https://www.supremecourtcases.com> accessed November 18, 2021.
[165] A.25, Universal Declaration on Human Rights 1948.
[166]A.12, International Covenant on Economic, Social and Cultural Rights.

documents further impose the states to provide proper medical services to its citizens to ensure the same. In addition to these instruments there are other specific instruments focuses on protection of rights of specific groups like for women there is CEDAW, Social minorities CERD, children CRC, for physically disabled CPRD and for protection of Migrant rights ICMW. Under all these instruments our nation is duty bound to meet the requirements of public in relation to healthcare after considering the economic capacity of the nation. (All International Instruments are discussed in detail under Chapter 4A-4.3)

3.4.2 Obligation under Constitution of India

The Constitution of India doesn't have any express provision on protection of healthcare under part III of the Constitution, but it has been read into Article 21 which provides for "Right to Life and Personal Liberty" by the judiciary. Article 21 says *"No person shall be deprived of his right to life and personal liberty except according to procedure established by law"*, which means the Constitution guarantees the fullest enjoyment of life and liberty to the citizen under this article. Anything which directly or indirectly intervenes in the fullest enjoyment of life is an infringement of this guaranteed right. Ill health interferes and deprives a person of his right to life. Furthermore, when this ill health is due to non-accessibility of medical care, malnutrition, starvation, unhealthy environment etc depicting the failure of the state in providing public health, it amounts to violation of the right guaranteed under A.21. One side the article provides for conditions and environment essential to lead a life with dignity and the other had it prevents the state from interfering with this right without just, fair and reasonable procedure. Thus, through the provision A.21, state has an obligation to protect the right to health and healthcare of the public.

Other provisions of the Constitution dealing with healthcare directly or indirectly are "Articles 38, 39(e) & (f), 41 and 47 under Part IV", it gives certain directives to the government.

Article 38 imposes a duty on the state to work towards attaining the welfare of the public. As per the article the state should create an environment where economic, social and political justice is ensured. This goal put forth by the Constitution imposes an

obligation on the state to provide healthcare justice to achieve the ultimate goal of social justice.

> *Article 38 (1) reads as "The State shall strive to promote the welfare of the people by securing and protecting as effectively as it may a social order in which justice, social, economic and political, shall inform all the institutions of the national life"*[167].

Article 39(e) and (f) provides for the protection of health of the vulnerable sections of the society like workers, women and children. Through this article the Constitution gives a directive to the state to implement policies intending to achieve the same. Article 39 (e) reads as;

> *"39(e): The State shall, in particular, direct its policy towards securing that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength*[168]*;*
>
> *39(f): The State shall, in particular, direct its policy towards securing those children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment"*[169].

The government of India has already formulated and implemented a number of policies and schemes to protect the health and vigour of the workers, men, women and children. There are laws in place to prevent the exploitation of these vulnerable sections including the children and to protect their rights. Though there are improvements in the condition these steps have not achieved the goal of achieving social justice yet.

Under Article 41 the Constitution emphasises that the state should make effective provisions for securing public health along with couple of other rights. However, the Constitution has made it clear that such provisions should be within the limits of economic capacity of the state. Considering the economic status of the country at the time of framing of the Constitution the architects of Constitution has wisely kept this provision under the Directive Principles of State Policy. The provision reads as;

> *"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*

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[167] A.38, The Constitution of India [As on 1st April, 1950].
[168] A. 39(e),The Constitution of India [As on 1st April, 1950].
[169] A. 39(f), The Constitution of India [As on 1st April, 1950].

assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want"[170].

Under Article 42, the Constitution directs the state to make provisions for just and human conditions of work along with provision for maternity relief. Article 47 is a direction given by the Constitution to invest time and money on improving the level of nutrition and standard of living of the public. Malnutrition, stunting and wasting are one of the severe health challenges our nation is undergoing now. The cases of malnutrition are still high in India. According to Article 47

> *"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"*[171].

Malnutrition is one of the serious challenge our country is encountering currently. It was in 2012 the World Health Organisation declared 6 Global Nutrition Targets with an aim to achieve them by 2025[172]. Those targets included reduction of anaemia among women at reproductive age to 50%, reducing the low-birth-weight cases to 30%, promotion of breastfeeding for the first 6 months up to at least 50%, reduction of stunting under age 5 up to 40%, reduction of under 5 wasting up to 5%, no increase in under-5 overweight; and also controlling the increase in obesity and diabetes prevalence[173]. On the other hand, the reports are depicting different data. The Global Nutrition Report of 2021 reported five out of the aforementioned six targets are off track. And the current pandemic crisis has added to the disease burden and food and nutrition insecurity of the country[174]. The NFHS 5 data as per the recent report, India has become home to 200 million undernourished people.

Under Article 243 G and 243 W the Constitution directs the state government to authorize the local self-government bodies such as Panchayats and Municipalities,

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[170] A.41 The Constitution of India [As on 1st April, 1950].
[171] A.47, The Constitution of India [As on 1st April, 1950].
[172] World Health Organisation, "Nutrition and Food Safety" (*World Health Organisation*, 2012) <https://www.who.int/teams/nutrition-and-food-safety/global-targets-2025> accessed May 25, 2022.
[173] Organisation, "Nutrition and Food Safety" (n 173).
[174] WHO, "Global Nutrition Report" (2021) <http://www.segeplan.gob.gt/2.0/index.php?option=com_content&view=article&id=472&Itemid=472>.

through a legislation, to ensure the proper implementation of schemes aiming economic development and social justice which includes public healthcare too[175]. Entry 23 of the eleventh schedule to the Constitution assigns to the panchayats the subject health and sanitation including hospitals primary health centres and dispensaries. Similarly, entry 6 of the twelfth schedule empowers the municipalities to implement the schemes in relation to public health in their respective areas. Entry 6 of the state list under schedule VII, empowers the state government to exercise their power under Article 246 to enact legislations to regulate the public health, sanitation, hospitals, dispensaries and related matters. Also, Article 253 empowers the Parliament to enact laws to give effect to international instruments. The Constitution makers have included some of the health-related subjects in the concurrent list to enable both Central and state governments to regulate those regimes, which include interstate element in public health; Lunacy and mental deficiency including the healthcare units meant to treat the same[176].

3.4.3 Obligation Based on Human Right Approach

The whole concept of human right based approach to healthcare has its origin in International Law. It was the idea of UN to change its basis from Rights VS. Needs to the philosophy of Human Right Based Approach (HRBA), which got acceptance in 2003 by the member states. Since then, for more inclusive and sustainable development of rights the UN agencies and the nation states are having this approach. As discussed under 4.2 this practice aims to remove all kind of discrimination in access to healthcare and make the right equally accessible to all with the active participation of the public in decision making and implementation of the schemes. Indian Government is currently working towards achieving Universal Health Coverage. UHC is defined as "*ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the*

[175] MP Jain, *Indian Constitutional Law* (8th edn, Lexis Nesis 2018).
[176] Constitution of India, 1950.

guarantor and enabler, although not necessarily the only provider, of health and related services"[177]. The same is reflected in the National Health Policy of 2017 too. The key principles of the National Health Policy were revised to include equity, universality, affordability, quality, leveraging technology/digital health and focus on preventive and promotive health among others[178]. This demonstrates that India has adopted the right based approach in its functions relating to public health.

In India the National Human Right Commission also has baked this idea of Human Right Based Approach to Health and has long back recommended the government to adopt this method in matters of public health.

3.4.4 Obligation under Legislations Enacted by the Parliament

The Parliament by exercising its power under A. 246 and 253 has enacted a number of legislations intending to regulate the public healthcare regime. The legal obligation of the state to govern public healthcare arises out of these legislations. Some of such legislations directly related to the delivery of quality public healthcare has been categorised under the below heads.

The important legislations pertaining to Public Healthcare in India can be classified into five;

(1) Legislations governing the qualification, practice and conduct of medical professionals and Quality of Healthcare services and facilities;
(2) Legislations on Disease Control and Medical Care;
(3) Laws Governing Safe Medication and Sale and storage of Drugs
(4) Some other legislations and rules directly or indirectly dealing with public healthcare.

Being a welfare state, it is the duty of the government to protect the health of its citizens and provide equal access to quality healthcare to all.

1. **Legislations governing the qualification, practice, and conduct of medical professionals and Quality Health Facilities and Services:** In India, there is no

[177] Charu Sehgal and others, "Medical Technology Shaping Healthcare For All In India" 1.
[178] National Health Policy.

uniform law to regulate the quality of healthcare services and facilities whereas there are various legislations indirectly governing the same. Public health being a state subject each state has the right to make their own legislation to govern the public healthcare sector. This has led to inequalities in access to healthcare within the country as some of the states are governing healthcare effectively and some are lagging behind. The legislations described in the below table aim to ensure that the staff working in the public healthcare sector is having enough qualifications and are authorized to perform the technical duties.

Sr. No	Name of the Legislation	The objective of the Legislation
1)	"The Medical Council Act 1956[179] replaced by the National Medical Commission Act, 2019	"Th act aims to provide for a medical education system that improves access to quality and affordable medical education, ensures availability of adequate and high quality medical professionals of Indian System of Medicine in all parts of the country; that promotes equitable and universal healthcare that encourages community health perspective and makes services of such medical professionals accessible and affordable to all the citizens; that promotes national health goals; that encourages such medical professionals to adopt latest medical research in their work and to contribute to research; that has an objective periodic and transparent assessment of medical institutions and facilitates maintenance of a medical register of Indian System of Medicine for India and enforces high ethical standards in all aspects of medical services; that is flexible to adapt to the changing needs and has an effective grievance redressal mechanism and for matters connected therewith or incidental thereto".
2)	Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002	This regulation provides for a certain code of medical ethics to be followed by the medical practitioners while practising their profession. This regulation has provisions on the character of the medical practitioner, good practices, maintenance of medical records, highest quality

[179] The Indian Medical Council Act, 1956.

		assurance in patient care, duties of the physician towards the sick etc[180].
3)	Indian Medical Council (Professional Conduct, Etiquette and Ethics) (Amendment Regulations) 2020	This amendment provides for tele-medical care. The aim of the regulation is *"the delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for the diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities"*[181].
4)	The Indian Medical Degrees Act, 1916	This is an act aimed to "*regulate the grant of title implying qualifications in western medical science*"[182].
5)	Indian Nursing Council Act 1947	The act provides for the establishment of a Nursing Council to regulate the training of nurses, midwives and health visitors in order to bring a uniform standard of training[183].
6)	The Pharmacy Act, 1948	The act aims to establish the Pharmacy Councils for better regulation of the profession of Pharmacy[184].
7)	The Dentist Act, 1948	The act aims to establish the Dental Councils for better regulation of the profession of Dentistry[185].
8)	All India Institute of Medical Sciences Act, 1956	This is an act that established the All-India Institute of Medical Sciences (AIIMS). AIIMS is an institution of national importance established by the Government of India[186]. It is a public hospital and Medical Research University aims (1) to develop a pattern of teaching in undergraduate and postgraduate medical education in all its branches to demonstrate a high standard of medical education to all

[180] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 (Published in Part III, Section 4 of the Gazette of India, dated 6th April, 2002) Medical Council of India Notification 2002.
[181] Indian Medical Council (Professional Conduct, Etiquette and Ethics) (Amendment Regulations) 2020.
[182] Indian Medical Degrees Act, 1916.
[183] Indian Nursing Council Act 1947.
[184] The Pharmacy Act, 1948.
[185] The Dentist Act, 1948 (16 OF 1948) 1948.
[186] Parliament of India, "All India Institute of Medical Sciences Act, 1956."

		medical colleges and other allied institutions in India. (2) to bring together in one place educational facilities of the highest order for the training of the personnel in all important branches of the health activity. (3) to attain self-sufficiency in postgraduate medical education[187].
9)	The Post Graduate Institute of Medical Education and Research, Chandigarh Act, 1966	This is an act that established the institution of national importance Post Graduate Institute of Medical Education and Research, Chandigarh[188]. The objective behind establishing this institute is to (1) Provide high-quality patient care. (2) Attain Self-Sufficiency in postgraduate medical education and meet the country's need for highly qualified medical teachers in all medical and surgical disciplines. (3) Provide educational facilities for the training of personnel in all important branches of health activity. (4) Undertake Basic Community based research[189].
10)	Bureau of Indian Standards Act 1986 and Rules, 1987	The act aimed to establish BIS, which is the National Standard Body of India for the harmonious development of the activities of standardization, marking and quality certification of goods[190].
11)	National Institute of Pharmaceutical Education and Research Act, 1998	The act established the National Institute of Pharmaceutical Education and Research, an institution of national importance[191]. The main objectives of the National Institute of Pharmaceutical Education and Research are; (1) "Toning up the level of pharmaceutical education and research by training the future teachers, research scientists and managers for the industry and profession.

[187]"All India Institute of Medical Sciences-Introduction" <https://www.aiims.edu/en/intro_about_aiims.html> accessed September 14, 2021.

[188] The Post Graduate Institute of Medical Education and Research, Chandigarh Act, 1966.

[189]PGIMER, "The Post Graduate Institute of Medical Education and Research, Chandigarh" <https://pgimer.edu.in/PGIMER_PORTAL/PGIMERPORTAL/home.jsp#> accessed September 14, 2021.

[190] The Bureau of Indian Standards Act, 1986.

[191] National Institute of Pharmaceutical Education and Research Act, 1998.

		(2) Continuing education programmes (3) Creation of National Centres to cater to the needs of pharmaceutical industries and other research and teaching institutes (4) Collaboration with Indian industries to meet the global challenges (5) National/International collaborative research (6) Curriculum and media development (7) Study of sociological aspects of drug 'use and abuse', and rural pharmacy, etc. (8) Conducting programmes on drug surveillance, community pharmacy and pharmaceutical management"[192].
12)	Public health Act of states in India	Six states in India are having Public Health Act only for consultation their own. Andhra Pradesh and Tamil Nadu had enacted the law in 1939. Goa, Uttar Pradesh, Madhya Pradesh and Assam are also having acts to regulate public health. Gujarat has a draft being used only for the purpose of consultation"[193].
13)	The Clinical Establishments (Registration and Regulation) Act, 2010	"This act of Parliament provides for registration of clinics. It also aims to maintain a standard treatment guideline for common diseases and conditions[194]".

(Table 8: Legislations governing the qualification, practice, and conduct of medical professionals and Quality Health Facilities and Services)

These legislations play a vital role in the Indian public and private healthcare sector as the primary objective of all these legislations are to establish a council to fix the standard of the education of healthcare professionals. This is one of the major step taken by government of India to towards enhancing the quality of healthcare. The councils established under each act work towards maintaining a high quality and high standards in education of the respective field by enacting policies; Regulates the medical Institutions through appropriate policies; develop road maps for meeting the requirements of healthcare sector; monitors the functioning of state councils, autonomous boards, commissions etc.; promotes practice of ethical and professional conduct in healthcare sector; regulates the fee structure of educational institutions of

[192]NIPER, "The National Institute of Pharmaceutical Education and Research" <http://www.niper.gov.in/about.htm> accessed September 14, 2021.

[193] The Gujarat Public Health Act, 2009.

[194] The Clinical Establishments (Registration and Regulation) Act.

the respective fields and maintains the central register of concerned healthcare professionals etc. It is essential as only quality education will ensure quality services by the professionals in the system.

One of the major steps of the Government which requires some deliberations here is the 'The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002'. This regulation addresses the code of ethics to be followed by the medical practitioners in practice of their profession. The regulation addresses each and every aspect of Doctor-Patient relationship. The regulation under chapter 1 declares that "Physician shall uphold the dignity and honour of his profession with prime objectives of rendering services to humanity and rewards or financial gains would be subordinate"[195]. The regulation addresses concerns like duties of physicians towards their patients, public, responsibilities of physicians to each other and other para medical staff. The regulation has included the concept of unethical acts and misconducts. It has identified some activities as unethical acts or misconduct and the punishment for the same is explained under the penal provisions[196].

Another notable step taken by government of India aiming to maintain the quality of healthcare in the country was the enactment of 'The Clinical Establishments (Registration and Regulation) Act, 2010'. This act was enacted by the Parliament as per the power vested in it under Article 252. Four states namely Arunachal Pradesh, Himachal Pradesh, Mizoram and Sikkim, passed the resolution in their respective legislative assembly and based on which the Parliament enacted this act. The act defined 'Clinical Establishment' as

(i) a hospital, maternity home, nursing home, dispensary, clinic, sanatorium or an institution by whatever name called that offers services, facilities requiring diagnosis, treatment or care for illness, injury, deformity, abnormality or pregnancy in any recognised

[195] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 (Published in Part III, Section 4 of the Gazette of India, dated 6th April, 2002) MEDICAL COUNCIL OF INDIA NOTIFICATION.

[196] Indian Medical Council, "The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations."

system of medicine established and administered or maintained by any person or body of persons, whether incorporated or not; or

(ii) a place established as an independent entity or part of an establishment referred to in sub-clause (i), in connection with the diagnosis or treatment of diseases where pathological, bacteriological, genetic, radiological, chemical, biological investigations or other diagnostic or investigative services with the aid of laboratory or other medical equipment, are usually carried on, established and administered or maintained by any person or body of persons, whether incorporated or not, and shall include a clinical establishment owned, controlled or managed by—

(a) the Government or a department of the Government;
(b) a trust, whether public or private;
(c) a corporation (including a society) registered under a Central, Provincial or State Act, whether or not owned by the Government;
(d) a local authority; and
(e) a single doctor,

but does not include the clinical establishments owned, controlled or managed by the Armed Forces"[197].

In January 2010, the act was implemented in four states of India later on ten other states also adopted it. Unfortunately, this, much-needed act which makes the registration of clinical establishments mandatory and provide for a standard treatment guideline for common diseases has not been uniformly implemented in the country. The Karnataka government through the clinical establishment act tried to regulate the private establishments as well. In 2017, the government went one step ahead to even regulate the fee for common diseases charged by private sector so as to improve the access to private healthcare through the Karnataka Private Medical Establishments (Amendment) Act, 2017. This legislation attracted a huge protest by the private medical practitioners'[198].

[197] The Clinical Establishments (Registration and Regulation) Act.
[198] Government of Karnataka, "The Karnataka Private Medical Establishments (Amendment) Act, 2017" <https://karunadu.karnataka.gov.in/hfw/kannada/MPIC/KPME Amendemnt 06-01-2018 English.pdf>.

2. **Legislations on Disease Control, Medical Care and Management of Patients:** Disease control is one of the important functions of the Ministry of Health and family Welfare. The government has created an institution called National Centre for Disease Control to work on this area. It is working on three main areas in relation to disease control namely services, trained health man power development and research. The Centre conducts investigations to understand the outbreaks of communicable diseases all over the country. It provides referral diagnostic services to the public, medical colleges and health directorates[199].

Sr. No	Name of the Legislation	The objective of the Legislation
1.	"The Epidemic Diseases Act, 1897	The Epidemic Diseases Act, 1897 is a law which was first enacted to tackle bubonic plague in Mumbai in former British India. The law is meant for containment of epidemics by providing special powers that are required for the implementation of containment measures to control the spread of the disease. This colonial act is still used in India as a primary legislation to combat episodes of epidemics[200].
2.	Indian Lunacy Act, 1912	The history of mental health legislations can be traced from 19th century. During British India there existed Lunatic Removal Act 1858 which ceases to exist

[199]"Mandate :: National Centre for Disease Control (NCDC)" <https://ncdc.gov.in/index1.php?lang=1&level=1&sublinkid=19&lid=34> accessed November 18, 2021.
[200] The Epidemic Diseases Act, 1897 1897 (Government of India) 1.

		by 1891[201]. . Later on India had couple of acts on mental health and in 1912 this act was legislated to consolidate and amend the law relating to lunacy[202].
3.	Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994	This is an act enacted by Parliament of India to stop female foeticides and control declining sex ratio of females. It bans the prenatal sex determination of the foetus[203].
4.	The Medical Termination of Pregnancy Act, 1971 and amendment act 2021	The initial act is made with an intention to protect the right to life of a foetus[204]. It regulates the conditions under which a pregnancy can be terminated. The act has tried to bring balance between right to life of foetus and the reproductive right of some categories of females like rape victims, minors and divorcees by allowing them to terminate the pregnancy up to 24 weeks' time[205].
5.	Mental Health Act 1987 and Mental Healthcare Act 2017	Giving effect to WHO's definition of health, the government of India enacted this act to consolidate and amend the laws relating to treatment and care of mentally ill persons[206]. Later on this act was amended and in addition to mental healthcare and services the new act also

[201] Muhammad Mudasir Firdosi and Zulkarnain Z Ahmad, "Mental Health Law in India: Origins and Proposed Reforms" (2016) 13 BJPsych International 65 </pmc/articles/PMC5618879/> accessed November 18, 2021.
[202] "INDIAN LUNACY ACT, 1912 | Lawsisto Cental Acts" <https://lawsisto.com/Read-Central-Act/1111/INDIAN-LUNACY-ACT-1912> accessed November 18, 2021.
[203] Pre-Conception-Pre-Natal-Diagnostic-Techniques-Act 1994.
[204] Medical Termination of Pregnancy Act 1971.
[205] Medical Termination of Pregnancy (Amendment) Act 2021 1.
[206] Mental Health Act 1987.

		provides for protection of full rights of such persons during the delivery of mental healthcare services[207].
6.	Transplantation of Human Organ Act 1994	It is the main legislation regulating organ donation and transplantation in India. The act aims to regulate the removal, storage and transplantation of human organs for therapeutic purposes. It prevents commercial dealings on human organs”[208].
7.	The Surrogacy (Regulation) Act, 2021	This is an act of Parliament in the broad area of Assisted Reproductive Techniques, that aims to regulate the Surrogacy contracts in India and also prohibits Commercial Surrogacy[209].
8.	Assisted Reproductive Technology (Regulation) Act, 2021	“An Act for the regulation and supervision of the assisted reproductive technology clinics and the assisted reproductive technology banks, prevention of misuse, safe and ethical practice of assisted reproductive technology services for addressing the issues of reproductive health where assisted reproductive technology is required for becoming a parent or for freezing gametes, embryos, embryonic tissues for further use due to infertility, disease or social or medical concerns and

[207] Abhisek Mishra and Abhiruchi Galhotra, “Mental Healthcare Act 2017: Need to Wait and Watch” (2018) 8 International Journal of Applied and Basic Medical Research 67 </pmc/articles/PMC5932926/> accessed November 18, 2021.
[208] Transplantation of Human Organs Act (1994).
[209] Government of India, “The Surrogacy (Regulation) Act.”

	for regulation and supervision of research and development and for matters connected therewith or incidental thereto"[210].

(Table 9: Legislations on Disease Control, Medical Care and Management of Patients)

The colonial legislation Epidemic Disease Act was essential during 1897 to deal with the bubonic plague in Mumbai. But the act, when evoked during the 2019 pandemic, was criticised on various grounds. The act proved to be ineffective to deal with the current situations. It has been criticised for being sweeping powers to the government, for not having clear provisions on the procedure to be adopted for quarantine and also for not covering the aspects of human rights standards to be maintained during lockdown or quarantine. It has also failed to define the term 'epidemic'[211]. Before the pandemic the government has taken a step to replace the age-old Epidemic Disease Act with a new legislation i.e., Public Health (Prevention, Control, and Management of epidemics, bioterrorism, and disasters) Bill, 2017. However, this bill has not been passed yet. This bill is suggesting a four-tier healthcare system at all National, State, District and Block level with well-defined powers and functions to deal with the healthcare emergencies[212].

Another great step by Government of India in the healthcare sector was the replacement of Mental Health Act 1987 with the Mental Healthcare Act 2017. The enactment of 1987 health itself was a praiseworthy step as the government acknowledged the WHO's definition of health which covers both physical and mental wellbeing. But the 1987 act was majorly concentrating on institutionalising the mental health patients rather than protecting their rights. Whereas the 2017 legislation is a progressive legislation aims to protect the rights of the patients. This is enacted in consonance with the principles adopted by UN general Assembly through resolution

[210] The Assisted Reproductive Technology (Regulation) Act , 2021 2021 1.
[211] The Epidemic Diseases Act, 1897.
[212] Public Health (Prevention, Control, and Management of epidemics, bioterrorism, and disasters) Bill, 2017 2017.

46/119 for the protection of persons with mental illness[213]. It also decriminalises the suicide attempt by the mentally ill people. In addition to that the patients are given the right to choose what kind of treatment they require. Most importantly the act recognises that all individuals have a right to mental healthcare and directs the state to make arrangements for treatment of mental illness at par with physical illness and ensure access to mental healthcare to the needy[214].

Later on, with an aim to protect the right to life of the unborn and to ensure reproductive autonomy of the female, the Parliament in 1971 enacted the Medical Termination of Pregnancy Act, 1971. The act specifies the conditions under which termination of pregnancy can be done. It also aimed at preventing the unscientific/ traditional methods of abortion which is highly risky to the women. The act was amended in 2021[215]. To prevent the female foeticides and control the declining sex ratio of females the Parliament enacted the Pre-Conception and Pre-Natal Diagnostic Techniques Act in 1994 to regulate and ban the practice of sex determination of the unborn child[216]. The decision of government of India to regulate the abortion regime has been very effective as there is improvement in the male to female sex ratio. It was 927 women for 1000 men in 1990 and now it is 1020 females per 1000 male[217].

Another unregulated regime in healthcare was the assisted reproductive technology and surrogacy. In the absence of a regulation India has become a surrogacy hub. The researcher's previous study on the legal and ethical issues involving surrogacy has found that majority of the women opted to be a surrogate were illiterates and economically poor, this has led to the exploitation of those poor women. In the absence of a law, the surrogacy clinics were mushrooming in India. This practice has reported many human right violations and other legal issues. In 2021, the government of Inida enacted two enactments to regulate the assisted reproductive technologies. The Assisted Reproductive Technology (Regulation) Act, 2021 aims at "regulation and

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[213] OHCHR, "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" (1991) <https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-protection-persons-mental-illness-and-improvement> accessed May 29, 2022.
[214] Mishra and Galhotra (n 208).
[215] Medical Termination of Pregnancy (Amendment) Act.
[216] Pre-Conception-Pre-Natal-Diagnostic-Techniques-Act.
[217] "India Sex Ratio 2022 | Indian States by Sex Ratio 2022" <https://www.findeasy.in/indian-states-by-sex-ratio/> accessed May 29, 2022.

supervision of the assisted reproductive technology clinics and the assisted reproductive technology banks, prevention of misuse, safe and ethical practice of assisted reproductive technology etc”[218]. It provides for the establishment of a national level body for regulating this regime so as the Surrogacy Regulation act 2021. The Surrogacy Act provides for prevention of commercial surrogacy intending to prevent exploitation of economically and educationally poor females in the country. But the act has been criticised for taking away reproductive autonomy of the female.

Health being a state subject, only few states have enacted their on legislation on public healthcare. The central government is in process of drafting the right to health and healthcare bill to ensure access to quality healthcare to all without any discrimination[219].

3. **Laws Governing Safe Medication and Sale and storage of Drugs:** These legislations regulate production, storage and sale of medicines, usage of drugs which are dangerous to human health, prevent adulteration of drugs, control the storage and usage of blood and provide penal provisions for the offenders. Some of them are discussed in the table below;

Sr. No	**Name of the Legislation**	**Objective of the Legislation**
1)	“Drugs and Cosmetics act 1940 and Amendment act 1982, 2016	This act aims to regulate the import, manufacture, distribution and sale of drugs. It provides for the establishment of Drugs Technical Advisory Board; The Central Drugs Laboratory and the Drugs Consultative Committee The act fixes the standard of quality of the drugs and prevents adulteration of drugs. It also

[218] The Assisted Reproductive Technology (Regulation) Act , 2021.

[219] Sumi Sukanya Dutta, “First Draft of Right to Health and Healthcare Bill Made by Private University Ready- The New Indian Express” *Indian Express* (2021) <https://www.newindianexpress.com/nation/2021/oct/17/first-draft-of-right-to-health-and-healthcare-bill-made-by-private-university-ready-2372294.html> accessed May 29, 2022.

		regulates the import-export of certain drugs[220]. The act has been amended in subsequent years to widen its scope[221].
2)	The Drugs and Magic Remedies (Objectionable Advertisement) Act, 1954	This act regulates the advertising of drugs in India. Prohibits advertisement claiming magical effects of drugs[222].
3)	The Drugs Control Act 1950	This act of Parliament regulates the price of drugs in India[223]. It controls the sale, supply and distribution of drugs.
4)	The Narcotic Drugs and Psychotropic Substances Act, 1985	The act consolidates and amend the laws relating to narcotic drugs, it aims to make provisions for control and regulation of operations relating to narcotic drugs and psychotropic substances"[224].

(Table 10: Laws Governing Safe Medication and Sale and storage of Drugs)

There were no regulations on drugs and pharmacy till early 20th century. The only legislation dealt with drugs was section 274 of Indian Penal Code 1860[225]. It was in 1927, the council of states passed a resolution and requested the Governor-General in council and the provisional governments to take some steps to govern the pharmaceutical regime. In 1930 in pursuance of the resolution the government appointed the R.N Chopra Committee to study the issues and concerns in relation to pharmaceutical regime. The committee recommended enacting a central law to control the drugs and pharmacy profession. They also suggested setting up of testing laboratories in all states to look after and safeguard the quality of production of drugs.

[220] The Drugs and Cosmetics Act 1940.
[221] Drugs and Cosmetics (Amendment) Act 2016.
[222] The Drugs and Magic Remedies (Objectionable Advertisement) Act 1954.
[223] The Drugs (Control) Act 1950.
[224] The Narcotic Drugs and Psychotropic Substances Act 1985.
[225] Adulterating any drug or medical preparation.

Starting training courses for pharmacist, registration of every manufactured and imported medicine, developing the pharmaceutical industry in India etc. In 1940 the government of India enacted the Drug and cosmetics act aiming to maintain the standard of production of drugs and prevent all kind of illegal and malpractices in relation to production, manufacturing, export, import, sale and storage of drugs and cosmetics[226]. Later on, in 1950 the government enacted the Drug Control Act with an aim to control the pricing of drugs in India[227]. With an aim to prevent spreading misinformation's through advertisements, the Parliament enacted The Drugs and Magic Remedies (Objectionable Advertisement) Act, 1954[228]. Finally, "to the production, manufacturing, cultivation, possession, sale, purchasing, transport, storage, and/or consumption of any narcotic drug or psychotropic substance" the government enacted the NDPS Act 1985[229].

4. **Some other legislations and rules directly or indirectly dealing with public healthcare:** other legislations directly or indirectly connected to healthcare include the legislations intending to control pollution like "Environment Protection Act and Rules 1986 and 1996; Air (Prevention and Control of Pollution) Act, 1981; Biomedical Waste Management Handling Rules 1998 and Amendment act 2000; Public health bye law 1959; Water Act 1974; legislations providing healthcare benefits to public and employees; Noise Pollution Control Rules 2000; Prohibition of Smoking in Public Places Rules 2008" etc[230].

Laws governing Medico-legal aspects like "Consumer Protection Act 1986; Indian evidence Act; Law of Torts"; IPC Section 52, 80, 89, 92 and 93[231]. Given the fact that healthcare is a complex system encompasses various aspects like Access to quality

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[226] Ministry of Health and Family Welfare, "The Drugs and Cosmetics Act and Rules" (1940) 1940 The Gazaette of India 1.
[227] The Drugs (Control) Act.
[228] The Drugs And Magic Remedies (Objectionable Advertisements) Act , 1954 1995.
[229] The Narcotic Drugs and Psychotropic Substances Act, 1985 1985.
[230] Madhav Madhusudan Singh and Uma Shankar Garg, "Laws Applicable to Medical Practice and Hospitals in India" (2013) 1 International Journal of Research Foundation of Hospital and Healthcare Administration 19.
[231] Singh and Garg (n 231).

healthcare, inequalities based on socio-economic factors, medical tourism, clinical trials, health insurance, pharmaceuticals, vaccine trials and surrogacy, medical education, unnecessary procedures, malpractices and negligence etc. it is essential to have specific legislations to address each of such issues. All the above mentioned legislations are enacted by the Parliament or state legislature to govern the Indian healthcare regime and the government is bound to implement those enactments effectively to regulate and monitor the syatem. Very recently some of the states have come up with some legislations to even regulate private healthcare sector in the concerned state. One of the examples is Karnataka Private Medical Establishment Act (KPME) 2007[232], which has a patient centric approach[233]. The government through this act has even tried to fix the fee of the private practitioners to make private hospitals and clinics accessible to public[234]. Currently the government of India is in process of drafting the Public Healthcare Act for the country.

3.4.5 Obligation Arising Out of Judicial Pronouncements Considering Healthcare as Part of Article 21

Judiciary, the guardian of fundamental rights and protector of rule of law has played a vital role in recognising healthcare as a fundamental right. The court through judicial review and activism has made it very clear that right to health and healthcare are integral part of right to life and personal liberty under Article 21 of the Constitution of India. The Constitution of India doesn't have any express provisions on right to health. Considering the economic status of the country at the time of drafting the Constitution, the Constitution makers have kept public healthcare as part of Directive Principles of State Policy under Part IV of the Constitution. However, the judiciary has widened the scope of A.21 through its judgement in **Maneka Gandhi vs. Union of India**[235] and **Francis Coralie Mullin Vs. Administration,**[236] to include 'life with dignity' as part of right to life and personal liberty. As per the interpretation of A. 21 by the court anything

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[232] The Karnataka Private Medical Establishment Act (KPME) 2007.
[233] Karnataka (n 199).
[234] Draft Rules on Karnataka Private Medical Establishment Act (KPME) 2007 2018.
[235] *Maneka Gandhi vs Union Of India* [AIR 1978 SC 597, 1978 SCR (2) 621].
[236] *Francis Coralie Mullin Vs Administrator, Union Territory of Delhi* [1981]2 SCR 516 SC.

which interferes with the fullest enjoyment of life is considered to be a violation. Hence inaccessibility to proper healthcare during illness is capable of depriving people of their life and the same will constitute an infringement.

The view in Francis Mullin was reiterated by the court in **Bandhua Mukti Morcha v Union of India & Ors**. In this judgement the court opined that "*it is the fundamental right of everyone in this Country, assured under the interpretation given to Article 21 by this Court in Francis Mullen's case, to live with human dignity, free from exploitation. This right to live with human dignity, enshrined in Article 21 derives its life breath from the Directive Principles of State Policy and particularly clauses (e) and (f) of Article 39 and Article 41 and 42 and at the least, therefore, it must include protection of the health and strength of workers men and women, and of the tender age of children against abuse, opportunities and facilities for children to develop in healthy manner and in conditions of freedom and dignity, educational facilities, just and humane conditions of work and maternity relief. These are the minimum requirements which must exist in order to enable a person to live with human dignity and no State neither the Central Government nor any State Government-has the right to take any action which will deprive a person of the enjoyment of these basic essentials. Since the Directive Principles of State Policy contained in clauses (e) and (f) of Article 39, Article 41 and 42 are not enforceable in a court of law, it may not be possible to compel the State through the judicial process to make provision by statutory enactment for ensuring these basic essentials which go to make up a life of human dignity but where legislation is already enacted by the State providing these basic requirements to the workmen and thus investing their right to live with basic human dignity, the State is certainly be obligated to ensure observance of such legislation for inaction*"[237].

In "**Vincent Panikulangara vs. Union of India**" the Apex court observed that "*a healthy body is the very foundation for all human activities. That is why the adage 'Sarira Madyam Khalu dharma Sanadhanam' (physical body is the medium for righteous action). In a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health*". The court has

[237] *Bandhua Mukti Morcha vs UOI* [1984] 2 SCR 67 SC.

also observed that it is essential to have high quality public healthcare system and it should be properly maintained and improved with the needs as it is indispensable to the very physical existence of the community[238].

In "**Paramananda Karta Vs Union of India**" considering the plea of the petitioner for immediate treatment of injured persons in medico-legal cases the court observed that "*Article 21 of the Constitution casts the obligation on the State to preserve life*[239]*. The provision as explained by this Court in scores of decisions has emphasised and reiterated with gradually increasing emphasis that position. A doctor at the Government hospital positioned to meet this State obligation is, therefore, duty-bound to extend medical assistance for preserving life. Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life. No law or State action can intervene to avoid/delay the discharge of the paramount obligation cast upon members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way*". The court has made it clear that the doctors both government and private are having a professional obligation to extend timely medical aid to the needy without any delay. The medical practitioner's paramount duty is to provide healthcare to the needy no law or state should interfere with this and they need not wait for legal formalities to be accomplished under CrPC in case of accidents[240]. In the same year the Hon'ble court treated a letter by two citizens of Patna highlighting the miserable condition of a mental health hospital in Ranchi was considered by the court as a Public Interest Litigation[241] and observed that health is a fundamental right.

Medical care in case of sickness has been recognised as a fundamental human right under Article 25 of the Universal Declaration of Human Rights, under Article 7(b) of international Convention of Economic, Social and Cultural Rights and under Articles

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[238] *Vincent v. Union of India* [1987] 2 SCR 468 SC.
[239] *State Of Punjab & Ors vs Mohinder Singh Chawla* [1997] 113 PLR 499 SC.
[240] *Pt Parmanand Katara vs Union Of India & Ors*. [1989] 3 SCR 997 SC.
[241] *Rakesh Chandra Narayan vs State Of Bihar And Others* [1988] 3 SCR Supl 306.

39(e), 38 and 21 of the Constitution of India[242]. While dealing a case on protection of health of the worker the court observed. "*Right to health and medical care is a fundamental right under Article 21 read with Articles 39(c), 41 and 43 of the Constitution. Compelling economic necessity to work in an industry exposed to health hazards due to indigence to bread-winning to himself and his dependents, should not be at the cost of the health and vigour of the workman. 'Right to life' in Article 21 includes protection of the health and strength of the worker. The expression 'life' in Article 21 does not connote mere animal existence. It has a much wider meaning which includes right to livelihood, better standard of life, hygienic conditions on workplace and leisure. The court held that the State, be it Union or State Government or an industry, public or private is enjoined to take all such action which will promote health, strength and vigour of the workman during period of employment and leisure and health even after retirement as basic essentials to life with health and happiness*"[243].

The inadequacy of medical health services was addressed by the court through a 1996 judgement. The question before the court was "whether the non-availability of services in the government health centres amount to a violation of Article 21?" "*It was held that that 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"*[244]. The Court further held that failure to extend medical assistance to the victim of accident was the violation of Article 21. *"Lack of financial resources could not be claimed as an excuse by states to deny its citizens fundamental rights guaranteed to them under the Constitution. It held that the Constitutional obligation to provide adequate medical services could not be ignored on account of financial burden".* This is a clear case of failure of government to provide quality healthcare and emergency care in the rural areas. In this case the victim dies because he was denied timely care due to non-

[242] *The Regional Director,ESI. vs Francis De Costa & Anr* [1992] 3 SCR 23 SC.
[243] *Consumer Education and Research Centre v. Union of India* [1995] 3 SCC 42 SC.
[244] *Paschim Banga Khet Mazdoorsamity. vs State Of West Bengal & Anr*.[1996] 4 SCC 37 SC.

availability of resources though he was taken in to number of healthcare units. The finding of court in Consumer Education and Research Center was reiterated by the court and held health as a fundamental right of workmen in Kirloskar Brothers Ltd and opined that "medical facilities are, therefore, part of social security and life gilt-edged security, it would yield immediate return to the employer in the increased production and would reduce absenteeism on ground of sickness, etc.[245]" The court while drawing relation between employers and welfare state pointed that employers are under an obligation to ensure a meaningful life to their employees and therefore "must be an equal participant in evolving and implanting welfare schemes." The Court cited Consumer Education & Research Center & Ors. v. Union of India & Ors. ((1995) 3 SCC 42) to hold that the right to life guaranteed by Article 21 of the Constitution is equally applicable to all so is the workmen, this right includes the right to health too. Hence the workers are eligible to claim health insurance while in service or after retirement. It was decided that even private businesses have a fundamental obligation to offer Healthcare to their workers.

"Mahendra Pratap Singh vs. State of Orissa" is a case pertaining to the failure of the government in opening a primary health care centre in a village, the court had held "*In a country like ours, it may not be possible to have sophisticated hospitals but definitely villagers within their limitations can aspire to have a Primary Health Centre. The government is required to assist people get treatment and lead a healthy life. Healthy society is a collective gain and no Government should make any effort to smother it. Primary concern should be the primary health centre and technical fetters cannot be introduced as subterfuges to cause hindrances in the establishment of health centre*." It was also stated that, "*great achievements and accomplishments in life are possible if one is permitted to lead an acceptably healthy life*". There is an indication here that the state's duty to enforce the right to life includes providing primary health care. As a result, the right to life would appear to include the right to basic health care[246].

"The judgement on **Confederation of Ex-servicemen Association v. UOI**, addressed the healthcare scheme for Retired Armed Forces personnel and their family members.

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[245] *Kirloskar Brothers Ltd. V. Employees State Insurance Corporation* [1996] 2 JT 196 SC.

[246] Mahendra Pratap Singh vs State Of Orissa And Ors [1997] AIR 37 Ori

These category of Armed Force Personnels were struggling to manage their medicare after retirement. The medical facilities provided under armed forces insurance schemes were inadequate as compared to Central Government pensioners. Aspiring quality healthcare, they filed Public Interest Litigation (PIL) in the Apex court to claim "full and free medicare to ex- servicemen and their dependents as one of the fundamental rights guaranteed under the Constitution of India".

The role played by judiciary through judicial review and activism in recognizing health and healthcare as a fundamental human right is noteworthy. The Supreme Court recently took 'Suo motto' notice of the appalling health conditions in the National Capital's state-run hospitals. In two lengthy rulings dated June 12th and June 19th, 2020, the Supreme Court stated that the "Right to Health is a basic right envisaged under the Indian Constitution". The Court did take an interventionist role, but it was limited to issuing directions based on pledges made by the State in affidavits filed with the Court. In a lawsuit challenging Kanwar Yatra during a pandemic, Hon'ble Justice R.F Nariman and Justice B.R Gavai stated, "Religious sentiments are subservient to the right to health and life".

Another notable judgement dealing with right to healthcare is **Karukola Simhachalam vs Union of India.** In this case Mr. Karukola Simhachalam, a practicing Advocate, filed Writ Petition under Article 226 of the Constitution of India before the Andra Pradesh High Court as a public interest litigation. This petition highlighted the prevalence of chronic kidney disease (CKD) in Uddanam in Andra Pradesh. According to the World Health Organization, Uddanam is one of the three areas in the world with the highest concentration of CKD after Sri Lanka and Nicaragua. This region is Known for Cashew and coconut farms. Between 2005-2015, this region recorded death of more than 4500 people and 34,000 CKD cases. The reports are saying that each family in the area had at least one person suffering from kidney ailment. Many organizations like ICMR, Harvard University, Andra Medical College, BARC etc have conducted research in this area to find out the reason for high prevalence of CKD and they reported excessive level of silica, phenol and mercury in water. However, this was not considered as the sole reason for the disease. Few scientific institutions and organizations also conducted tests of blood, urine, water and

soil and opined the reason for kidney diseases as high level of silica in water, prolonged dehydration, heat stress, anti-inflammatory drug use, gene mutations, high pesticides use and heavy metals in water and usage of adulterated local made tea power with cashew nut seed coat etc. However, exploring the cause of CKD is still an enigma.

The petitioners contended that the disease is intensifying quickly from village to village and it appears more in young male agricultural workers and indigent in rural working population, thereby, 70% of the patients die due to inadequate resources to continue treatment, as such, several families lost their sole breadwinners. The petitioner contends that, due to lack of systematic screening, less number of dialysis centers, expensive treatment in private hospitals, lack of providing free medicines, 80% patients are dying at home due to their non-affordability to costly treatment. Hence the petitioner contended that, sufferance of public at large in Uddanam area due to CKD is a public issue, as right to health is inclusive of Right to Life under Article 21 of the Constitution of India.

The hon'ble high court by referring to a few judgements like Virender Gaur vs. State of Haryana, Consumer Education and Research Centre vs. Union of India, Kirloskar Brothers Ltd. vs. Employees' State Insurance Corporation, Municipal Council etc highlighted the importance of right to health and healthcare. The court also referred to the judgement in Ratlam vs Shri Vardhichand in which the Hon'ble court said "*A responsible municipal council constituted for the precise purpose of preserving public health and providing better finances cannot run away from its principal duty by pleading financial inability. The state will realize that Art. 47 makes it a paramount principle of governance that steps are taken for the improvement of public health as amongst its primary duties. The municipality also will slim its budget on low priority items and elitist projects to use the savings on sanitation and public health*".

In this judgment, the court in detail discussed the provisions of all International Documents involving Health and healthcare, Committee reports, Constitutional Provisions etc. "*The court held the State failed to take adequate measures to prevent spread of CKD among residents of Uddanam area, which is health hazard and on account of such sufferance, their capacity to work is drastically reduced and it has its own impact on the productivity in those areas and on economy of State. Therefore, in*

view of the law declared by the various Courts as discussed, it is the duty of the State to provide adequate medical care and failure to provide such adequate medical care amounts to violation of fundamental right to life guaranteed under Article 21 of the Constitution of India, so also human right recognized by various Courts and several international. Apart from that, it is the obligation of the State under Article 47 of the Constitution of India to provide adequate medical care to the citizens of the State. This medical condition prevalent in Uddanam is one of the 7 such instances around the world where no specific reason has been identified for the cause of the disease. When such serious disease-causing deaths in the area, the State has to make every endeavor to prevent such spread, but the State miserably failed to take steps to provide adequate medical care to the residents of Uddanam area besides failure to take preventive measures".

The court directed the state government to follow the guidelines provided by the hon'ble Supreme Court in Paschim Benga Khet Mazdoor Samiti Judgement. Which includes;

1) Adequate facilities for basic treatment should be available at the PHCs.
2) Upgradation of the hospitals at the district and sub-divisional level to make them capable of attending serious cases.
3) The District and Sub-divisional level hospitals should be upgraded with facilities for specialist treatment.
4) A centralized communication system functioning at the state level with record of availability of bed has to be created so that the patient can be sent immediately to the hospital where bed is available.
5) Ambulance with necessary equipment's and medical professionals should be made available at Primary Healthcare Centre's for transport of a patient.
6) Ambulance should be adequately provided with the necessary equipment and medical personnel.
7) Suggested decentralization of healthcare system by giving more power to the Panchayati Raj Institutions (PRIs) 24. The adoption of an integrated community health worker programme with adequate provisioning and support, so as to reach out to the weakest rural and urban sections, providing basic primary

care and strengthening community level mechanisms for preventive, promotive and curative care.

8) Making the health professionals at Panchayati Raj Level accountable to local self-governing bodies.

3.4.6 Obligation Under Welfare State

The Constitution of India declares India as a welfare state and it envisages the establishment of welfare state both at central and state level. In a welfare state the primary obligation of the government is to ensure the welfare of the public by providing access to all their basic needs like potable water, food, shelter, sanitation, education, healthcare etc. Hence providing quality medical care to all has become an obligation of both state and central government. This has been over and again emphasized by the court in a series of cases. In one of the judgement the hon'ble apex court commented on the duty of the state by saying that "*the Constitution envisages the establishment of a welfare state both at federal and state level".* One of the ways in which this obligation can be discharged is by *"running hospitals and health centres which provide medical care to the person seeking to avail those facilities.*"

Healthy population is an asset to the nation as they contribute towards development of the nation. It is possible only if the government invest in improving the status of health, ensure good living conditions, education, employment and proper medical care to them. But in India even 21st century is witnessing all social evils like starvation deaths, poverty, malnutrition, Gender based discrimination, atrocities based on caste, death due to unavailability of proper healthcare etc. It is high time that the government should concentrate more on effective implementation of schemes to improve the status of life of the people in India especially the marginal groups.

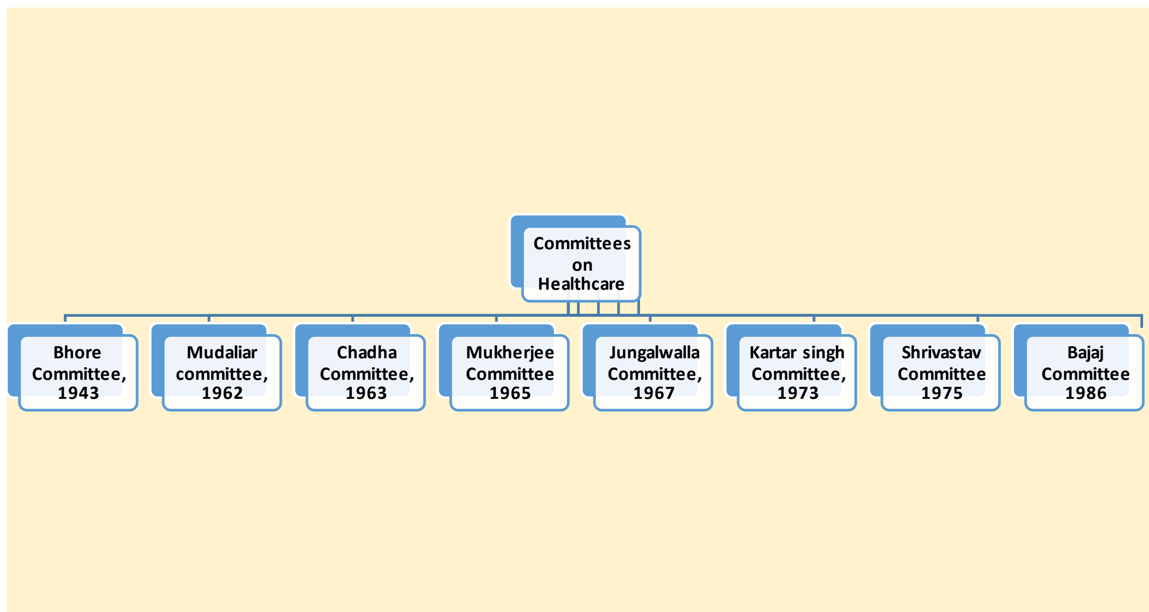
3.5 Health Planning in India and Role Played by Government of India in making Quality Healthcare Accessible to Public

In addition to enacting the above discussed (refer 4.4.4), the governments initiative to alleviate the challenges haunting healthcare and make the system accessible to public is appreciable though the same has not achieved the intended goals yet. The

Government from time to time appointed several expert committees to evaluate the healthcare system and make recommendations based on their findings; many specific schemes intending to prevent the diseases and provide healthcare assistance to public were adopted and implemented; laws were enacted to set the standard of medical education to ensure quality in healthcare; various councils were established through acts to regulate the functioning of pharmacy, nursing etc; three tier system is adopted to bring decentralized approach and large number of Sub-Centres, PHC's, CHC's, District Hospitals and Medical Colleges were created to meet the needs of the public. Some of such initiatives are discussed below.

3.5.1 Committees on Healthcare Setup by Government of India

There were many committees appointed by the government of India to review the healthcare sector of the country. The first committee was set up before independence in 1943.



(Figure 5: Committees on Healthcare Setup by Government of India)

1. Bhore Committee, Health Survey and Development Committee, 1946

Health Survey and development Committee popularly known as the Bhore Committee was set up by the government in 1943 to evaluate the healthcare system. The Committee gave comprehensive recommendations for remodelling health services in India[247]. The report recommended integration of preventive and curative services of all administrative levels; development of Primary Health Centers in 2 stages namely short-term measures intending to have one PHC for 40,000 populations to be managed by 2 Doctors, one nurse, 4 public health nurses four midwives, two sanitary inspectors, two health assistants, one pharmacist and fifteen other class IV employees. Secondly it suggested a long-term programme, under which the government should set up a PHC with 75 beds to 10,000-20,000 population and a secondary unit with 650 beds and District hospitals with 2500 beds. It also suggested establishing a central Institute for Post Graduate Education in Medicine and Research and in 1956 The All-India Institute of Medical Sciences came in to existence and recommended development of National Programmes on health services.

2. Mudaliar Committee, 1961

The Mudaliar Committee on Health survey and Planning was appointed by Government of India to evaluate the healthcare system of the country after implementation some of the recommendations of Bhore committee. It has been found by the committee in the evaluation that the working of the PHC's is unsatisfactory and hence they suggested strengthening of existing PHC's before creating new ones. They also recommended strengthening of district hospitals and making specialist services available at district hospitals. They also recommended creation of regional organizations in each state between headquarter organization & the district in charge of a Regional deputy or assistant directors each to supervise 2 or 3 district medical & health officers[248].

3. Chadah Committee, 1964

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[247] Bhore Committee, 'Bhore Committee,1946' (*National Health Portal Of India*) <https://www.nhp.gov.in/bhore-committee-1946_pg> accessed 19 November 2021.

[248] Mudaliar Committee, 'Mudaliar Committee, 1962' (*National Health Portal of India*) <https://www.nhp.gov.in/mudaliar-committee-1962_pg> accessed 19 November 2021.

This committee was set up by the government to advice on maintenance phase of National Malaria Eradication Programme. The committee recommended to have provision of health worker in the ration of 1:10,000 for conducting vigilance operations through home visits under the National Malaria Education Programme. Such health workers are to be entrusted with additional; duties of collection of vital statistics and family planning[249].

4. Mukherjee Committee, 1965

In 1965 the government of India appointed another committee under the leadership of the Union Health Secretary of that time B.Mukherji to study the basic health services. The report was published in 1968. The primary duty of the committee was to device pattern and methodology for providing improved basic healthcare to public. As per the recommendations of the committee the main programmes to be included in the basic health services should include eradication of Malaria and Small pox; family planning and production of health statistics. Secondly the committee recommended health worker in ratio of 1:10,000 for rural areas, 1: 15,000 in urban areas and 1: 8,000 for sparse populations. Appointment of health inspector to supervise the basic health worker was the next suggestion. The health agencies at district level should be entrusted with duties of conducting epidemiological investigations, consultative and referral services to PHC's in matters of family planning, nursing, health education, laboratory work, sanitation and control of communicable work etc. The committee also recommended the participation of non-governmental organizations in improving the basic healthcare along with the state governments. The Central government is directed to provide financial, administrative and technical support to state governments in enhancing the basic health services[250].

5. Jungalwalla Committee, 1967

[249] Chadha Committee, "Chadha Committee" (*National Health Portal of India*, 1963) <https://www.nhp.gov.in/chadha-committee-1963_pg> accessed November 19, 2021.

[250] Mukherjee Committee, "Mukherjee Committee" (*National health Portal of India*, 1965) <https://www.nhp.gov.in/mukherjee-committee-1965_pg> accessed November 19, 2021.

The major recommendations of the committee include abolition of private practice by government Doctors; Equal pay for equal work in the healthcare sector along with special pay for special work; improvement of service conditions etc[251]. The Committee on Integration of Health Services was created by government study integration of health services, abolition of private practice by doctors in government services, and the service conditions of doctors. Integration of Health Services as defined by the committee is "Service with a unified approach for all problems instead of a segmented approach for different problems and Medical care and public health programmes should be put under charge of a single administrator at all levels of hierarchy".

6. **Kartar Singh Committee, 1973**

Committee on Multi-purpose workers under Health and Family Planning was set up by the government of India under the leadership of Additional Secretary of Health. The committee was directed by the government to device a framework for the integration of health and medical services at peripheral and supervisory level. The suggestions made by the committee included amalgamation of various peripheral workers to Multipurpose workers, Conversion of Auxiliary Midwives to MPW(F) and basic health workers, malaria surveillance workers etc. to MPW(M). One Health Supervisor to monitor the work of MPW's. The PHC to population ratio to be shifted to 1:50,000. Sub-centers to be created with a ratio of 16:50,000 with a male and a female health worker[252].

7. **Shrivastav Committee**

This committee was set up as a 'Group on Medical Education and Support Manpower' in 1974 by Government of India. The committee recommended creation of bands of para and semiprofessional health workers from within the community like school teachers, gram sevak etc., suggested the development or referral service complexes to link PHC's and higher level referral service centers, appointment of Medical and Health Education Commission for planning and implementation of reforms, appointment of male and female health worker for every 5,000 population, appointment of Health Assistants in Sub-centers instead of PHC's[253].

8. Bajaj Committee, 1986

The Government set up an Expert Committee for Health Manpower Planning, Production and Management in 1986. The committee was assigned with the task of evaluating the planning, production and management of allied health professionals needed at intermediate and primary levels. The committee suggested to attain healthcare for all there has to be integration of health and human development policies with the overall national socio-economic development process especially with sectors like drugs and pharmaceuticals; agriculture and food production; rural development; education and social welfare; housing, water supply and sanitation; prevention of food adulteration and the conservation of the environment. National Health Policy should be revised to include comprehensive healthcare services. Recommended formulation of National Medical & Health Education Policy and National Health Manpower Policy; establishment of an Educational Commission for Health Sciences (ECHS), establishment of Health Science Universities in various states and union territories and Establishment of health manpower cells at centre and in the states finally carrying out a realistic health manpower survey[254].

3.5.2 Analysis of National Health Policies

According to "World Health Organization", Health Policy refers to "decisions, plans, and actions that are undertaken to achieve specific Healthcare goals within society". Health policy of a Nation is a blue print which provides for every aspect of healthcare services to be taken care of by the government also strategies for controlling and optimizing the social uses of its health knowledge & health resources.

1. **National Health Policy 1983:** It was only in 1983 India devised its first National Policy after 36 years of independence, prior to that the schemes were implemented

[251] Jungalwalla Committee, "Jungalwalla Committee" (*National Health Portal Of India*, 1967) <https://www.nhp.gov.in/jungalwalla-committee-1967_pg> accessed November 19, 2021.
[252] Kartar Singh Committee, "Kartar Singh Committee" (*National Health Portal Of India*, 1973) <https://www.nhp.gov.in/kartar-singh-committee-1973_pg> accessed November 19, 2021.
[253] Shrivastav Committee, "Shrivastav Committee" (*National Health Portal Of India*, 1975) <https://www.nhp.gov.in/shrivastav-committee-1975_pg> accessed November 19, 2021.
[254] Bajaj Committee, "Bajaj Committee" (*National Health Portal Of India*, 1986) <https://www.nhp.gov.in/bajaj-committee-1986_pg> accessed November 19, 2021.

under the Five-Year Plans. “The basis of policy was to materialise Universal Health Coverage. The policy emphasised on preventive, promotive and rehabilitative primary Healthcare; decentralization and community participation and increased role of private investors. The policy could not achieve the goals as more attention was given to selective Healthcare, there was increase in privatization and delink with the ground realities. The policy stresses the need of establishing comprehensive primary Healthcare services to reach

The policy aimed at creating time-bound programme for setting up a well-dispersed network of comprehensive primary Healthcare services, linked with extension and health education, designed in the environment of the ground reality that abecedarian health problems can be resolved by the people themselves; Intermediation through ‘Health volunteers’ having applicable knowledge, simple chops and needful technologies; Establishment of a well worked out referral system to insure that patient cargo at the advanced situations of the scale isn't needlessly burdened by those who can be treated at the decentralized position; An intertwined network of unevenly spread thing and super-specialty services; stimulant of similar installations through private investments for cases who can pay, so that the draw on the Government’s installations is limited to those entitled to free use.

2. **National Health policy 2002**

The National Health policy 2002 focuses on organisational restructuring of the National Public Health Initiatives and increased funding with an aim to make healthcare accessible to all without any discrimination. More attention was given to diseases which are contributing to the disease burden of the country, which include malaria, blindness, HIV/AIDS etc. The policy suggested an adequately robust disaster management plan to be in place. Notable emphasis has been provided for expanding and improving the primary health facilities. It has included a concept of provisioning of essential drugs through central funding. It promotes rational resource allocation by prioritizing the funding by the government. Policy advocated for enhanced Central budget for the healthcare needs of the state government. Highlights the role to be played by state government and civil society

in achieving healthcare for all. Policy emphasises on the need for concentrating on population stabilisation and cooperative efforts from other social sectors to ensure good health. The policy also acknowledged the role of traditional medicine too[255].

3. **National Health policy 2017**

The government came up with a new national policy after 14 years of gap in 2017. National health policy 2017. The policy aimed to improve the health status of the nation through policy action and provides for preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector by assuring quality. The policy is made in consonance with the Sustainable Development Goal. The key policy principles of the policy included Professionalism, Integrity and Ethics; Equity; Affordability; Universality; Patient Centred Approach and Quality of Care; Accountability; Inclusive Partnerships; Pluralism; Decentralisation; Dynamism and Adaptiveness. The specific aims of the policy included progressive achievement of the Universal Health Coverage, reinforcing trust in public healthcare system, align the growth of private healthcare system with public healthcare goals. More specifically it aimed at enhancing the life expectancy, reduction of IMR, Elimination of leprosy and blindness, increase the utilization of public health facilities by 50%, strengthening of health system by ensuring availability of more healthcare professionals Etc[256].

The policy proposed seven crucial shifts in the healthcare delivery system. In primary care from picky care to assured comprehensive care with liaison to referral hospitals; In secondary and tertiary care from an input acquainted to an affair grounded strategic purchasing; In public hospitals from stoner freights & cost recovery to assured free medicines, individual and exigency services to all; In structure and mortal resource development from normative approach to targeted approach to reach under-serviced areas; In civic health from token interventions to on-scale assured interventions, to organize Primary Health Care delivery and referral support for civic poor; Collaboration with other sectors to address wider

[255] National Health Policy 2002 (National Medical Journal of India).
[256] National Health Policy.

determinants of civic health is supported; In National Health Programmes integration with health systems for programme effectiveness and in turn contributing to strengthening of health systems for effectiveness; In AYUSH services from stage-alone to a three dimensional mainstreaming[257].

3.5.3 Other initiatives by Government of India to improve the Healthcare

In addition to devising policies and appointing committees to evaluate the functioning of the healthcare system, the government of India has taken many other initiatives to make the healthcare accessible to public.

National Health Mission (NHM): The National Rural Health Mission and the National Urban Health Mission were combined into the National Health Mission (NHM) by the Indian government in 2013. In March 2018, it was extended again, this time to March 2020. It is led by a Mission Director and overseen by the Government of India's National Level Monitors.

National Rural Health Mission (NRHM): The history of NHM is that the Manmohan Singh government launched the "National Rural Health Mission" in 2005 to address the health needs of rural areas that are underserved. The mission initially was entrusted with addressing the health needs of 18 states classified as having poor public health indicators. Empowered Action Group (EAG) States as well as North Eastern States were the primary focus of the NHRM. The mission's focus is on establishing a fully functional, community-owned, decentralized health delivery system with cross-sectoral convergence at all levels, ensuring simultaneous action on a wide range of health determinants such as water, sanitation, education, nutrition, social, and gender equality. Institutional integration within the fragmented health sector was supposed to offer a focus on outcomes for all health facilities, as assessed against Indian Public Health Standards [258].

[257] National Health Policy.
[258] National Health Mission (NHM) (2005).

The goals set by NRHM include Reduce the MMR to 1 per 1000 live births, the IMR to 25 per 1000 live births, and the TFR to 2.1. Anemia prevention and decrease in women aged 15 to 49 years; Prevent and minimize mortality and morbidity due to communicable and non-communicable diseases, as well as injuries and new diseases. Reduce total health-care spending through lowering household out-of-pocket costs; Reduce annual tuberculosis incidence and death by half; Reduce the prevalence of leprosy to 1/10000 of the population in all districts, and the incidence to zero. Annual Malaria Incidence of 1/1000; Microfilaria incidence of less than 1% in all areas; Elimination of Kala-azar by 2015, with 1 case per 10,000 people in all blocs[259].

- Some of the initiatives under National Health Mission include Community health volunteers called Accredited Social Health Activists (ASHA) has been appointed to work towards building link between community and health system.
- A group of trustees known as Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society were created to manage the affairs of the hospital.
- Utilization of grants for grass root level improvement.
- The mission has provided Healthcare Contractors to the areas which are under served with an aim to provide training to the healthcare professionals.
- A safe motherhood intervention scheme called as Janani Suraksha Yojna was implemented with an aim to promote institutional delivery among the poor women to reduce MMR and IMR.
- National Mobile Medical Units were introduced to serve the underserved areas.
- Free Ambulance service is made available through toll-free number to each corner of the nation.
- Rashtriya Bal Swasthya karyakram for child health screening and early intervention has been launched in 2013. It will cover children between the age of 0-18.
- Another initiative launched under NRHM is Free drugs free diagnostic service aiming at reduction of OOP.

[259] National Health Mission (NHM).

- Provision for Mother and Child health wings to focus on reduction of IMR and MMR was created in CHC's and District hospitals[260].
- Strengthening of District Hospital to provide multi-specialty healthcare including dialysis care, intensive cardiac care, cancer treatment, mental illness, emergency medical and trauma care etc.
- Supply of iron and folic acid supplements were initiated under the National Iron +initiative to deal with iron deficiency and anemia.
- Tribal TB eradication project[261].
- Initiated Janani Shishu Suraksha Karyakram with an aim to provide free services including transport, food, medicine, blood, diagnosis etc. to poor women who opt for institutional delivery.

National Urban Health Mission: It is a submission of National Health Mission approved by cabinet in 2013. NUHM aims to satisfy the Healthcare needs of the urban population, with a particular focus on the urban poor, by making critical primary Healthcare services available to them and lowering their out-of-pocket treatment costs. This will be accomplished by bolstering the existing health-care delivery system, focusing on people living in slums, and combining it with various health-related schemes implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development, and Women & Child Development, such as drinking water, sanitation, and school education. All state capitals, district headquarters, and cities/towns with a population of above 50000 people would be covered by NUHM. Slum dwellers and other marginalised groups like as rickshaw drivers, street sellers, railway and bus station coolies, homeless people, street children, and construction site employees will be the main targets (Ministry of Health and Family Welfare[262].

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[260] National Rural Health Mission Meeting people's health needs in rural areas Framework for Implementation 2005-2012 Ministry of Health and Family Welfare.
[261] National Rural Health Mission Meeting people's health needs in rural areas Framework for Implementation 2005-2012 Ministry of Health and Family Welfare.
[262] National Urban Health Mission: Framwork for Implementation 2013 80.

Objectives of the mission include:

- To satisfy the unique health care needs of the urban poor and other vulnerable sectors, a need-based city-specific urban health care system is required.
- Institutional mechanisms and management systems to address the health-related concerns of an urban population that is quickly rising.
- Collaboration with neighbourhood and local organisations to increase proactive participation in the design, implementation, and monitoring of health-related activities.
- Availability of resources for delivering basic primary health care to the poor in metropolitan areas; Collaborations with non-governmental organisations (NGOs), for-profit and non-profit health service providers, and other stakeholders[263].

3.5.4 Table 11: Healthcare Programmes and Schemes Initiated by Government of India

Health Programmes / Wellness		
Sr. No	**Name of the Programme**	**Brief Description about the programme**
I.	**"Reproductive, Maternal, Neonatal, Child and Adolescent health"**	
1.	"Janani Shishu Suraksha Karyakaram (JSSK)	Janani Shishu Suraksha Karyakaram (JSSK) was inaugurated by the Indian government on June 1, 2011. Over 12 million pregnant women who use government health facilities for their delivery are expected to benefit from the programme. It will also encourage individuals who still prefer residential deliveries to switch to institutional services. It aims to provide the following

[263] National Urban Health Mission: Framwork for Implementation.

		services free of cost to the women choosing institutional delivery. Free and cashless delivery, C-Section, drugs and consumables, diagnostics, diet during stay in the health institutions, blood, transport from home to health institutions[264]".
2.	Rashtriya Kishor Swasthya Karyakram(RKSK)	"On the 7th of January, 2014, the Rashtriya Kishor Swasthya Karyakram was unveiled. Adolescent engagement and leadership, equity and inclusion, gender equity, and strategic relationships with other sectors and stakeholders are all important principles in this programme. The initiative aims to help all adolescents in India reach their full potential by empowering them to make informed and responsible health and well-being decisions and by providing them with the services and support they require[265]."
3.	Rashtriya Bal Swasthya Karyakram	"Rashtriya Bal SwasthyaKaryakram (RBSK) is a creative and ambitious effort that envisions Child Health Screening and Early Intervention Services, a holistic approach to early diagnosis of medical issues and linking to care, support, and treatment. The existing school health programme will be absorbed into this one. Defects at birth, diseases in children, deficiency conditions, and developmental delays, including disabilities, are all covered by early identification and intervention for children from new born to 18 years[266]."

[264] National Health Mission, "Janani Shishu Suraksha Karyakaram (JSSK)" (*National Health Mission*, 2011) <https://nhm.gov.in/index4.php?lang=1&level=0&linkid=150&lid=171> accessed November 20, 2021.

[265] Government of India, "Rashtriya Kishor Swasthya Karyakram (RKSK)" (*National Health Portal Of India*, 2014) <https://www.nhp.gov.in/rashtriya-kishor-swasthya-karyakram-rksk_pg> accessed November 20, 2021.

[266] Governmnet of India, "Rashtriya Bal SwasthyaKaryakram (RBSK)" (*National Health Portal Of India*) <https://www.nhp.gov.in/rashtriya-bal-swasthyakaryakram-(rbsk)_pg> accessed November 20, 2021.

4.	“Universal Immunization Programme”	“The Government of India's Ministry of Health and Family Welfare launched the 'Expanded Programme of Immunization' (EPI) in 1978. In 1985, the initiative was renamed the Universal Immunization Program (UIP), and it was planned to be expanded in phases to cover all of the country's districts by 1989-90, making it one of the world's largest health programmes.” Vaccines provided under UIP: 1. BCG 2. OPV 3. Hepatitis B vaccine 3. Pentavalent Vaccine 4. Rotavirus Vaccine 5. PCV 6. fIPV 7. Measles/ MR vaccine 8. JE vaccine 9. DPT booster 10. Tetanus and adult diphtheria (Td) vaccine[267]
5.	Mission Indradhanush	“The Government of India established Mission Indradhanush in December 2014 to improve and re-energize the programme to attain 100% immunization coverage for all children and pregnant women at a rapid pace. Mission Indradhanush's ultimate goal is to fully immunize children under the age of two and pregnant women with all available vaccines. The government has designated 201 high-focus districts in 28 states across the

[267] National Health Portal Of India, “Universal Immunisation Programme” (*National Health Portal Of India*, 1978) <https://www.nhp.gov.in/universal-immunisation-programme_pg> accessed November 20, 2021.

		country with the highest percentage of partially immunized and unimmunized children[268]."
6.	"Janani Suraksha Yojana (JSY)"	"The Janani Suraksha Yojana (JSY) is a safe motherhood project within the National Rural Health Mission (NRHM) that promotes institutional delivery among poor pregnant women with the goal of lowering maternal and neo-natal mortality. The Yojana, which was announced by the Hon'ble Prime Minister on April 12, 2005, is being implemented in all states and UTs, with a specific focus on the states with the lowest performance. JSY is a completely government-funded programme that combines cash support with pre- and post-natal care[269]."
7.	"Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)"	"The National Health Mission introduced the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) in 2016. On the 9th of every month, the initiative seeks to give all pregnant women with guaranteed, comprehensive, and high-quality antenatal care, free of charge. Every month, on a specific day, the ANC is distributed across the country. If the 9th of the month falls on a Sunday or a holiday, the Clinic will be held the following business day. This service is provided in addition to the regular ANC provided by the hospital. Surakshit Mantri Pradhan Mantri Pradhan Mantri Pradhan Mantri Pradhan Man As part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) Strategy, Matritva Abhiyan aims to increase the quality

[268] Governmnet of India, "Mission Indradhanush" (*National Health Portal Of India*) <https://www.nhp.gov.in/mission-indradhanush1_pg> accessed November 20, 2021.
[269] Governmnet of India, "Janani Suraksha Yojana (JSY)" (*National Health Portal Of India*, 2005) <https://www.nhp.gov.in/janani-suraksha-yojana-jsy-_pg> accessed November 20, 2021.

		and coverage of Antenatal Care (ANC), which includes diagnostics and counselling services[270]."
8.	"NavjaatShishu Suraksha Karyakram (NSSK)"	NSSK is a programme that aims to teach health professionals in basic new born care and resuscitation. It was created to address care at birth issues such as hypothermia prevention, infection prevention, early breastfeeding initiation, and basic new born resuscitation. New born care and resuscitation are critical components of every neonatal programme, as they offer the best possible start. The goal is to have a trained health professional on hand at every delivery station to provide basic new born care and resuscitation. The programme will last two days and is projected to drastically lower new born mortality in the country[271].
9.	National Programme for Family planning	"In 1952, India became the first country in the world to implement a National Family Planning Programme. The programme has evolved in terms of policy and real programme execution over the years, and it is now being repositioned to not only meet population stability goals, but also to enhance reproductive health and reduce mother, newborn, and child mortality and morbidity. Various family planning services are provided at various levels of the health system under the programme by the public health sector."

[270] Government of India, "Pradhan Mantri SurakshitMatritva Abhiyan (PMSMA)" (*National Health Portal Of India*, 2016) <https://www.nhp.gov.in/ pradhan-mantri-surakshitmatritva-abhiyan-(pmsma)_pg> accessed November 20, 2021.

[271] Government of India, "NavjaatShishu Suraksha Karyakram (NSSK)" (*National Health Portal Of India*) <https://www.nhp.gov.in/navjaatshishu-suraksha-karyakram-(nssk)_pg> accessed November 20, 2021.

		For improved access to contraceptives and family planning services, targeting the high fertility districts the government of India started Mission Pariwar vikas under the same[272].
II.	**"National Nutritional Programmes"**	
1.	"National Iodine Deficiency Disorders Control Pro gramme"	"National Goiter Control Program (NGCP) was renamed National Iodine Deficiency Disorder Control Program (NIDDCP) in 1992. (NIDDCP). The National Iodine Deficiency Disorders Control Programme (NIDDCP) has the following major objectives and components: • Iodine deficiency disorders are being assessed by surveys. • Iodated salt instead of regular salt is available. • To determine the degree of Iodine Deficiency Disorders and the influence of lodated salt, re-survey every 5 years." • Iodized salt and urine iodine excretion are monitored in the lab. • Publicity and health education[273]
2.	"MAA (Mothers' Absolute Affection) P rogramme f	MAA stands for Mother's Absolute Affection, and it is a statewide programme run by the Ministry of Health and Family Welfare with the goal of putting a single-minded focus on breastfeeding promotion and the provision of breastfeeding counselling services through health

[272] Government of India, "National Programme for Family Planning" (*National Health Portal Of India*, 1952) <https://www.nhp.gov.in/national-programme-for-family-planning_pg> accessed November 20, 2021.
[273] Government of India, "National Iodine Deficiency Disorders Control Programme" (*National Health Portal Of India*, 1992) <https://www.nhp.gov.in/national-iodine-deficiency-disorders-control-progr_pg> accessed November 20, 2021.

	or Infant and Young Child Feeding"	institutions. The programme is called 'MAA' because it represents the assistance that a nursing mother needs from her family and from healthcare providers in order to properly breastfeed her child. The goal of the 'MAA' Program is to re-energize efforts to increase breastfeeding rates by promoting, protecting, and supporting breastfeeding habits through health systems[274].
3.	"National Programme for Prevention and Control of Fluorosis (NPPCF)"	Fluorosis is a public health issue induced by long-term fluoride exposure from drinking water, food, and industrial emissions. Dental fluorosis, skeletal fluorosis, and non-skeletal fluorosis are just a few of the primary health issues caused by it. The National Fluorosis Prevention and Control Program has the following objectives: • Assess and make use of the Ministry of Drinking Water and Sanitation's baseline survey data on fluorosis. • Comprehensive fluorosis management in the target locations; • Capacity development for fluorosis prevention, diagnosis, and treatment[275].
4.	"National Iron Plus Initiative	"Anemia is a severe public health problem in India, with more than half of the population suffering from it, including pregnant women, infants, young children, and teenagers. Because iron deficiency is the most frequent form of nutritional anemia, the Adolescent Division of the

[274] Government of India, "MAA (Mothers' Absolute Affection) Programme for Infant and Young Child Feeding" (*National Health Portal Of India*) <https://www.nhp.gov.in/maa-(mothers'-absolute-affection)-programme-for-infant-and-young-child-feeding_pg> accessed November 20, 2021.

[275] Government of India, "National Programme for Prevention and Control of Fluorosis (NPPCF)" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-programme-for-prevention-and-control-of-fluorosis-(nppcf)_pg> accessed November 20, 2021.

	for Anaemia Control"	Ministry of Health and Family Welfare (MoHFW), Government of India, initiated the National Iron+ Initiative[276]."
5.	"National Vitamin A prophylaxis Programe"	Vitamin A is necessary for normal growth, cellular proliferation and differentiation, development regulation, and the maintenance of visual and reproductive capabilities. Vitamin A intake in young children, adolescent girls, and pregnant women has been found to be much lower than the recommended daily requirement. India has one of the world's highest rates of clinical and subclinical vitamin A deficiency. After examining recommendations from the WHO, UNICEF, and the "Ministry of Women and Child Development", the age bracket of eligible children was finally expanded to cover children aged 6 months to 5 years in 2006. All children between the ages of 9 months and 5 years are welcome (oral prophylactic dose). The goal is to make Vitamin A insufficiency less common[277].
6.	"Integrated Child Development Services (ICDS)"	In response to the National Policy for Children, the Integrated Child Development Service (ICDS) programme was inaugurated in 33 experimental blocks on October 2, 1975 (5th Five-Year Plan). The goal now is for ICDS to be implemented nationwide. "The Department of Women and Child Development, Ministry of Human Resources Development, and nodal departments at the state level, such as Social Welfare, Rural Development, Tribal

[276] Government of India, "National Iron Plus Initiative for Anemia Control" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-iron-plus-initiative-for-anemia-control_pg> accessed November 20, 2021.

[277] Government of India, "National Vitamin A Prophylaxis Program" (*National Health Portal Of India*, 2006) <https://www.nhp.gov.in/national-vitamin-a-prophylaxis-program_pg> accessed November 20, 2021.

		Welfare, Health and Family Welfare, or Women and Child Development, have primary responsibility for the program's implementation.” “The program's beneficiaries are Children under the age of six; pregnant and nursing women; women aged 15 to 44; adolescent females in specific blocks. The key goals were as follows: Improve the nutritional and health status of children aged 0 to 6 years; Lay the groundwork for the child's proper psychological, physical, and social development; Effective policy coordination and implementation among the various departments; Improve the mother's ability to care for her child's normal health and nutrition needs through proper nutrition and health education[278].”
7.	Mid-Day Meal Programme	“Tamil Nadu was the first state to offer children a free noon meal. It is impossible to expect a child to study if he or she is hungry or sick. The Mid-Day Meal (MDM) Scheme was introduced in primary schools in 1962-63, in response to this demand. Three aspects of the Mid-Day Meal are improved: 1. Attendance in school. 2. A decrease in the number of people who drop out of school 3. It has a positive effect on the nutrition of youngsters. The midday meal program's goals are as follows: • Improving the nutritional status of children in grades I through VIII at government, local government, and government-aided schools, as well as EGS and AIE centers.

[278] Government of India, “Integrated Child Development Services (ICDS)” (*National Health Portal Of India*, 1973) <https://www.nhp.gov.in/integrated-child-development-services-icds_pg> accessed November 20, 2021.

		• Encouraging impoverished children from underprivileged backgrounds to attend school on a more frequent basis and assisting them in concentrating on classroom tasks. • Providing nutritional assistance to elementary school children in drought-stricken areas[279]."
III.	**Communicable diseases**	
1.	"Integrated Disease Surveillance Programme (IDSP)"	In 2004, the World Bank assisted in the establishment of the Integrated Disease Surveillance Program (IDSP). The National Health Mission continues to fund the programme throughout the 12th Plan (2012–17), with a budget of Rs. 64.04 crore coming only from domestic funds. The plan aimed to improve infectious disease surveillance so that epidemics might be detected and dealt with quickly. "The National Center for Illness Control's (NCDC) Central Surveillance Unit (CSU) receives disease outbreak reports from states and territories on a weekly basis. Even though no weekly reporting is required, disease outbreaks and notifications are compiled on a weekly basis. It aims to strengthen/maintain a decentralized laboratory-based IT-enabled disease monitoring system for epidemic-prone diseases in order to track disease trends and detect and respond to outbreaks in the early stages of their development through a trained Rapid Response Team (RRTs)[280]."
2.	Revised National	For more than 50 years, the country has been engaged in tuberculosis (TB) control efforts. The Government of India

[279] Government of India, "Mid-Day Meal Programme" (*National Health Portal Of India*) <https://www.nhp.gov.in/mid-day-meal-programme_pg> accessed November 20, 2021.
[280] Government of India, "Integrated Disease Surveillance Program (IDSP)" (*National Health Portal Of India*, 2004) <https://www.nhp.gov.in/integrated-disease-surveillance-program-(idsp)_pg> accessed November 20, 2021.

	Tuberculosis Control Programme (RNTCP)	began the National Tuberculosis Program (NTP) in 1962 as a District Tuberculosis Center model that included BCG vaccination and TB treatment. The Expanded Programme on Immunization took over BCG immunization in 1978. One of the key features of the programme TB patients seeking treatment in the private health sector are eligible for free medications and diagnostic testing under the scheme. The first is access to program-provided treatments and diagnostics through attractive connections, and the second is reimbursement of market-available drugs and diagnostics for TB patients in the private sector[281].
3.	"National Leprosy Eradication Programme (NLEP)"	It is a government-funded health programme run by the Ministry of Health and Family Welfare. "The programme objectives include Early detection by active surveillance by trained health professionals; regular treatment of cases through provision of Multi-Drug Therapy (MDT) at fixed sites or centers in a nearby hamlet of moderate to low endemic areas/district; Increased health education and public awareness activities to reduce the disease's social stigma; Medical rehabilitation and leprosy ulcer treatment that is appropriate[282].""

[281] Government of India, "Revised National Tuberculosis Control Programme" (*National Health Portal Of India*, 1962) <https://www.nhp.gov.in/revised-national-tuberculosis-control-programme_pg> accessed November 20, 2021.
[282] Government of India, "National Leprosy Eradication Programme" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-leprosy-eradication-programme_pg> accessed November 20, 2021.

4.	“National Vector Borne Disease Control Programme”	“The National Vector Borne Disease Control Programme is an outcome of merging National Anti -Malaria Control Programme, National Filaria Control Programme and Kala Azar Control Programmes, Japanese B Encephalitis and Dengue/DHF by the Government of India in 2003-03. Capacity development; Surveillance for disease and outbreaks; early diagnosis and case management; vector control through community participation and social mobilization are among the program's objectives[283].”
5.	“Programme for Prevention and Control of Leptospirosis”	“Leptospirosis is a zoonotic disease caused by the bacteria Leptospira, which can be found in the urine of rats, cattle, and pigs. It is a major public health issue in Kerala, Gujarat, Tamil Nadu, Maharashtra, and Karnataka, among other states in India. The population's morbidity and death can be reduced if the disease is detected early and treated quickly. In response to the rising disease burden, the Government of India launched the Programme for Prevention and Control of Leptospirosis (PPCL) in the 12th Five-Year Plan in endemic states such as Gujarat, Kerala, Tamil Nadu, Maharashtra, Karnataka, and the UT of Andaman and Nicobar Islands, with the National Centre for Disease Control (NCDC) serving as the program's nodal agency[284].”
6.	“National AIDS Control	“From December 1999, the National AIDS Control Organization of the Ministry of Health and Family Welfare launched the National AIDS Control Programme-II. It aims to reduce the spread of HIV infection in the country

[283] Government of India, “National Vector Borne Disease Control Programme” (*National Health Portal Of India*) <https://www.nhp.gov.in/national-vector-borne-disease-control-programme_pg> accessed November 20, 2021.

[284] Government of India, “Programme for Prevention and Control of Leptospirosis(PPCL)” (*National Health Portal Of India*) <https://www.nhp.gov.in/ppcl_pg> accessed November 20, 2021.

	Programme (NACP)"	and to strengthen the capacity of the country to fight back the same[285]."
7.	Pulse Polio Programme	Pulse Polio Immunization was begun in India in 1995 as part of a global campaign to eradicate polio in 1988, following a World Health Assembly resolution. Every year, polio drops are provided to children aged 0 to 5 years during national and sub-national immunization rounds (in high-risk areas). Each National Immunization Day, over 172 million children get inoculated (NID). The Pulse Polio Initiative was launched with the goal of reaching 100% coverage with the Oral Polio Vaccine. It planned to immunize youngsters through increased social mobilization, prepare mop-up operations in places where the poliovirus had practically vanished, and keep public morale high[286].
8.	"National Viral Hepatitis Control Program"	On the occasion of World Hepatitis Day, July 28, 2018, the Ministry of Health and Family Welfare, Government of India, announced the National Viral Hepatitis Control Program. It is an integrated project in India aimed at preventing and controlling viral hepatitis in order to meet Sustainable Development Goal (SDG) 3.3, which calls for the eradication of viral hepatitis by 2030. This is a complete approach that covers Hepatitis A, B, C, D, and E, as well as the entire range of prevention, detection, and treatment, as well as mapping treatment outcomes[287].

[285] Government of India, "National AIDS Control Programme" (*National Health Portal Of India*, 1999) <https://www.nhp.gov.in/national-aids-control-programme_pg> accessed November 20, 2021.
[286] Government of India, "Pulse Polio Programme" (*National Health Portal Of India*, 1995) <https://www.nhp.gov.in/pulse-polio-programme_pg> accessed November 20, 2021.
[287] Government of India, "National Viral Hepatitis Control Program (NVHCP)" (*National Health Portal Of India*, 2018) <https://www.nhp.gov.in/national-viral-hepatitis-control-program-(nvhcp)_pg> accessed November 20, 2021.

9.	National Rabies Control Programme	National Rabies Control Program (NRCP) was adopted under the 12th five-year plan. Human and animal health are both addressed in the NRCP. Human Component - this is a component that is being implemented in all states and UTs. For the Human Component of the programme, the National Centre for Disease Control is the nodal agency. Human component strategies are as follows: • Health-care providers' education • Intradermal inoculation of cell culture vaccines is being used. • Raising the bar on human rabies surveillance • Communication and Information Education • Strengthening in laboratories • To raise knowledge of the sensible use of antibiotics among healthcare providers and the general public[288].
10.	"National Programme on Containment of Anti-Microbial Resistance (AMR)"	Antimicrobial resistance (AMR) is a serious problem in India, and the government has developed a National Programme on Antimicrobial Resistance Containment as part of the 12th five-year plan to address it (2012-2017). The program's main goals are to build a laboratory-based antimicrobial resistance surveillance system with 30 network labs around the country and to collect high-quality antibiotic resistance data for diseases of public health concern. Infection control rules and practises should be strengthened, and antibiotics should be used wisely. To

[288] Government of Gujarat, "National Rabies Control Programme" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-rabies-control-programme_pg> accessed November 20, 2021.

		raise knowledge of the sensible use of antibiotics among healthcare providers and the general public[289].
IV.	**Non-communicable diseases**	
1.	National Tobacco Control Programme(NTCP)	"In May of 2003, the Indian government passed the Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003, which is the country's national tobacco-control legislation. In February 2004, India adopted the WHO-FCTC (World Health Organization Framework Convention on Tobacco Control). In addition, in 2007-08, the Ministry of Health and Family Welfare, Government of India, launched the National Tobacco Control Programme (NTCP) in order to facilitate the effective implementation of the Tobacco Control Law, raise awareness about the harmful effects of tobacco, and fulfil the obligations under the WHO-FCTC. Its goal is to raise public awareness about the dangers of tobacco usage and Tobacco Control Laws; To make it easier for the Tobacco Control Laws to be implemented effectively; The goal of this programme is to reduce tobacco consumption and the number of people who die as a result of it[290]."
2.	"National Programme for Prevention	The NPCDCS intends to integrate NCD (non-communicable diseases) interventions into the NRHM framework in order to optimize scarce resources and provide seamless services to end customers / patients, as

[289] Government of India, "National Programme on Containment of Anti-Microbial Resistance (AMR)" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-programme-on-containment-of-anti-microbial-resistance-(amr)_pg> accessed November 20, 2021.

[290] Government of India, "National Tobacco Control Programme" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-tobacco-control-programme1_pg> accessed November 20, 2021.

	and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS)"	well as to ensure long-term sustainability of interventions. "Among the program's key aims are: Changes in behavior and lifestyle can help prevent and control common NCDs; Detect and treat common NCDs early; Increase capacity for preventing, diagnosing, and treating common NCDs at various levels of Healthcare; To cope with the rising burden of NCDs, train human resources in the public health system, such as doctors, paramedics, and nursing staff. Finally to Establish and develop capacity for palliative and rehabilitative care[291]."
3.	National Programme for Control Treatment of Occupational Diseases	"Occupational health was one of the components of the National Health Policy of 1983, and it was also included in the National Health Policy of 2002, however there has been very little attention dedicated to mitigating the effects of occupational disease through adequate programmes. In 1998-99, the Indian Government's Ministry of Health and Family Welfare began the National Programme for Control and Treatment of Occupational Diseases. The National Institute of Occupational Health (ICMR) in Ahmedabad has been designated as the nodal agency. The programme deals with occupational injuries; occupational lung diseases; Occupational cancers; Occupational dermatoses; Occupational Infections; Occupation toxicology; Occupational mental disorders and Others[292]."
4.	"National Programme for	"In an effort to combat the high incidence of deafness in the country, the Ministry of Health and Family Welfare of the Government of India began the pilot phase of the

[291] Government of India, "National Program for Prevention and Control of Cancer, Diabetes, CVD and Stroke(NPCDCS)" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-programme-for-prevention-and-control-of-c_pg> accessed November 20, 2021.

[292] Government of India, "National Programme for Control and Treatment of Occupational Diseases" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-programme-for-control-and-treatment-of-oc_pg> accessed November 20, 2021.

	Prevention and Control of Deafness (NPPCD)”	National Program for Prevention and Control of Deafness (from 2006 to 2008) in ten states and one union territory.” During the 11th Five-Year Plan, the programme was completely funded by the government. However, under the 12th Five-Year Plan, the Centre and States will be required to pool resources and mutas mutandis adhere to the NRHM financial criteria. In 2007, the programme was piloted in 25 districts across 11 states and territories. The programme has now been expanded to include 192 districts across 20 states and territories. To avert hearing loss caused by sickness or damage that could have been avoided. The program's key goals are as follows: • Early detection, diagnosis, and treatment of ear disorders that cause hearing loss and deafness are critical. • Persons suffering from deafness of all ages must be medically rehabilitated. • Strengthening existing inter-sectoral ties to ensure the continuation of the rehabilitation programme for deaf people • By providing support for equipment and materials as well as training employees, the institution's capability for ear care services will be developed[293].
5.	“National Mental Health	The Mental Healthcare Act of 2017 was signed into law on April 7, 2017, and went into effect on July 7, 2018. "An Act to provide for mental healthcare and services for persons with mental illness, and to protect, promote, and

[293] Government of India, “National Programme for Prevention and Control of Deafness (NPPCD)” (*National Health Portal Of India*) <https://www.nhp.gov.in/national-programme-for-prevention-and-control-of-d_pg> accessed November 20, 2021.

	Programme"	fulfil the rights of such persons during delivery of mental healthcare and services, and for matters connected therewith or incidental thereto," according to the law's first paragraph. This Act repealed the Mental Health Act of 1987, which was passed on May 22, 1987. "The program's goals are to ensure that everyone has access to basic mental Healthcare in the near future; to encourage the application of mental health knowledge in general healthcare and social development; to encourage community participation in the development of mental health services; and to ensure that everyone has access to basic mental Healthcare in the near future and to increase the number of people working in mental health subspecialties[294]."
6.	National Programme for Control of Blindness& Visual Impairment	The National Programme for the Control of Visual Impairment and Blindness (NPCVIB) was established in 1976 as a 100% federally funded initiative, and it integrates the older Trachoma Control Program, which began in 1963. **Goals:** • To lower the prevalence of blindness from 1.49 percent in 1986-89 to less than 0.3 percent in the future. • To build an infrastructure and increase efficiency in the programme so that it can handle new cases of blindness every year and avoid future backlogs[295].

[294] Government of India, "National Mental Health Programme" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-mental-health-programme_pg> accessed November 20, 2021.
[295] Government of India, "National Programme for Control of Blindness" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-programme-for-control-of-blindness_pg> accessed November 20, 2021.

7	Pradhan Mantri National Dialysis Programme	"A significant step in this direction would be to enhance district hospitals by providing cheap multispecialty care, including dialysis services, in district hospitals. "It has been proposed that the Dialysis programme be undertaken in Public Private Partnership to benefit from the existing capacity of the private sector in the dialysis care segment, as well as their ability to install and operate dialysis care systems in a timely manner, and to complement the emerging strengths of the public sector, such as the availability of drugs and diagnostics[296].'"'
8.	"National Programme for the Healthcare for the Elderly (NPHCE)"	"India, as the world's second-largest country with geriatric population, established this initiative with the goal of providing accessible, cheap, and high-quality long-term, comprehensive, and specialized care to an ageing population. Developing a new architecture for ageing; establishing a framework for creating an enabling environment for a Society for all Ages; promoting the concept of active and healthy ageing[297]."
9.	National Programme for Prevention & Managemen t of Burn	The programme aims to • "Burn injury incidence, mortality, morbidity, and disability must all be reduced. • To raise awareness among the general public and vulnerable groups, particularly women, children, and industrial and hazardous employees.

[296] Government of India, "Pradhan Mantri National Dialysis Programme" (*National Health Portal Of India*) <https://www.nhp.gov.in/pradhan-mantri-national-dialysis-programme_pg> accessed November 20, 2021.
[297] Government of Gujarat, "National Programme for Health Care of the Elderly(NPHCE)" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-programme-for-health-care-of-the-elderly(nphce)_pg> accessed November 20, 2021.

	Injuries (NPPMBI)	• To build an adequate network of infrastructural facilities for burn management and rehabilitation, as well as qualified people. • Conduct research to examine behavioral, social, and other determinants of burn injuries in our country in order to develop effective need-based programme design, monitoring, and assessment for burn injuries[298]."
10.	National Oral Health programme	"Overall health and a decent quality of life are dependent on oral health. The program's goals are to enhance oral health determinants, reduce morbidity from oral diseases, integrate oral health promotion and preventive services into the general Healthcare system, and promote the use of public-private partnerships (PPP) to improve oral health[299]."
V.	**Health system strengthening programs**	
1.	"Ayushman Bharat Yojana"	"Ayushman Bharat, or Healthy India, is a nationwide project initiated by the Union Government as part of the National Health Policy of 2017, with the goal of achieving Universal Health Coverage (UHC). This effort was created to meet the SDGs and their underpinning pledge to leave no one behind. Ayushman Bharat is an endeavor to transition from a sectoral and segmented strategy to a comprehensive, need-based health-care system. At the elementary, secondary, and tertiary levels, Ayushman Bharat aims to implement

[298] Government of India, "National Programme for Prevention and Management of Burn Injuries" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-programme-for-prevention-and-management-of-burn-injuries_pg> accessed November 20, 2021.

[299] Government of India, "National Oral Health Programme" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-oral-health-programme_pg> accessed November 20, 2021.

		ground-breaking interventions that address health holistically (including prevention, promotion, and ambulatory care).” Ayushman Bharat has taken a long-term approach to healthcare. **“Benefits of PM-JAY** At Beneficiary Level it includes • Government provides health insurance cover of up to Rs. 5,00,000 per family per year. • More than 10.74 crore poor and vulnerable families (approximately 50 crore beneficiaries) covered across the country. • All families listed in the SECC database as per defined criteria will be covered. No cap on family size and age of members. • Priority to girl child, women and senior citizens. • Free treatment available at all public and empaneled private hospitals in times of need. • Covers secondary and tertiary care hospitalization. • 1,350 medical packages covering surgery, medical and day care treatments, cost of medicines and diagnostics. • All pre-existing diseases covered. Hospitals cannot deny treatment. • Cashless and paperless access to quality Healthcare services. • Hospitals will not be allowed to charge any additional money from beneficiaries for the treatment. • Eligible beneficiaries can avail services across India, offering benefit of national portability. Can reach out

		for information, assistance, complaints and grievances to a 24X7 helpline number – 14555." **The benefits to Health System are;** • Helping India achieve Universal Health Coverage (UHC) and Sustainable Development Goals is one of the benefits to the health system (SDG). • Ensure increased access to and affordability of excellent secondary and tertiary care services by combining public hospitals with well-measured strategic purchasing of services from private care providers, particularly not-for-profit providers, in health-care deficit areas. • Reduce hospitalization-related out-of-pocket costs significantly. Reduce the financial risk of poor and vulnerable families becoming impoverished as a result of catastrophic health crises. • Align improved health outcomes through improved utilization of evidence-based Healthcare and cost control. • Infuse insurance monies into public health-care systems to strengthen them. • Enable the construction of new health infrastructure in rural, underserved, and distant communities. • Increase the government's health spending as a percentage of GDP. • Patient satisfaction has increased. • Health results are better. • Increased productivity and efficiency at the population level

		• The population's quality of life has improved[300].
2	Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)	"The Ministry of Labour and Employment of the Government of India has created the RSBY programme to provide health insurance to families living below the poverty line (BPL). The goal of RSBY is to safeguard low-income families from financial obligations resulting from hospitalization." **Eligibility** • The scheme will benefit BPL unorganized sector employees and their families (a family unit of five). • The implementing agencies will be responsible for determining the eligibility of unorganized sector workers and their family members who are expected to benefit from the scheme. • For the purpose of identification, the recipients will be given smart cards. **Benefits** • The beneficiary will be entitled for any in-patient Healthcare insurance benefits that the respective State Governments develop depending on the needs of the people/geographic area. State governments, on the other hand, are encouraged to include at least the following minimum benefits in the package/scheme: • The unorganized sector worker and his family (a five-person unit) will be covered. • On a family floater basis, the total sum covered per year would be Rs. 30,000/-. • All covered illnesses are treated without charge.

[300] National Health Authority (n 135).

		• Hospitalization costs, with as few exclusions as possible, for the most frequent ailments • To be covered for all pre-existing conditions • Cooperative transport[301].
3.	LaQshya' programme (Labour Room Quality Improvement Initiative)	"The Ministry of Health and Family Welfare's 'LaQshya' programme aims to improve the quality of treatment in the delivery room and the maternity ward (OT). The main goal of the programme is to reduce unnecessary mother and new born mortality, morbidity, and stillbirths linked with maternity care in the labour room and maternity OT, as well as to provide compassionate maternity care[302]."
4.	National Health Mission	Already discussed under 4.5.3
5.	Ayushman Bharat Digital Mission (ABDM)	The Ayushman Bharat Digital Mission was launched by the Ministry of Health and Family Welfare of the Government of India with the goal of providing the essential assistance for the country's digital health infrastructure integration. This forward-thinking effort, which is based on the 2017 National Health Policy, aims to digitise Indian healthcare"[303].

(Table 11: Source National Health Portal of India[304])

[301] Government of India, "Rashtriya Swasthya Bima Yojana" (*National Portal of India*) <https://www.india.gov.in/spotlight/rashtriya-swasthya-bima-yojana> accessed November 20, 2021.
[302] Government of India, "'LaQshya' Programme (Labour Room Quality Improvement Initiative)" (*National Health Portal Of India*) <https://www.nhp.gov.in/'laqshya'-programme-(labour-room-quality-improvement-initiative)_pg> accessed November 20, 2021.
[303] Government of India, "Ayushman Bharat Digital Mission (ABDM)" (*National Health Portal Of India*) <https://www.nhp.gov.in/national-digital-health-mission-(ndhm)_pg> accessed November 20, 2021.
[304] Government of India, "Health Programmes / Wellness" (*National Health Portal Of India*) <https://www.nhp.gov.in/healthprogramme/national-health-programmes> accessed November 20, 2021.

3.6 Status of Healthcare in India

The analysis of Indian healthcare system presents a spectrum of complex and conflicting realities. Achieving "Healthcare for All" or "Universal Healthcare" in a complex system like India shall remain a myth if there is no proper planning and implementation from the government. The grass root cause of all the problems the country currently facing are due to fastest growing population and low level of human development.

India has a hybrid system of healthcare where we can locate both public and private players. Most of the private hospitals are located in urban areas. Majority of the rural areas has access only to public basic healthcare units. India's public healthcare system is three tiered. There are three levels namely Primary healthcare, Secondary healthcare and tertiary healthcare. Sub-Centres (SC) are the first point of contact between the Primary Healthcare System and the community. Each SC covers 5000 people in plain areas and 3000 people in hilly/ tribal areas. Each SC must have one auxiliary nurse midwife (ANM)/female health worker and one male health worker (for further information, see the Indian Public Health Standards (IPHS) recommended staffing structure). There is a provision for one additional ANM on a contract basis under the National Rural Health Mission (NRHM). The next level is Primary Healthcare Centre which covers up to 30,000 people in plains and 20,000 in hilly/tribal areas. A PHC must have a medical officer and 14 paramedical and other staff members to meet the minimum requirements. Two more staff nurses at PHCs are available on a contract basis under the NRHM. It has 4-6 beds for in-patients and serves as a referral unit for 5-6 SCs. PHCs engage in both preventative and curative health-care activities[305].

In secondary level Community Health Centers are developed by the government to cover 1,20,000 populations in plains and 80,000 in hilly/tribal areas. As per the norms CHC's should have four medical specialists, that is, surgeon, physician, gynecologist/obstetrician and pediatrician supported by 21 paramedical and other staff.

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[305] M Chokshi and others, "Health Systems in India" (2016) 36 Journal of Perinatology S9 </pmc/articles/PMC5144115/> accessed November 20, 2021.

It has 30 beds with an operating theater, X-ray, labor room and laboratory facilities. It is the referral pint for the PHC's within the block. Next healthcare unit in secondary level is the sub district hospitals[306].

The current healthcare infrastructure of India is depicted in the table below.

"State/UT/India	No. of Public facilities					No. of beds available in public facilities
	PHC	CHC	SDH	DH	Total	
Andaman & Nicobar Islands	27	4		3	34	1246
Andhra Pradesh	1417	198	31	20	1666	60799
Arunachal Pradesh	122	62		15	199	2320
Assam	1007	166	14	33	1220	19115
Bihar	2007	63	33	43	2146	17796
Chandigarh	40	2	1	4	47	3756
Chhattisgarh	813	166	12	32	1023	14354
Dadra & Nagar Haveli	9	2	1	1	13	568
Daman & Diu	4	2		2	8	298
Delhi	534	25	9	47	615	20572
Goa	31	4	2	3	40	2666
Gujarat	1770	385	44	37	2236	41129
Haryana	500	131	24	28	683	13841
Himachal Pradesh	516	79	61	15	671	8706
Jammu & Kashmir	702	87		29	818	11342
Jharkhand	343	179	13	23	558	7404

[306] Chokshi and others (n 306).

Karnataka	2547	207	147	42	2943	56333
Kerala	933	229	82	53	1297	39511
Lakshadweep	4	3	2	1	10	250
Madhya Pradesh	1420	324	72	51	1867	38140
Maharashtra	2638	430	101	70	3239	68998
Manipur	87	17	1	9	114	2562
Meghalaya	138	29		13	180	4585
Mizoram	65	10	3	9	87	2312
Nagaland	134	21		11	166	1944
Odisha	1360	377	27	35	1799	16497
Puducherry	40	4	5	4	53	4462
Punjab	521	146	47	28	742	13527
Rajasthan	2463	579	64	33	3139	51844
Sikkim	25	2	1	4	32	1145
Tamil Nadu	1854	385	310	32	2581	72616
Telangana	788	82	47	15	932	17358
Tripura	114	22	12	9	157	4895
Uttar Pradesh	3277	671		174	4122	58310
Uttarakhand	275	69	19	20	383	6660
West Bengal	1374	406	70	55	1905	51163
All India	29,899	5,568	1,255	1,003	37,725	7,39,024”

(Table 12 –Source: Ministry of Health and Family Welfare[307])

[307]Ministry of Health and Family welfare, Hospitals in the Country <https://pib.gov.in/PressReleasePage.aspx?PRID=1539877> accessed 20 November 2021.

Nearly 60% of the total population of India lives in rural areas and for the healthcare needs of rural population country has created 158417 Sub-centres, 29899 PHC's, 5568 CHC's, 1225 Sub District Hospitals and 1003 District Hospitals. There are 739024 beds available in public healthcare units[308].

"States/UTs	Rural hospitals		Urban hospitals		As on
	No.	Beds	No.	Beds	
Andhra Pradesh	193	6480	65	16658	01.01.2017
Arunachal Pradesh*	208	2136	10	268	31.12.2017
Assam	1176	10944	50	6198	31.12.2017
Bihar	930	6083	103	5936	31.12.2016
Chhattisgarh	169	5070	45	4342	01.01.2016
Goa*	17	1405	25	1608	31.12.2017
Gujarat	364	11715	122	20565	31.12.2016
Haryana*	609	6690	59	4550	31.12.2016
Himachal Pradesh*	705	5665	96	6734	31.12.2017
Jammu & Kashmir	56	7234	76	4417	30.12.2016
Jharkhand	519	5842	36	4942	31.12.2015
Karnataka*	2471	21072	374	49093	31.12.2017
Kerala	981	16865	299	21139	01.01.2017
Madhya Pradesh	334	10020	117	18819	01.01.2016
Maharashtra	273	12398	438	39048	31.12.2015
Manipur	23	730	7	697	01.01.2014

[308]Ministry of Health and Family welfare, Hospitals in the Country <https://pib.gov.in/PressReleasePage.aspx?PRID=1539877> accessed 20 November 2021.

Meghalaya*	143	1970	14	2487	31.12.2017
Mizoram*	56	604	34	1393	31.12.2017
Nagaland	21	630	15	1250	31.12.2015
Odisha*	1655	6339	149	12180	31.12.2017
Punjab*	510	5805	172	12128	31.12.2017
Rajasthan	602	21088	150	10760	31.12.2016
Sikkim*	24	260	9	1300	31.12.2017
Tamil Nadu*	692	40179	525	37353	31.12.2017
Telangana*	802	7668	61	13315	31.12.2017
Tripura*	99	1140	56	3277	31.12.2017
Uttar Pradesh*	4442	39104	193	37156	31.12.2017
Uttarakhand	410	3284	50	5228	31.12.2015
West Bengal	1272	19684	294	58882	01.01.2015
Andaman & Nicobar Islands	27	575	3	500	31.12.2016
Chandigarh	0	0	4	778	31.12.2016
Dadra & Nagar Haveli*	10	273	1	316	31.12.2017
Daman & Diu	5	240	0	0	31.12.2015
Delhi	0	0	109	24383	01.01.2015
Lakshadweep	9	300	0	0	01.01.2016
Puducherry	3	96	11	3473	01.01.2016
INDIA	19810	279588	3772	431173”	

(Table 13 –Source: Ministry of Health and Family Welfare[309])

[309]Ministry of Health and Family welfare, Hospitals in the Country <https://pib.gov.in/PressReleasePage.aspx?PRID=1539877> accessed 20 November 2021.

Inaccessibility of healthcare units is one of the challenge the rural and tribal population is facing in our country. The above table demonstrates the healthcare infrastructure of rural and urban areas of the nation. It has been shown that there is a huge gap between the number of beds in urban and rural areas of the country. The second populous nation of the world with a population of 1,398,753,940 people and major population lives in rural area has only 279588 beds and 19810 healthcare units in rural areas where as for 40% of the total population living in urban areas it is 431173 beds. Majority of the urban population doesn't prefer public healthcare units whereas the low income, illiterate and marginalised population of rural and tribal regions public healthcare is the only ray of hope.

Another major challenge of the healthcare sector is related to quality. Poor quality and negligence in healthcare sector has been a much-debated issue in our country and the same has claimed several lives. One of the study has highlighted that in a year almost 122 per 100000 people die due to poor quality of care. In category death due to poor quality, India's condition is worse in BRIC countries. Though the country has put a lot of efforts on reaching the public and making the system accessible, there exist lack of quality. The study highlights clinical care as inadequate[310].

The Malkangiri incident has actually proved that government is neglecting the trbal population. In 2016 between September to December encephalitis syndrome and Japanese Encephalitis has claimed lives of 100 children[311]. Even after devising many programmes and schemes under NRHM, the cases of malnutrition, Stunting, Wasting, IMR and MMR are very high in India. India ranked 154 among 195 countries in Healthcare Index as per the Global Burden of Disease study published by Lancet in 2017[312].

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[310] Margaret E Kruk and others, "Mortality Due to Low-Quality Health Systems in the Universal Health Coverage Era: A Systematic Analysis of Amenable Deaths in 137 Countries" (2018) 392 The Lancet 2203 <http://www.thelancet.com/article/S0140673618316684/fulltext> accessed November 20, 2021.

[311] Sagar Kumbhar, "Why India's Health Care Systems Fail to Provide for Marginalised Citizens" *TheLeaflet* (2021) <https://www.theleaflet.in/why-indias-health-care-systems-fail-to-provide-for-marginalised-citizens/> accessed November 20, 2021.

[312] "India Ranks 154 Among 195 Countries in Healthcare Index" *The Wire* (2017) <https://thewire.in/health/india-rank-healthcare-index> accessed November 20, 2021.

Disparity in healthcare system in India is not limited to Geographical region in which it is situated, there are inequality based on gender, economic status, community etc too. Indian women, poor, Muslim community, tribal population all are experiencing medical poverty, apathy and denial[313]. The pandemic has made it much more difficult for the marginalised and vulnerable population. One of the Oxford studies highlighted that the current pandemic could push 260 million Indians to poverty[314].

Some of the problems to an extent can be managed if the government is ready to increase the healthcare expenditure in India. It has been found that the private healthcare sector invests three times more than what the public sector is investing in healthcare. 2/3rd of the healthcare expenditure in India comes from private sector. The below table is a comparison of healthcare expenditure in public and private sector from 2000-2018.

Year	Domestic Public Health Expenditure Per Capita in PPP's	Domestic Private Health Expenditure Per Capita in PPP's
2018	74.16	199.06
2017	68.76	182.62
2016	62.52	168.93
2015	56.55	162.43
2014	48.67	155.48
2013	45.43	150.97
2012	45.75	116.17
2011	43.35	105.48
2010	38.12	105.93
2009	36.57	104.77

[313] Kumbhar (n 312).
[314] Rohit Inani, "Coronavirus Could Reduce 260 Million Indians To Poverty, Say Oxford University Researchers" (*HuffPost null*, 2020) <https://www.huffpost.com/archive/in/entry/coronavirus-indians-poverty-oxford-university_in_5ebd2ccbc5b6078ff41ceb80> accessed November 20, 2021.

2008	30.51	101.8
2007	27.15	100.8
2006	25.07	95.42
2005	23.58	91.79
2004	20.09	89.13
2003	19.42	82.77
2002	18.45	80.63
2001	18.59	77.61
2000	18.31	67.86

Table 14 – Source: Per-capita PPP against USD in India[315], [316]

3.7 Conclusion

The above analysis makes it clear that India has an inadequate healthcare system with poor quality. The current healthcare system, both in the public and private sectors, has shown its limitations as demand for health services increased amid pandemic. The government is responsible for ensuring an effective healthcare system, as well as health education, preventive programmes, curative treatments, and affordable health care for the poor. Even after 7 decades of independence we lack a quality healthcare system which is accessible to all without any discrimination.

One of the reasons for the above discussed challenges are the low expenditure in healthcare by the government. Between 2008 and 2015, India's public health spending (comprising both the central and state governments) stayed stable at around 1.3 percent of GDP, increasing slightly to 1.4 percent in 2016-17. It remained 1.2-1.6 % of GDP between 2018-2020 too. This is significantly lower than the global average of 6%. It should be noted that the 2017 National Health Policy recommends raising this to 2.5 percent of GDP by 2025.

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[315] "GHO | By Category | Domestic General Government Health Expenditure (GGHE-D) per Capita in PPP Int$ - Data by Country" (*WHO*).
[316] "GHO | By Category | Domestic Private Health Expenditure (PVT-D) per Capita in PPP Int$ - Data by Country" (*WHO*).

Every year, around 2.2 lakh new patients with end-stage renal disease (ESRD) are diagnosed in India, resulting in an additional 3.4 crore dialysis patients. With roughly 4950 dialysis centres in India, mostly in the private sector, demand is less than half met. Dialysis costs an extra Rs.2000 every session, resulting in a monthly outlay of Rs.3-4 lakhs for patients each year. Furthermore, most families must travel frequently and frequently across large distances to get dialysis services, resulting in high travel expenditures and lost wages for the patient and family members accompanying the patient.

Ineffective healthcare systems and ineffective legal safeguards have resulted in the necessity for right to healthcare legislation. Despite the fact that the judiciary has affirmed it as a fundamental right in a number of cases, the separation of powers limits the judiciary's role to upholding current laws. Because law making is the responsibility of the legislature, and healthcare is a state matter under the Constitution, states must control this regime. Because it is a state matter, the centre is prohibited from enacting legislation, which has resulted in inequities between states.

Regular monitoring, more work on awareness, quality education to healthcare professionals, a national legislation on public healthcare to fix the standard etc. can be some of the possible direct solutions to the above discussed problems. As discussed above healthcare is a multifaceted issue which cannot be addressed in isolation, hence along with ‘Healthcare for All’ the government should concentrate on education for all, access to food, potable water, standard living conditions, sanitation, employment, pollution free air etc.

CHAPTER 4
DISCUSSION AND FINDINGS-
COMPARATIVE ANALYSIS OF PUBLIC HEALTHCARE SYSTEM OF INDIA WITH SELECTED COUNTRIES OF THE WORLD

4.1 Right to health and Healthcare: A Multi-country Analysis

Comparative research is to compare our countries healthcare system with the best-performing countries of the world. This approach would help in expanding our thinking about the drawbacks in the functioning of the Indian Health care system. This would also help in finding answers for questions like, "How are these developed nations managing their health sector? How have others dealt with the similar kind of complexities that India is facing? What are the best methods or the practices to be adopted by India to tackle such complexities?" Comparative research is predominantly useful when trying to identify best practices in a particular field. It is a process that allows us to investigate, understand and criticise different countries functioning, policies, administration etc. and to build on the merits and demerits of our own system. In this chapter, all the countries identified by the researcher are the best performers in the public health care sector as per the reports of WHO[317]. Through this chapter, the researcher is trying to investigate and understand the health care system, the policies, programmes, role of federal and state governments, legislations and judiciary in boosting the health care sector of the selected countries and also understand the role of each stakeholder in making them the best players in the health sector[318].

As mentioned in the research methodology chapter, this chapter is completely based on secondary sources, hence Doctrinal in nature. The researcher has reviewed all available materials on the healthcare of the selected countries including the legislations and Constitutions of the selected countries, government websites, reports by government and non-government organisations, journal articles, articles published in magazines and

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[317] WHO World Health Organisation, "World Health Statistics 2018" (2018) <https://www.who.int/docs/default-source/gho-documents/world-health-statistic-reports/6-june-18108-world-health-statistics-2018.pdf>.

[318] 5th objective of the study " *To compare the healthcare system of India with the best performing selected countries in the public healthcare sector*". (Countries are selected based on their performance in public health care based on the Health Index reports of WHO and UNO reports post 2018. The selected countries are Australia, China, France, United States of America, and Myanmar).

newspaper articles. All the reviewed materials were critically analysed by the researcher and based on the findings of the review; the chapter is prepared.

4.2 Right to Healthcare in the USA with Special Reference to Access to Healthcare

As mentioned above the study is strictly doctrinal. An extensive literature review was carried out, all new reports and materials available on this area are referred. After completion of the literature review, it was found that Health care in the United States is provided by many distinct organizations. Health care facilities are largely owned and operated by private sector businesses. 58% of US community hospitals are non-profit, 21% are government-owned, and 21% are profit-based. It was recorded by the World Health Organization report that the United States spent the highest on health care[319].

The health care system of the US is a matter of polarized debate. Some believe that Americans have the best health care system in the world, pointing to the freely available and most advanced medical technologies. On the other hand, people criticize the system as being fragmented and inefficient, pointing to the fact that though America spends maximum on health care than any other country as per the reports of WHO, yet has failed to achieve Universal Health Coverage and inequality in access and quality continues to exist. Understanding the debate between these two diametrically opposed viewpoints and comparing the concept of the right to health and the health care system of the USA with our Indian health care system, requires a basic understanding of the structure of the U.S. health care system. This part of the Chapter will explain the historical background, the different stakeholders in the US healthcare system, Health sector reforms, the role of both federal and state governments in improving the health care, Role played by the legal system and legislations in reforming the health care system of the USA and the working of the American Health care system.

[319] OECD Library, “Health Expenditure in Relation to GDP” <https://doi.org/10.1787/888934016816> accessed September 18, 2021.

4.2.1. History of Health Care Reforms in the USA

Like most other countries, both private and public insurers play a vital role in the U.S. health care system[320]. The unique feature of the U.S. health care system is the supremacy of the private element over the public element. How much the government should be involved in Facilitating Health care is a most debated political question in the USA. The same can be easily accessed with a simple reading of the history of the U.S health care system. America's history of recorded healthcare dated back to the end of the 19th century. After the Civil War in 1865, the federal government under the leadership of President Abraham Lincoln passed legislation with an intention 'to establish a Bureau for the Relief of Freedmen and Refugees' to provide food, shelter, clothing, medical services, and land to displaced Southerners, including newly freed African Americans for a period of one year[321]. The act established the first system of medical care in the South called the 'Freedmen's Bureau'[322]. The government constructed 40 hospitals, employed over 120 physicians and treated more than one million sick and dying former slaves. But the second proposal to the extent of the duration and applicability of the act was vetoed by the president and was not passed.

During this period, the industrial revolution brought steel mill jobs to many U.S. cities. As a result of industrialisation, the hazardous nature of work led to many workplace injuries. The worker's union started offering certain medical protection schemes to its workers to avoid the financial loss that occurred to them due to such accidents[323]. But these schemes were not well organised or consistent. Later in the year of 1905 'The American Association for Labour Legislation' was established to provide for national health insurance in the United States of America. AALL proposed a bill that covered health care for low income and working-class citizens. The proposed bill contained provisions for sick leave, to cover funeral expenses, and maternity leave etc[324]. But due

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[320] Steven H Woolf and Laudan Aron, *Public Health and Medical Care Systems* (National Academies Press (US) 2013) <https://www.ncbi.nlm.nih.gov/books/NBK154484/> accessed September 18, 2021.
[321] Freedmen's Bureau Acts 1865 &1866.
[322] Diane L. Richard, "The Freedmen ' s Bureau Diane L . Richard Looks at a Great Resource for Post Civil War Research !" [2012] *Family Chronicle*.
[323] Jones and Bartlett, "History of the U . S . Healthcare System," *Jones and Bartlett Publishers* (2014).
[324] J. Dennis Chasse, *The American Association for Labour Legislation and the Institutionalist Tradition in National Health Insurance*, Journal of Economic Issue, 063-090, (1994). Available at: http://www.jstor.org/stable/4226887 (Accessed on 07/09/2018).

to the objections raised by a few medical societies and non-backing from American Medical Association the bill didn't see the light.

After World War I, the cost of health care became very expensive. The hospitals and physicians began to increase the prices for the medical services, making it unaffordable for the common man[325]. The first non-profit insurance company, known as the precursor to Blue Cross Blue Shield (BCBS), was created to help cover hospital services. Blue Cross was developed by Justin Ford Kimball in 1929 to guarantee 21 days of hospital care for teachers up to $6 per year and was later extended to other employee groups in Dallas, and then nationally[326]. Employers in the Pacific Northwest's timber and mining towns created Blue Shield to offer medical care by paying monthly fees to medical service bureaus made up of groups of doctors. In 1939, California established the first official Blue Shield plan. The United States government opted to administer Medicare in the 1960s by partnering with Blue Cross and Blue Shield corporations[327]. The Blue Cross and Blue Shield Association was formed in 1982 when Blue Shield joined with The Blue Cross Association (BCBS). Now it is one of the largest insurance providers in the country and is very profitable. Now BCBS is concentrating on improving health care quality and affordability, health care access and also enabling healthier living to all Americans by providing disease prevention and management resources[328].

The 1930s was very critical for the USA due to the economic depression, unemployment and old-age care superseded health care issues. President Roosevelt's step to address health-related issues through a health insurance bill was not supported

[325] George B Moseley, "The U.S. Health Care Non-System, 1908-2008" (2008) 10 Virtual Mentor, American Medical Association Journal of Ethics 324.

[326] Robert J Feiser Burton A. Weisbrod, "Hospitalization Insurance and Hospital Utilization" (1961) 51 The American Economic Review 126 <https://www.scholars.northwestern.edu/en/publications/hospitalization-insurance-and-hospital-utilization> accessed September 18, 2021.

[327] Blue California, "History of Blue Shield" <https://www.blueshieldca.com/bsca/bsc/public/member/mp/contentpages/!ut/p/z1/tVLLUsIwFP0VXXRZctsCTd0FVKTjYwZBIJtO04a2TpuUNFD9e1NFZ5xRGBdmlce5955HEEUrREW8L7JYF1LEpTmv6TBy8RTfADjhA7gABMM4vA8CjH0fPSGKaJ0UKVp7ATgBd1ybDdLU7jset1nqYjsdwCCJ_YQHCevQidC1ztG64hXjKk> accessed September 18, 2021.

[328] Blue Cross Blue Shield, Investing in Americans Health, 2015, Available at: https://www.bcbs.com/sites/default/files/file-attachments/page/2015.BCBS_.InvestingInAmericasHealth.pdf (Accessed on 07/09/2018).

by AMA[329], the same led to the making of the Social Security Act of 1935[330] intending to assist the old age, unemployed, women and children and improvement of the public health care system.

In the 1940s, the federal government introduced wages and price controls due to World War II. In an effort to retain employees, employers started offering health insurance to employees. This is another instance of the third party paying in the USA which replaced Out of Pocket paying[331]. President Truman's efforts to pass Universal Health care as part of his fair deal didn't get the required majority in Congress. Later Truman's Plan came into existence intending to cover all Americans[332] but the same ceased to operate by 1948 due to lack of public support[333].

During the period of John F Kennedy (1961-63), though he tried to implement health care plans for senior citizens but had failed miserably due to AMA opposition. The next great step was the Medicare national Health Insurance Program began in 1966 by President Lyndon B. Johnson under the social security Act 1965[334]. The initiative aimed at ensuring the provision of cheap healthcare for senior residents and disabled persons, via doctors and hospitals. By 1970, 6.5% of GDP was in national health expenditure[335]. Two related duties could be performed by next President Richard Nixon. Firstly, he expanded Medicare in the Social Security Amendment of 1972[336] and secondly the Health Maintenance Organization Act of 1973 was enacted to establish some order in the healthcare industry chaos. The act aimed at providing an alternative for the

[329] Jones and Bartlett (n 324).

[330] Social Security Act of 1935, available at: https://www.ssa.gov/history/pdf/Downey%20PDFs/Social%20Security%20Act%20of%201935%20Vol%201.pdf (Accessed on 07/09/2018).

[331] Institute of Medicine (US) Committee on Employment-Based Health Benefits, *Employment-Based Health Benefits* (Marilyn J Field and Harold T Shapiro eds, National Academies Press (US) 1993) <https://www.ncbi.nlm.nih.gov/books/NBK235989/> accessed September 18, 2021.

[332] Harry. S Truman, *Special Message to the Congress Recommending a Comprehensive Health Program* (1945). Available at: https://www.trumanlibrary.org/publicpapers/index.php?pid=483&st=&st1= (accessed on 09/09/2018).

[333] Sheila Mulrooney Eldred, "When Harry Truman Pushed for Universal Health Care - History" <https://www.history.com/news/harry-truman-universal-health-care> accessed September 18, 2021.

[334] 42 U.S. Code Subchapter XVIII - HEALTH INSURANCE FOR AGED AND DISABLED | U.S. Code | US Law | LII / Legal Information Institute.

[335] Edward Berkowitz, "Medicare and Medicaid: The Past as Prologue" (2005) 27 Health Care Financing Review 11 </pmc/articles/PMC4194925/> accessed September 18, 2021.

[336] Social Security Amendment Act, 1972. (Public Act 1972 No 133, Available at: https://www.finance.senate.gov/imo/media/doc/Sprt37.pdf (Accessed on 06/09/2018).

traditional solo practice fee for the practice of the system. By 1980 NHE accounted for 8.9% of the GDP[337]. President Reagan signed the Consolidated Omnibus Budget Reconciliation Act in 1986, which permits former employees to remain registered as long as they pay full premiums. The new unemployed who may otherwise have had difficulty in buying private insurance provided access to health insurance[338].

By 1990 the NHE accounted for 12.1% of the GDP[339]. One of the major concerns of the Bill Clinton Administration was health care reform. The Clinton Health care plan introduced in 1993 provided for mandatory enrolment in the health insurance plan. The plan aims at offering subsidies to guarantee affordability to all income ranges. It also provided for the establishment of health alliances in each state. Every citizen or permanent resident would thus be guaranteed medical care. Unfortunately, the Clinton plan had to face multiple issues that resulted in the death of the bill. The Clinton Administration's final healthcare contribution was the Children's Health Insurance Program, which was included in the Balanced Budget Act of 1997[340]. This programme sought to help uninsured children up to the age of 19 who lived in homes with incomes too high to qualify for Medicaid. It is still in use and is managed by individual states. Clinton's health-care reform effort, on the other hand, was a political disaster[341].

The 2000s witnessed a 1.2% increase in health expenditure making it 13.3% of GDP. During the Presidency of Bush, he updated Medicare to include prescription drug coverage. This was made possible by enacting the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

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[337] Aaron C Catlin and Cathy A Cowan, "History of Health Spending in the United States, 1960-2013" [1960] Centers for Medicare and Medicaid Services 1 <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf> accessed September 18, 2021.

[338] M Ross and C Hayes, "Consolidated Omnibus Budget Reconciliation Act of 1985." (1986) 49 Social security bulletin 22.

[339] Katharine R Levit and others, "National Health Expenditures, 1990" (1991) 13 Health Care Financing Review 29 </pmc/articles/PMC4193227/> accessed September 18, 2021.

[340] Plaut TF and Arons BS, "President Clinton's Proposal for Health Care Reform: Key Provisions and Issues" (1994) 45 Hospital & community psychiatry 871 <https://pubmed.ncbi.nlm.nih.gov/7989016/> accessed September 18, 2021.

[341] TF and BS (n 341).

Later in 2009 when Barack Obama came into power Universal Health coverage was one of the stated goals of the Obama Administration. With the help and support of congressional Democrats and Health Policy experts, he implemented 'The Patient Protection and Affordable Care Act' also known as 'Obamacare'. Obamacare's major goals were to make affordable health insurance more accessible to more people, to extend Medicaid to cover all individuals with incomes below 138 percent of the federal poverty line and to encourage innovative medical care delivery systems aimed at lowering healthcare costs in general. During the first open enrolment season, almost 8 million individuals signed up for insurance via the ACA. The number of people insured by the ACA grew to 11.7 million in 2015, and it is projected that 11.4 million people have been covered on an annual basis since then. Furthermore, the Affordable Care Act allows for prompt coverage of maternal and prenatal care, which was previously prohibited under commercial insurance policies[342].

The new President Donald Trump has proposed to repeal the Obama Care Act and replace it with the American Health Care Act of 2017. Proposed reforms include allowing individuals to deduct the full amount of premiums for individual health plans from their federal tax returns, providing block grants to finance state Medicaid programs, and allowing insurers to sell insurance across state lines. The main objectives behind this proposal are to assess how each of these reforms when implemented individually would affect insurance coverage, consumer OOP spending on health care, and the federal deficit in 2018[343]. The proposal is passed by the house of representatives but yet to be passed by the Senate[344].

4.2.2. Different Stakeholders of U.S Health Care System

It is very clear from the above discussion that today's health care system in America is not of sudden origin, it is the product of decades of progression through different

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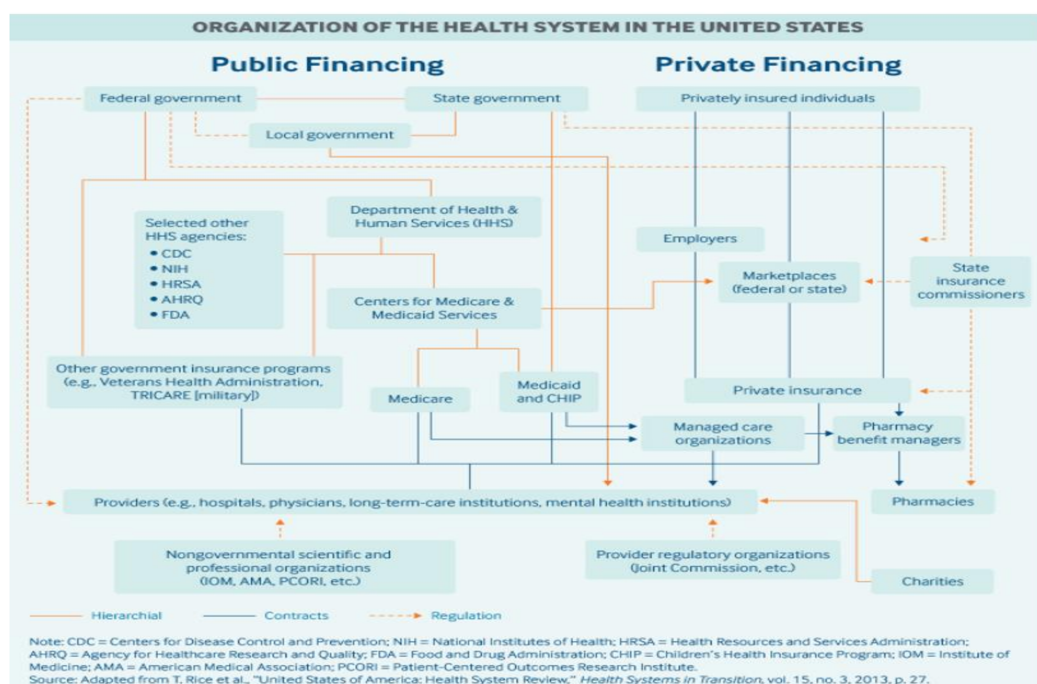
[342] C Lee Ventola, "President Obama's Health Care Reform Policies: Issues of Interest to P&T Committees" (2009) 34 Pharmacy and Therapeutics 296 </pmc/articles/PMC2697918/> accessed September 18, 2021.

[343] Sheryl Gay Stolberg, "Trump Administration Asks Supreme Court to Strike Down Affordable Care Act" *The New York Times* (2020) <https://www.nytimes.com/2020/06/26/us/politics/obamacare-trump-administration-supreme-court.html> accessed September 18, 2021.

[344] American Health Care Act of 2017, H.R.1628. Available at: https://www.congress.gov/bill/115th-congress/house-bill/1628 (Accessed on 09/09/2018).

policies, programs and legislation. The Constitution of the USA does not explicitly set forth the right to health or health care and also the SC judgements have never identified health as a fundamental right still the congress incrementally has established health care rights through legislation, the same is evident from the above discussion. Congress has provided broad rights to healthcare for the elderly, disabled, people living in poverty, and children by establishing Medicare, Medicaid, and CHIP through different legislations.



(Figure 6-Source: The Common Wealth fund[345])

The health care sector of the USA is managed by different authorities. On the top of the pyramid, there is the Federal Government to control and regulate the right to health and health care system. In the United States, the federal government purchases healthcare for millions of elderly and disabled Americans through Medicare. The government guarantees Health insurance to American employees, retirees, and their dependents through the Federal Employee Health Benefits Plan. Millions of low-income individuals are entitled to get the benefit of health insurance via Medicaid. Children and military retirees and their dependents have been assured the health insurance

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345 The Commonwealth Fund, "United States" <https://www.commonwealthfund.org/international-health-policy-center/countries/united-states> accessed September 18, 2021.

through the Tri-Care program. In addition to the said insurance schemes the federal government offers health care directly to active-duty military employees and their beneficiaries, veterans, American Indians and Alaskan natives, and the prison population. The federal government operates hospitals and nursing homes and also employs health professionals. For the vulnerable sections of society, the government offers programs, such as community health centres to provide health care to these groups. The federal government is neither the primary purchaser nor provider of health care, it plays a vital role in measuring and monitoring the quality of care and in developing the tools to monitor quality. Moreover, the government monitors the quality of care in organizations that receive federal funding.

The Medicare program, established under the Social Security Act in 1965[346] is the largest health care program enacted by Congress under its power to tax and spend for the general welfare. Medicaid[347], and the Children's Health Insurance Program enacted in 1997[348], are examples of voluntary federal/state partnership programs providing health care benefits to certain low-income persons[349]. Another step to improve healthcare was the enactment of the Hospital Survey and Construction Act, enacted in 1946. This legislation allows hospitals, nursing homes, and other health institutions to receive federal construction funding on the condition that they offer a fair number of services to poor patients and make these services available to all residents in the facility's region[350]. Under the Emergency Medical Treatment and Active Labour Act, Congress also established a legislative entitlement to some emergency services[351]. The Act was passed to make it mandatory for hospitals that participate in Medicare to screen, examine, and stabilise women in labour before transferring them to another

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[346] 42 U.S. Code Subchapter XVIII - Health Insurance For Aged And Disabled | U.S. Code | US Law | LII / Legal Information Institute.

[347] 42 U.S. Code § 1396 - Medicaid and CHIP Payment and Access Commission | U.S. Code | US Law | LII / Legal Information Institute.

[348] MACPAC, "History and Impact of CHIP" <https://www.macpac.gov/subtopic/history-and-impact-of-chip/> accessed September 18, 2021.

[349] Adebayo Adeyinka, Ayesan Rewane and Louisdon Pierre, "Children's Health Insurance Program" <https://www.ncbi.nlm.nih.gov/books/NBK539903/> accessed September 19, 2021.

[350] U.S. Health Resources & Services Administration, "Hill-Burton Free and Reduced-Cost Health Care" <https://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html> accessed September 19, 2021.

[351] Congressional Research Service, 'EMTALA: Access to Emergency Medical Care' (2010).

institution[352]. Later in 2009 Obama Government with the help and support of congressional Democrats and Health Policy experts, he implemented 'The Patient Protection and Affordable Care Act'[353]. As discussed above Obama Care's major goals were to make affordable health insurance more accessible to more people, to extend Medicaid to cover all individuals with incomes below 138 percent of the federal poverty line, and to encourage new medical care delivery systems aimed at lowering healthcare costs in general[354].

Virginia was the First Nation to enact a statute that tried to opt out federal health care provisions in 2010 by stating that, as a matter of law in Virginia, no individual "shall be required to obtain or maintain a policy of individual insurance coverage"[355]. This state provision of the State statute can be considered to be contradictory with Section 1501 of the PPACA, which mandates individuals to buy health insurance coverage beginning in 2014. Subsequent to the action taken by Virginia, Idaho also enacted a similar law,[356] a bill is made which prohibits the mandatory feature of individual health insurance as well as prevented state agencies from implementing federal health reform measures without the Utah legislature.[357] Later, legislators in at least 48 states proposed measures to limit, alter, or reject various federal acts related to health care reform, such as the compulsion to acquire health insurance or the creation of a single-payer system.[358] The state actions to limit federal initiatives also includes the suit filed by a coalition of 20 states declaring Obama care unConstitutional on the ground that the U.S. Supreme Court had already admitted that an individual mandate without a tax penalty

[352] 42 U.S. Code § 1395dd - Examination and treatment for emergency medical conditions and women in labor | U.S. Code | US Law | LII / Legal Information Institute.

[353] P.L. 111-148, Patient Protection And Affordable Care Act Of 2010.

[354] Leigh Cellucci, "A Brief History Of The Development Of Healthcare In America," *Essentials of Healthcare Management: Cases, Concepts, and Skills* (2019) <www.copyright.com.> accessed September 18, 2021.

[355] CRS Report for Congress Health Care: Constitutional Rights and Legislative Powers 2012.

[356] Christopher, Health Insurance Legislators in 38 States, <https://www.coursehero.com/file/p2r2ml6/health-insurance-legislators-in-at-least-38-state-legislatures-have-introduced/> (Accessed on 07/09/2018).

[357] HB67, Health System Amendments (2010) State of Utah, <http://le.utah.gov/~2010/bills/hbillenr/hb0067.pdf> (Accessed on 07/09/2018).

[358] Richard Cauchi, State laws and actions challenge certain Health Reforms, 2018, Available at: <http://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx> (Accessed on 07/09/2018).

is unConstitutional whereas Obama care mandates that people have health insurance or pay fine.

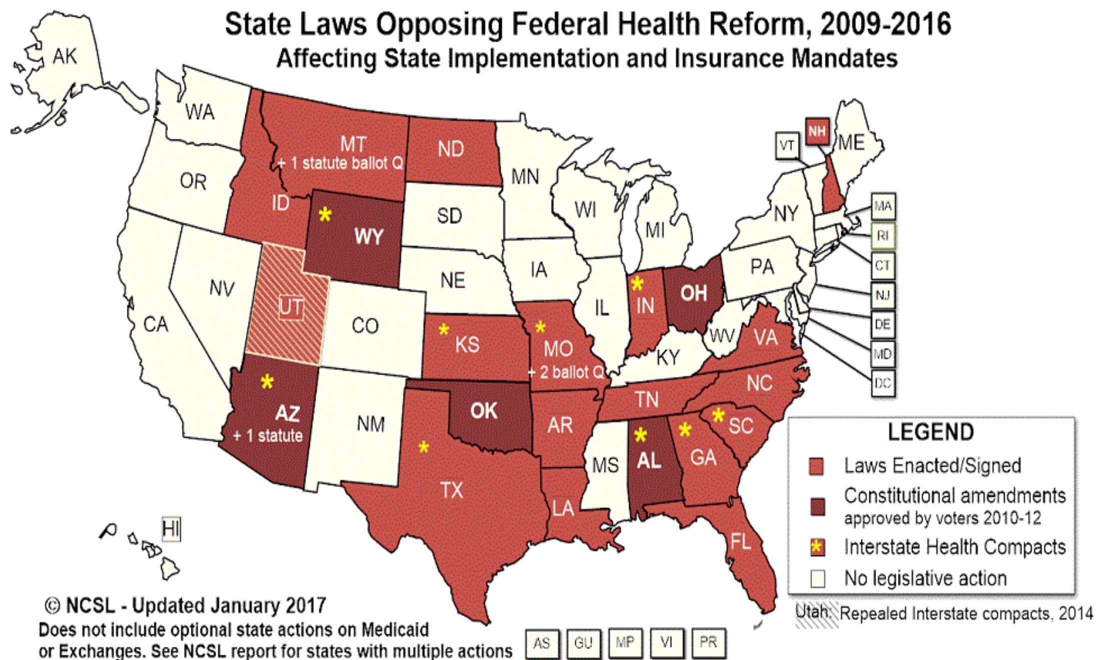

Figure 7-Source: NCSL updated on January 2017[359]

Few state Constitutions include requirements on the government to provide health care services to the general public or a specific set of people. Around 13 state Constitutions of the states contain provisions that specifically provide for the health and health care. Alaska's Constitution provides that "the legislature shall provide for the promotion and protection of public health"[360]. Similarly, Wyoming's Constitution states, "As the health and morality of the people are essential to their well-being, … it shall be the duty of the legislature to protect and promote these vital interests"[361]. Mississippi has a Constitutional provision that reads as "it shall be the duty of the Legislature to provide by law for the treatment and care of the insane, and the Legislature may provide for the care of the indigent sick in the hospitals in the State"[362]. The state legislature of Arkansas is required under the state Constitution to provide for the care of mentally ill

[359] National Conference of State Legislatures, <http://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx> (Accessed on 07/09/2018).
[360] Art. VII, Sec 4 Constitution of Alaska, 1956.
[361] Art. 7, Section 20,Constitution of the State of Wyoming, 1889.
[362] Art IV, Sec 86 Constitution of Mississippi, 1890.

people[363]. State Constitutions, on the other hand, generally permit but do not mandate the provision of health care services. A joint endeavour by the federal government and state governments might improve health care in the United States and help the country attain Universal Health Coverage.

4.2.3 Role of Health Insurance in the U.S Healthcare System

A. **Public Health Insurance:** NHE rose by 4.6% to $3.8 billion in 2019 or $11,582 per person, representing 17.7% of the Gross Domestic Product (GDP) Federal expenditure accounted for 28% of overall expenditures on healthcare[364]. Federal funding accounted for 28% of overall spending on health care. Federal taxation funds government insurance programmes, such as Medicare, Medicaid, CHIP and Veteran Health Administration (TRICARE). The Medicare and Medicaid Center is the main public health financing source. Medicare is supported by a mix of federal general taxation, a compulsory payroll tax payable for Part A and individual premiums. Medicare expenditure increased 6.7%, or 21% of the NHE total, to US$799.4 billion and Medicaid spending has grown by 2.9 percent, or 16 percent of total NHE, to $613.5 billion in 2019. The federal government provides matching payments to states, which are used to finance CHIP[365].

B. **Private Insurance:** In 2018, private health insurance costs represented for one-third (34%) of overall health expenditures. For two-thirds of Americans, private health insurance is their major source of coverage (67%). In 2019, it increased by 3.7 percent to $1,195.1 billion, accounting for 31% of total NHE[366]. The bulk of private insurance (55%) is provided by employers, with a lesser percentage (11%) acquired by individuals through for-profit and non-profit insurers[367]. According to

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[363] Art. 19, Sec 19 Constitution of Arkansas, 1836.
[364] Centre for Medicare and Medicaid Services, "NHE Fact Sheet | CMS" <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet> accessed September 19, 2021.
[365] Robin Rudowitz; Elizabeth Williams; Elizabeth Hinton; Rachel Garfield, "Medicaid Financing The Basics – Issue Brief – 8953-03 | KFF" <https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/> accessed September 19, 2021.
[366] Centre for Medicare and Medicaid Services (n 365).
[367] Louis S Reed, "Private Health Insurance in the United States: An Overview" [1965] *Social Security Bulletin*.

the report, in 2019, more than one-third of Medicare recipients chose a private Medicare Advantage health plan to obtain their coverage[368].

C. Services Covered: No nationally defined benefit package is available in the USA. Medicare registered individuals are eligible for hospital treatment (part A), including inpatient care and short-term care. Part B of Medicare covers medical services, sustainable medical facilities and home health services. Medicare supports short-term aftercare, such as rehabilitation treatments in or at home, but not long-term care. Citizens are allowed to purchase private prescription drug coverage under part D[369].

Whereas Medicaid includes a wide range of services according to federal rules, including hospital services, hospital care and outpatient treatments for long-term, laboratory and diagnostic services, family planning, nursing siblings, freestanding delivery and medical services. States can choose for further benefits, including physical treatment, dentistry and eye services. Dental protection is provided in most states. The optional benefits under federal law include ambulatory prescription medicines, although now all states offer coverage of pharmaceuticals. Insurance for the private sector. Private health insurance provides different benefits. The health coverage of employers does not normally involve dentures or eyesight[370].

In addition to public insurance schemes such as Medicare and Medicaid, the dollars of taxpayers are utilised to fund numerous non-insured, low-income and exposed patients. The ACA has, for example, boosted financing to federally designated health centres, where over 27 million underprivileged individuals are provided primary and preventive services, irrespective of their payment

[368] Gretchen Jacobson, Anthony Damico and Tricia Neuman, "Medicare Advantage 2019 Spotlight: First Look" (*KFF*, 2018) <https://www.kff.org/medicare/issue-brief/medicare-advantage-2019-spotlight-first-look/> accessed September 19, 2021.
[369] Patricia A Davis and others, "Medicare Primer (Updated)" [2020] Key Congressional Reports for August 2019: Part X 55.
[370] Robin Rudowitz; Elizabeth Williams; Elizabeth Hinton; Rachel Garfield (n 366).

capabilities[371]. Uninsured people also have access to acute treatment due to the mandate of the federal rule which provides for all hospitals to treat emergency patients without any hesitation, including women in labour, regardless of their capacity to pay, insurance status, national origin, or race. As a result, private providers are a major source of uncompensated care and charity[372].

4.2.4. Current Healthcare Delivery System in the USA

A. **Primary Healthcare:** Primary care is the foundation of the healthcare system in the USA. Primary care physicians account for around one-third of all professionally active doctors and include specialists in family medicine, general practice, internal medicine, paediatrics, and geriatrics. In 2018, almost half of primary care doctors worked in physician-owned clinics, with general internists rather than family practitioners being the most frequent. Negotiated fees, capitation, and administratively fixed fees are some of the ways primary care physicians are compensated. Fee-for-service payments account for the majority of primary care practice revenue (66%) [373].

B. **Outpatient specialist care:** Specialists might work in private and hospital settings. Specialist practises are more integrated and consolidated with hospital systems. The bulk of experts are specialising in group practises, usually in single groups. Experts are free to pick whatever type of insurance to take. For example, as Medicaid and Medicare's comparatively give lower reimbursement rates, not all specialists take publicly insured patients[374].

C. **After Care:** Primary healthcare doctors are not obligated to offer their registered patients with or intend to have after-hours access. However, 45% of primary

[371] HRSA.gov, "HRSA Fact Sheets" <https://data.hrsa.gov/data/fact-sheets> accessed September 19, 2021.
[372] Joseph Zibulewsky, "The Emergency Medical Treatment and Active Labor Act (EMTALA): What It Is and What It Means for Physicians" (2001) 14 Proceedings (Baylor University. Medical Center) 339 </pmc/articles/PMC1305897/> accessed September 19, 2021.
[373] Leiyu Shi, "The Impact of Primary Care: A Focused Review" (2012) 2012 Scientifica 1 </pmc/articles/PMC3820521/> accessed September 19, 2021.
[374] David M Levine, Bruce E Landon and Jeffrey A Linder, "Quality and Experience of Outpatient Care in the United States for Adults With or Without Primary Care Supplemental Content" (2019) 179 JAMA Intern Med 363 <https://jamanetwork.com/>.

physicians in 2019 had post-hour treatments: 38% provided for nights and 41% for weekend care[375].

D. Long-term care and social support: no universal coverage exists for services of long-term care. Public expenditure is roughly 70% of the overall long-term care expenditure, the majority being Medicaid. 31 Medicare and most plans funded by employers are only covered by post-acute care after hospitalisation, including hospice and short-stay nursing care (up to 100 days following acute hospitalization)[376].

E. Hospitals: In 2018, there were 5,198 short-term acute care hospitals in the United States, with 57% being non-profit, 25% being for-profit, and 19% being public (state or local government-owned).27 There were also 209 federal government hospitals. Hospitals are allowed to accept any insurance they choose, although the majority of them accept Medicare and Medicaid.

4.2.5. Steps to Ensure Quality Healthcare Accessible and Available to Public

A. Medical Education in the USA: Physician education and licencing requirements vary considerably throughout the world. Between graduating from secondary school and becoming an attending physician with full medical licencing in the United States (US), the medical education process generally entails a minimum of 11 years of formal training and several standardised tests. In contrast to most other countries, where medical training begins after high school graduation, students in the United States typically join a 4-year medical school after earning an undergraduate bachelor's degree[377].

B. Strategies to Ensure Quality of Healthcare: Certain providers must disclose statistics on the quality of their treatment under federal law, and the Centres for

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[375] Nancy De Lew, George Greenberg and Kraig Kinchen, "A Layman's Guide to the U.S. Health Care System" (1992) 14 Healthcare Financing review 151 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193322/>.

[376] The Commonwealth Fund (n 346).

[377] Yvonne M Mowery, "Medical Education: Duke Experience A Primer on Medical Education in the United States through the Lens of a Current Resident Physician" (2015) 3 Ann Transl Med 270 <www.atmjournal.org>.

Medicare and Medicaid Services must publicly publish quality measures performance. The annual National Healthcare Quality and Disparities Report have been published by the Agency for Healthcare Research and Quality since 2003, and it details national progress in improving healthcare quality. The quality of health care in the United States improved overall from 2000 to 2016, according to the 2018 study, although the progress was uneven. One of the most commonly utilised methods for evaluating provider quality is the Healthcare Effectiveness Data and Information Set. It is used by health plans to assess the quality of providers. The data collection contains cancer screening rates, chronic condition medication management, follow-up visits, and other indicators[378].

C. **Healthcare Disparities**: Several government entities are in charge of keeping track of inequalities prevailing in healthcare and decreasing them. An annual national study from the Agency for Healthcare Research and Quality highlights inequalities in health care quality by race/ethnicity, age, and gender. Wealth and race discrepancies exist but have shrunk between 2000 and 2016. Disparities exist based on the origin of birth and impoverished and uninsured too[379]. Certain government agencies have special duties for addressing inequity. The Office of Minority Health is responsible for establishing policies and initiatives to minimise racial and ethnic inequalities. The Health Resources and Services Administration is responsible for awarding funds to states, local governments, and community-based groups for the treatment and care of low-income, uninsured, or otherwise disadvantaged people. The Affordable Care Act mandated that nonprofit hospitals, which are free from some taxes due to their charity status, perform community health needs assessments in collaboration with community partners to identify and address unmet needs[380].

D. **Electronic Health Records:** United States of America established the "Office of the National Coordinator for Health Information Technology (ONC)" in 2004 with

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[378] Ronda G Hughes, "Tools and Strategies for Quality Improvement and Patient Safety" [2008] Patient Safety and Quality: An Evidence-Based Handbook for Nurses <https://www.ncbi.nlm.nih.gov/books/NBK2682/> accessed September 19, 2021.

[379] Rachel LJ Thornton and others, "Evaluating Strategies For Reducing Health Disparities By Addressing The Social Determinants Of Health."

[380] The Commonwealth Fund (n 346).

an aim to "coordinate national efforts to adopt and improve health information technology and electronic health information exchange". Year 2017 witnedded certified electronic health record (EHR) system was being used by 96% of non-federal acute care hospitals and 86% of office-based physicians. 80% percent of hospitals and 54% of physician offices have implemented an EHR with advanced capabilities, such as the capacity to track patient data, list drugs, record clinician notes, and manage prescription orders, according to the study[381].

E. **How are Costs Controlled:** The United States has the largest annual per capita health expenditures in the world (USD 11,172 on average in 2018). Tiered provider pricing and increased patient cost-sharing are the strategies adopted by private insurance providers to control the cost. The federal government monitors expenses through establishing Medicare and Veterans Health Administration provider rates; capitalising payments to managed healthcare companies; Capping of out-of-pocket yearly costs for Medicare benefit recipients plan members and market/trading plans; negotiating Veterans Health Administration prescription pricing[382].

4.3 Right to Healthcare in Australia with Special Reference to Access to Healthcare

Australia is a Federal Parliamentary Constitutional monarchy with a 24.77 million population. Ranking 6th among the OECD nations the country is known for having one of the healthiest populations in the world[383]. In United Nations Human Development Index-Health Index Australia ranked 2nd position in 2018.[384]

The welfare state model, the market model, and the hybrid model are the three major types of healthcare systems that exist across the world. The welfare and market

[381] Daniel J Friedman, R Gibson Parrish and David A Ross, "Electronic Health Records and US Public Health: Current Realities and Future Promise" (2013) 103 American Journal of Public Health 1560 <http://www.ajph.org.>.
[382] The Commonwealth Fund (n 346).
[383] Australian Institute of Health and Welfare., *Health Expenditure Australia* (2002) <http://www.aihw.gov.au/publications/index.cfm/criteria/Health expenditure Australia>.
[384] Australian Institute of Health and Welfare. (n 384).

economics are combined in a hybrid model. The government pays for all healthcare expenditures in a welfare state through tax dollars. A market paradigm allows individuals and private enterprises to pick and pay for healthcare services. Individuals can supplement their public insurance with private insurance to meet their healthcare requirements under a hybrid system, in which the government provides baseline coverage through public insurance and individuals can supplement their public insurance with private insurance. Citizens, permanent residents, and refugees in Australia can acquire private insurance on top of their current public insurance, giving them access to both private and public healthcare[385].

4.3.1. Healthcare Governance in Australia

In Australia, universal healthcare is the responsibility of all three levels of government: federal, state, and local. National policies are mostly established by the federal government. They are in charge of the "Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS), jointly funding state and territory-owned and operated public hospitals, subsidizing and regulating aged care services such as residential care, care at home, and other types of care such as respite care, and supporting quality, effectiveness, and efficiency in primary health care, Financing and dissemination of health and health care information and statistics on a wide spectrum of public health programmes and public health promotion and chronic disease prevention campagnas, support for primary mental health services and suicide prevention, national leadership, regulation of therapeutic and medical supply via the therapeutic Goods Administer, Supporting and regulating private health insurance to maintain a strong private health sector that promotes choice, funding programmes specifically for Aboriginal and Torres Strait Islander health, such as community-controlled health care organisations, providing veterans' health care through the Department of Veterans Affairs, and providing safe, high-quality vaccines for the National Immunisation Program and funding or jointly funding preventive health screening for bowel cancer, cervical cancer and breast cancer, enabling access to organ and tissue transplants, including through a nationally coordinated and consistent

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[385] Sunil K Dixit and Murali Sambasivan, "A Review of the Australian Healthcare System: A Policy Perspective" (2018) 6 SAGE Open Medicine 205031211876921.

approach and system, enabling access to a secure supply of safe and affordable blood products through national supply arrangements and best practice standards, subsidising hearing services, coordinating the national response to health emergencies, including pandemics, ensuring a safe food supply in Australia and New Zealand, providing radiation protection to Australian people and the environment through nuclear safety research, policy, and regulation, providing national leadership in cancer control, with targeted research, cancer service development, education and consumer support[386]. The health portfolio is also responsible for national sports programs, including programs to improve opportunities for community participation in sport and recreation, promote excellence in high-performance athletes, protect the integrity of sport, and coordinate Commonwealth involvement in major sporting events"[387].

The federal government has only a very limited role in direct health service delivery. As per the distribution of legislative power, Health is a state subject so states have the majority of responsibility for public health care services Manage public hospitals, License private hospitals, regulate ambulance services, responsible for public community-based and primary health services (including mental health, dental health, alcohol and drug services), deliver preventive services such as cancer screening and immunization programs and also handles health complaints. In addition to the funds supplied by the federal government, states contribute their own funds[388]. Local governments also play an extremely critical role in the delivery of community and preventative health programmes, such as immunization, food standard regulation and providing services related to environmental health [389].

In Australia the Council of Australian Government (COAG)" represented by the prime minister and first ministers of every state, is responsible for intergovernmental and federal collaboration and decision-making. The platform to discuss the matters of

[386]Australian Government Department of Health, "The Australian Health System" <https://www.health.gov.au/about-us/the-australian-health-system> accessed September 19, 2021.
[387]Australian Institute of Health and Welfare, "Australia's Health 2016," vol 18 (2016) <http://dx.doi.org/10.1016/j.jplph.2009.07.006%0Ahttp://dx.doi.org/10.1016/j.neps.2015.06.001%0Ahttps://www.abebooks.com/Trease-Evans-Pharmacognosy-13th-Edition-William/14174467122/bd>.
[388]Parliament of Australia, "Health in Australia: A Quick Guide" <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1314/QG/HealthAust> accessed September 19, 2021.
[389] Welfare (n 388).

mutual interest in relation to health policy between Australian government, the government of New Zealand and territory governments are felicitated by the COAG Health Council (CHC), its advisory body and the Australian Health Ministers' Advisory Council (AHMAC) [390]. The COAG focuses on key topics, for example, significant financing negotiations and the exchange of duties and responsibilities among states. The Health Council of COAG is in charge of the policy concerns and is backed by the Consultative Council of Australia's Health Ministers[391].

Many national agencies and state governments are under an obligation to look after the quality and safety of care. The state governments administer their health departments and have transferred hospital management to LHNs. The LHNs are in charge of working together with PHNs. There are national and state-level patient consumer organizations and groups working in the country[392].

The primary suppliers of health data in Australia is the Australian Institute of Health and Welfare and the Australian Bureau of Statistics (ABS). The Therapeutic Goods Administration, which oversees supply, imports, exports, manufacturing, and advertisement; the Australian Health Practitioner Regulation Agency, which ensures workforce registration and accreditation in collaboration with National Boards; and the Australian Prudential Regulation Authority, for private healers, are the agencies engaged with regulatory oversight. The Competition and Consumer Commission of Australia encourages competition between private health insurers[393]. In 2015, the Australian Government established a Primary Health Care Advisory Group to investigate possible reforms to primary health care to improve the management of people with complex and chronic diseases.

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[390] "Health Council (Formerly the COAG Health Council)" <https://www.coaghealthcouncil.gov.au/> accessed September 19, 2021.
[391] "Health Council (Formerly the COAG Health Council)" (n 391).
[392] Elias Mossialos and others, "2017 International Profiles of Health Care Systems" 89.
[393] Mossialos and others (n 393).

4.3.2. The Organisational Structure of Healthcare System in Australia

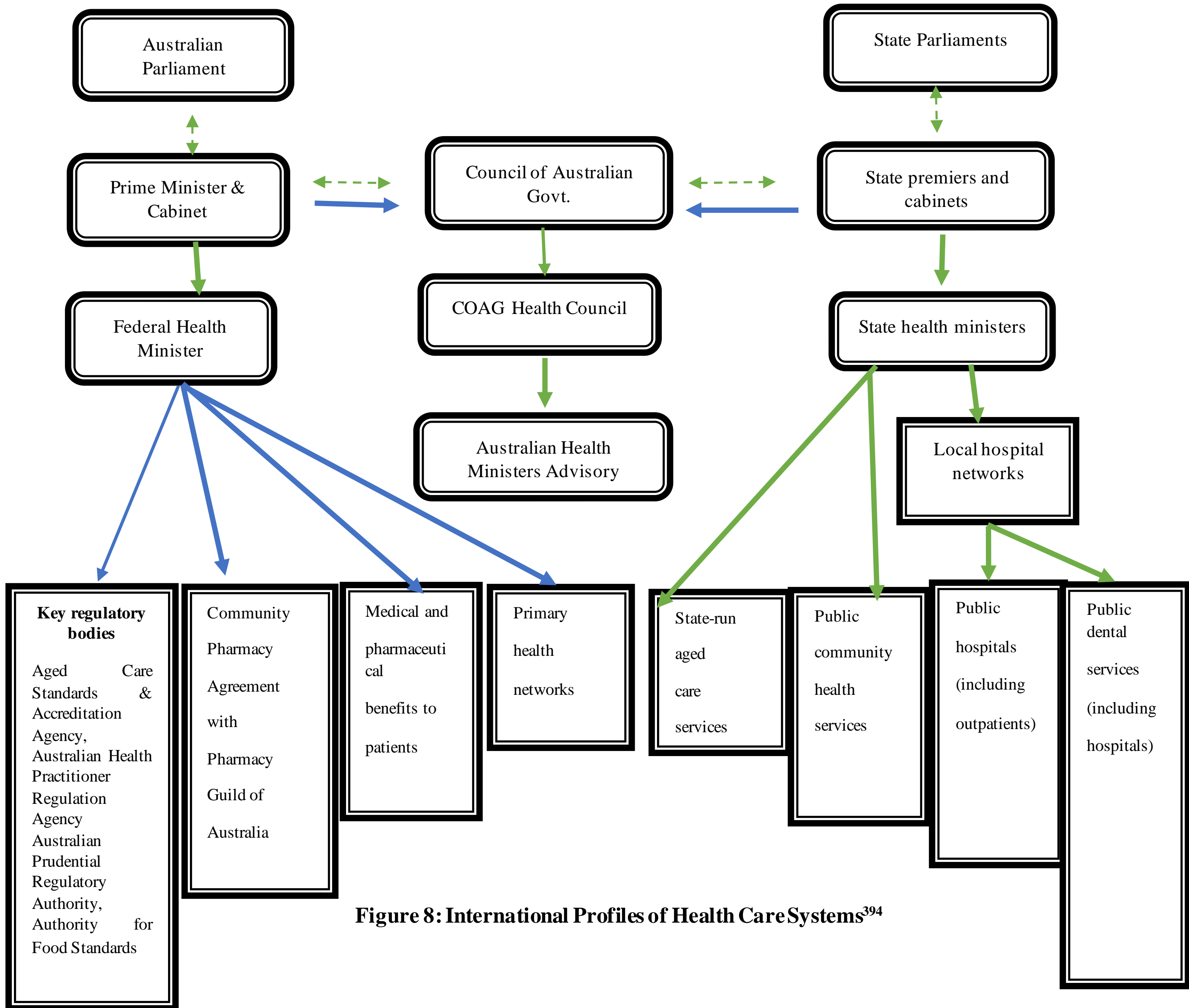

Figure 8: International Profiles of Health Care Systems[394]

[394] Elias Mossialos, Robin Osborn & Dana Sarnak (ed). International Profiles of Health Care Systems, (2016).

4.3.3. Role of Health Insurance in the Australian Healthcare System

A. **Public Health Insurance:** In 2015–2016, total health expenditures accounted for 10.3% of GDP, with an enhanced 3.6% from 2014–2015. In 2019-20 it was $81.8 billion which is 16.3% of the Australian Government's total spending[395].

   Medicare is supported in part by a government charge, which collected an estimated AUD 114.6 billion (USD 80.14 billion)5 in the 2015–2016 financial year. Since 2014, a portion of the funds generated from this levy has gone toward the National Disability Insurance Scheme[396].

B. **Private Health Insurance:** Private health insurance in Australia permits the patient to be treated as a private patient at a hospital. It may also be used to cover healthcare expenditures not covered by Medicare, such as physiotherapy. Your policy determines how much and what it covers. To obtain private health insurance the person should buy coverage from a licenced health insurer and pay regular premiums[397].

   The advantage of private health insurance is that it is widely accessible and provides coverage for out-of-pocket expenses, faster access to non-emergency treatments, and rebates on some services. Hospitalization, general therapy, and ambulance services may all be covered by private health insurance. Dental, physiotherapy, chiropractic, podiatry, home nursing, and optometry treatments are all included under general treatment coverage[398].

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[395] Parliament of Australia, "Health-Budget Review of 2019-2020" <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201920/Health> accessed September 20, 2021.

[396] Commonwealth Fund, "Australia" (*The Commonwealth Fund*, June 5, 2020) <https://www.commonwealthfund.org/international-health-policy-center/countries/australia> accessed September 20, 2021.

[397] Australian Government Department of Health, "About Private Health Insurance" <https://www.health.gov.au/health-topics/private-health-insurance/about-private-health-insurance> accessed September 20, 2021.

[398] Commonwealth Fund, "Australia" (n 397).

The Lifetime Health Coverage programme offers a lifetime discount on health insurance premiums. The base premium does, however, grow by 2% each year beyond the age of 30. As a result, people aged 30 and younger are the most likely to join up, with a tendency toward opting out beginning at the age of 50. As per the reports in June 2019, 11.2 million Australians (44%) had private patient hospital insurance, while 13.6 million (53%) had general treatment insurance[399].

C. **Services Covered:** Medicare Benefits, which include hospital and medical services, including mental health and maternity care, are defined and funded by the federal government. Limited optometry and children's dental treatment are also covered by MBS. The government provides pharmaceutical subsidies through the Pharmaceutical Benefits Scheme (PBS). Pharmaceuticals must be approved for cost-effectiveness by the Pharmaceutical Benefits Advisory Committee in order to be included. Cancer screening and vaccination programmes are also funded by the federal government and are offered free to certain demographic groups[400].

4.3.4. Current Healthcare Delivery System in Australia

According to the data furnished in 2018 by the Australian Government Department of Health, the total registered healthcare practitioners in Australia is 586,000, which includes 98,400 medical practitioners, 334,000 nurses and midwives, 20,600 dentistry practitioners, and 133,400 allied health professionals[401].

A. **Primary Healthcare in Australia:** For the vast majority of Australians, primary health care is their initial point of contact with the health system. Primary care offers a variety of services for the prevention and treatment of acute and chronic illnesses. In 2015, there were 34,367 general practitioners, 49,060 practitioners who were both generalists and specialists, and 8,386 specialists. In general, GPs

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[399] Australian Institute of Health and Welfare, "Private Health Insurance" <https://www.aihw.gov.au/reports/australias-health/private-health-insurance> accessed September 20, 2021.

[400] Department of Health Medical services advisory Committee, "What Is the MBS and Medicare?"

[401] Australian Institute of Health and Welfare, "Health Workforce" <https://www.aihw.gov.au/reports/australias-health/health-workforce> accessed September 20, 2021.

are self-employed, with an average of four physicians per practice. GPs made an average of AUD 3,024 (USD 2,115) per week in 2013–2014, around half (56%) of what specialists made[402]. The federal health minister determines the MBS service pricing structure. Patients can choose whether or not to register with a GP[403].

GPs are mostly payable via MBS, but may also be funded by a percentage programme called the Practice Incentives Program. The GP is funded mainly through the MBS model. The federal government also supports the coordination of multidisciplinary treatment by financing broad multidisciplinary GP clinics called super clinics and by creating primary medical health systems that provide for more efficient, efficient, and coordinated primary care[404].

B. Out-Patient Care: Outpatient treatment is provided by experts in private practice (8,001 experts in 2015) or public institutions (3,745). Patients can pick whatever specialist they want to consult. Specialists are compensated on a case-by-case basis. They receive government subsidies for 85% of the MBS charge and establish out-of-pocket costs for their patients. Many doctors alternatively practise in the private and public sectors[405].

C. After-Hour Care: In Australia it is the responsibility of the General Physicians to ensure that their patients are getting access to after care however they are not under an obligation to provide it by themselves. Their duty is to provide required information about the aftercare to the patients. After-hours walk-in services are accessible at primary care offices and hospitals. Some people may use emergency departments for after-hours primary care because they are free to use[406].

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[402] Datasets |data gov a Beta, "Taxation Statistics 2013-14" <https://data.gov.au/dataset/ds-dga-25e81c18-2083-4abe-81b6-0f530053c63f/details> accessed September 20, 2021.

[403] Australian Commission on Safety and Quality in Health Care, "Primary Health Care" <https://www.safetyandquality.gov.au/our-work/primary-health-care> accessed September 20, 2021.

[404] Australian National Audit Office, "Practice Incentives Program" <https://www.anao.gov.au/work/performance-audit/practice-incentives-program> accessed September 20, 2021.

[405] NSW, "Outpatient Services - Performance" <https://www.health.nsw.gov.au/Performance/Pages/outpatients.aspx> accessed September 20, 2021.

[406] Royal Australian College of General Practitioners, "After-Hours Home Visiting in Primary Healthcare-Position Statement."

D. Long-Term Care: Long-term care mainly covers the aged care. It includes medical services, personal care, and help in living independently for persons who have long-term health-care needs. Long-term care can be delivered in institutions or through community programmes such as respite care.[407] Australia offers institutional long-term care to over 20% of the population over the age of 80, and 6% of those over the age of 65. Australia has the greatest proportion of long-term care users in institutional care compared to home or community care, with 52.5 percent of long-term care beneficiaries aged 65 years and 58.6% of long-term care recipients aged 80 years in institutional care[408].

E. Hospitals: As per the 2017-18 data there were 693 public hospitals and 657 private hospitals in Australia. The records show a decrease in the number of public hospitals from 747 in 2013-14 to 693 in 2017-18. It was owing to a reclassification between 2013–14 and 2014–15, of 46 institutions in Queensland. 41% of public hospitals and 24% of private hospital financing were provided by the government of Australia. The public healthcare units are having 2.4 beds per 1000 population in major cities it is in 4:1000 ratio in Remote areas. In 2017–18, public hospitals had 61,647 available beds, with 2,161 (3.5%) of these in public mental institutions and around 34,300 licensed beds recorded for private hospitals[409].

4.3.5. Steps to Ensure Quality Healthcare Accessible and Available to Public

A. Medical Education: Physicians are generally educated at public (but not exclusively private) colleges, with their tuition funded by the government[410]. Annual tuition costs for Australian nationals are around AUD 65,000 (USD

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[407] Suzanne M Dyer and others, "Is Australia Over-reliant on Residential Aged Care to Support Our Older Population?" (2020) 213 The Medical Journal of Australia 156 </pmc/articles/PMC7496246/> accessed September 20, 2021.

[408] Dyer and others (n 408).

[409] Australian Institute of Health and Welfare, "Hospital Resources 2017–18: Australian Hospital Statistics, Hospitals and Average Available Beds" <https://www.aihw.gov.au/reports/hospitals/hospital-resources-2017-18-ahs/contents/hospitals-and-average-available-beds> accessed September 20, 2021.

[410] Parliament of Australia, "Medical Practitioners: Education and Training in Australia" <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/~/link.aspx?_id=4FB58821DB2B49F58743E7802D1C4ED3&_z=z> accessed September 20, 2021.

45,454), with a student contribution capped at a maximum of AUD 10,754 (USD 7,520) each year[411].

B. Strategies to ensure Quality Healthcare: Several organizations are working to enhance healthcare safety and quality. They may concentrate their efforts on a national level, at the state or territorial level, at the service level, at the clinical level, or for specific health care sectors. The Australian Commission on Safety and Quality in Health Care (ACSQHC) leads efforts to enhance the safety and quality of health care in Australia on a national basis[412]. Health ministries have accepted the ACSQH's service criteria. Standards for conducting patient surveys are among them, and hospitals and day surgery clinics must adhere to them in order to be accredited. An annual patient experience survey is also conducted by the Australian Bureau of Statistics, the country's statistics agency[413]. National Safety and Health Quality standard fixed by the commission is depicted in the figure below;

Figure 9-Source: The Australian Commission on Safety and Quality in Health Care[414]

[411] Commonwealth Fund, "Australia" (n 397).
[412] Australian Institute of Health and Welfare, "Safety and Quality of Health Care" <https://www.aihw.gov.au/reports/australias-health/safety-and-quality-of-health-care> accessed September 20, 2021.
[413] Australian Commission on Safety and quality Healthcare, "Activities for the Australian Safety and Quality Framework for Health Care Putting the Framework into Action."
[414] Australian Commission on Safety and Quality in Health Care, "The NSQHS Standards" <https://www.safetyandquality.gov.au/standards/nsqhs-standards> accessed September 20, 2021.

The Australian Council on Healthcare Standards is the (non-government) body in charge of accrediting healthcare providers[415]. States regulate the operation of public hospitals, license and register commercial hospitals, and collaborate through the National Registration and Accreditation Scheme to allow worker mobility between jurisdictions while ensuring patient safeguards. Accreditation of GPs is handled by the Royal Australian College of General Practitioners[416]. Aged-care services must be accredited by the government-owned Aged Care Standards and Accreditation Agency in order to be eligible for government subsidies. The new Aged Care Quality and Safety Commission will be in charge of regulation, compliance, and complaints about aged care starting in January 2019[417]. The NHA reports on the comparative performance of local hospital networks, public, private and other major health service providers, but not nursing homes or home care organizations. According to the Board of Australian Governments, the reporting framework covers equality, efficiency and effectiveness indicators[418].

C. **Healthcare Disparities:** The health inequalities between Aboriginal and Torres Strait Islander people and the rest of Australia's population are the most pronounced. Disparities between large metropolitan areas and rural and distant locations, as well as disparities across socioeconomic classes, are important issues. The below figure demonstrates the clinical Full-Time Equivalent (cFTE) by profession and remoteness between 2013-2018. The figure shows that access to healthcare is more in major cities as compared to other parts.

[415] "The Australian Council on Healthcare Standards" <https://www.achs.org.au/about-us> accessed September 20, 2021.
[416] RACGP, "The Royal Australian College of General Practitioners - About Us" <https://www.racgp.org.au/the-racgp/about-us> accessed September 20, 2021.
[417] ACQSC, "Home | Aged Care Quality and Safety Commission" <https://www.agedcarequality.gov.au/> accessed September 20, 2021.
[418] Commonwealth Fund, "Australia" (n 397).

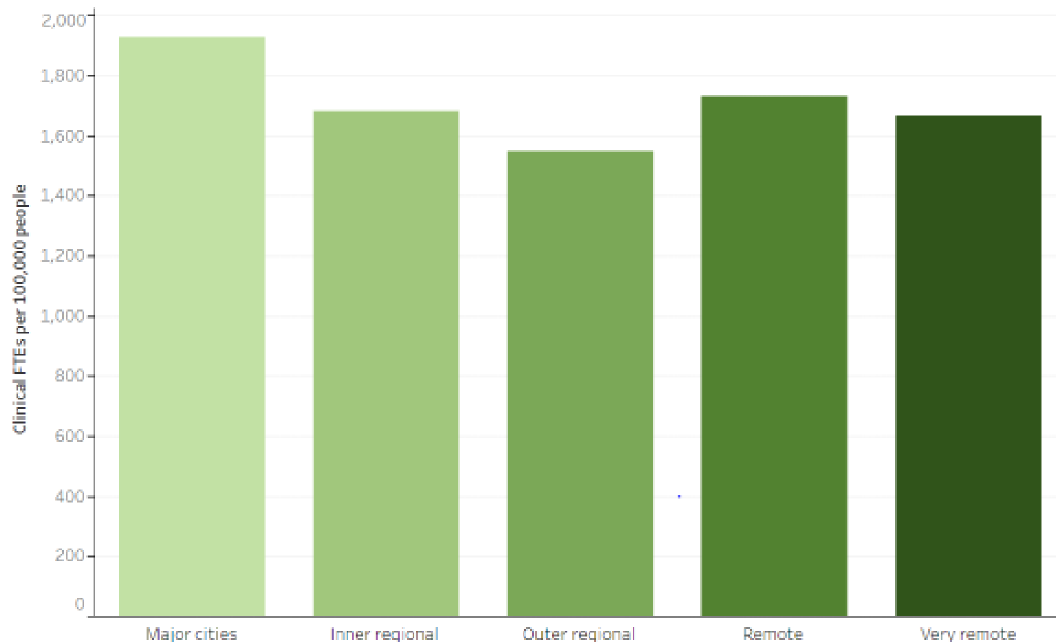

Figure 10 -Source: Australian Commission on Safety and Quality in Healthcare[419]

D. Electronic Health Records: Attempts to digitalize the healthcare system started in 2000 in Australia. In 2012 the government released the national Personally Controlled Electronic Health Record system. My Health Record in EDs project is now the responsibility of The Australian Digital Health Agency, and the Australian Commission on Safety and Quality in Health Care (ACSQHC). A national e-health program that is interoperable, based on unique identifiers controlled by patients, is now available. The network is currently registered with more than 6 million patients (one-quarter of all Australians) and 13.4 million healthcare providers[420].

4.3.6. Challenges for Health Care System

Like any other countries health system, Australia's health system is also facing several challenges. One of the challenges is the ageing population[421]. Like most developed

[419] Australian Commission on Safety and Quality in Health Care (n 404).
[420] Paul Miles and others, "Towards Routine Use of National Electronic Health Records in Australian Emergency Departments" (2019) 210 The Medical Journal of Australia S7 <https://www.mja.com.au/journal/2019/210/6/towards-routine-use-national-electronic-health-records-australian-emergency> accessed September 20, 2021.
[421] Parliament of Australia, "Challenges of an Ageing Population" <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BriefingBook43p/ageingpopulation> accessed September 20, 2021.

countries of the world, Australia also has a growing rate of the geriatric population as a result of sustained low fertility and increasing life expectancy. As per the 2017 report, there were 3.8 million Australians aged 65 and over comprise 15% of the total population. By 2057, it is projected there will be 8.8 million older people in Australia which will cover 22% of the population[422]. The Australian Government has already made the Budget allocation of $33 million from 2017-18 to 2019-20 to help aged care and disability care service providers located in rural, regional and outer suburban areas. An increase in Consumer expectation is another problem faced by the Australian Health sector. In addition to the above-mentioned expensive technologies, and a growing burden of chronic conditions can be said to be the other problems faced by the health care system of Australia are among the factors driving increased demand for services and rising health expenditure.

4.4 Right to Health and Public Healthcare in France

Because there was no real government in place after World War II, the National Council of the Resistance, which was initially formed to oppose the German occupying forces, established the social security system, which included pensions and public health insurance. It formed a social pact to reconstruct the country by uniting individuals from across the French political spectrum. France's health system was known as "Bismarckian" just as German Chancellor Otto von Bismarck founded the same in 1880. Initially, the French system was based on ideas of solidarity and redistribution – from all to all according to their needs – and access was provided following the employment of an individual.

The concept drawn out by the British economist William Beveridge was eventually implemented by France. While the jobless have for a long time been excluded from the system, the 'Couverture illadie Universell'e health insurance coverage was extended to the poorest citizens in 1999, maintaining the right to universal health care as enshrined in

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[422] Australian Bureau of Statistics (ABS) 2014. Australian historical population statistics, 2014. ABS cat. no. 3105.0.65.001. Canberra: ABS.< http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3105.0.65.0012014?OpenDocument>(Accessed on 08/09/2018).

the French Constitution. In the same year, a special programme was created to cover illegal inhabitants, the so-called "Aide medicale d'Etat." The present approach, therefore, combines solidarity with universality in an innovative manner[423].

The French model is composed of institutions of public health which account for 61% of beds and other rooms in the hospital, and of relatively restricted private services. The commercial sector prefers to cover out-of-hospital treatment (consultations without overnight stays) or less invasive surgery for hospital care, and patients with relatively simple illnesses. The quality of French healthcare is equal to that of other western nations with similar living standards. France was well at five-year cancer survival rates, notably breast cancer, according to research in 67 nations. France has also had strong results for crucial events such as the heart, according to the OECD[424].

The French government establishes the national health policy and distributes the funds for planning and service delivery for regional health agencies. Registration is compulsory in the French medical insurance system. The system includes most expenses for hospital, medical, long-term health, as well as recruitment medications; co-insurance, copayments and counts for medical expenditures above-covered prices are the responsibility of individuals. The scheme of insurance is supported largely by salary taxes, a national income tax and taxes on particular sectors and goods (paid by employers and employees). 95% of residents are covered by additional insurance[425].

4.4.1. Healthcare Governance in France

France spends more than 11% of its GDP on public healthcare. It was 11.2% in 2018. This is one of the factors which helped France achieve Universal Health Coverage. France covered all staff under health insurance (SHI) in 1945, it was extended to all retirees too in 1945, gradually the self-employed were covered under the same in 1966

[423] Hernández-Quevedo Chambaud L, "France - Organization and Financing of Public Health Services in Europe," *European Observatory on Health Systems and Policies; 2018* (2018) <https://www.ncbi.nlm.nih.gov/books/NBK507320/> accessed September 21, 2021.
[424] Victor G Rodwin, "The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States" (2003) 93 American Journal of Public Health.
[425] Simone Sandier and others, "Health Care Systems in Transition" (2004).

and finally the unemployed category was covered under the scheme in 2000. Couverture Maladie Universelle (Universal Health Coverage), or CMU was established for residents who were not qualified for SHI in 2000. Less than 1% of people were left without baseline coverage following the introduction of CMU[426].

Later on, the universal eligibility of SHI under the Universal Health Protection Law (PUMA) was provided to fill the few other coverage gaps as of January of 2016. The legislation has been revised and simplified by giving all French inhabitants systemic coverage. It has combined cover to cover those formerly covered by the Universal Health Cover and immigrant health insurance funded by the state.[427]

Healthcare is a national duty in France. Developing the national health strategy is the task of the Ministry for Social Affairs, Health and Women's rights. It establishes and implements government public health policy as well as health care structure and funding[428].

The state has been progressively participating in regulating health spending financed by SHI during the past two decades. It governs around 75% of health expenditure based on Parliament's overarching framework[429].

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[426] David Barroy, Helene; Or, Zeynep; Kumar, Ankit; Bernstein, "Sustaining Universal Health Coverage in France : A Perpetual Challenge" (2014).

[427] Assurance Maladie, http://www.ameli.fr/assures/droits-et-demarches/la-protection-universelle-maladie.php accessed May 2021.

[428] Rodwin (n 425).

[429] Olivier Nay and others, "Achieving Universal Health Coverage in France: Policy Reforms and the Challenge of Inequalities" (2016) 387 Lancet (London, England) 2236 <https://pubmed.ncbi.nlm.nih.gov/27145707/> accessed September 20, 2021.

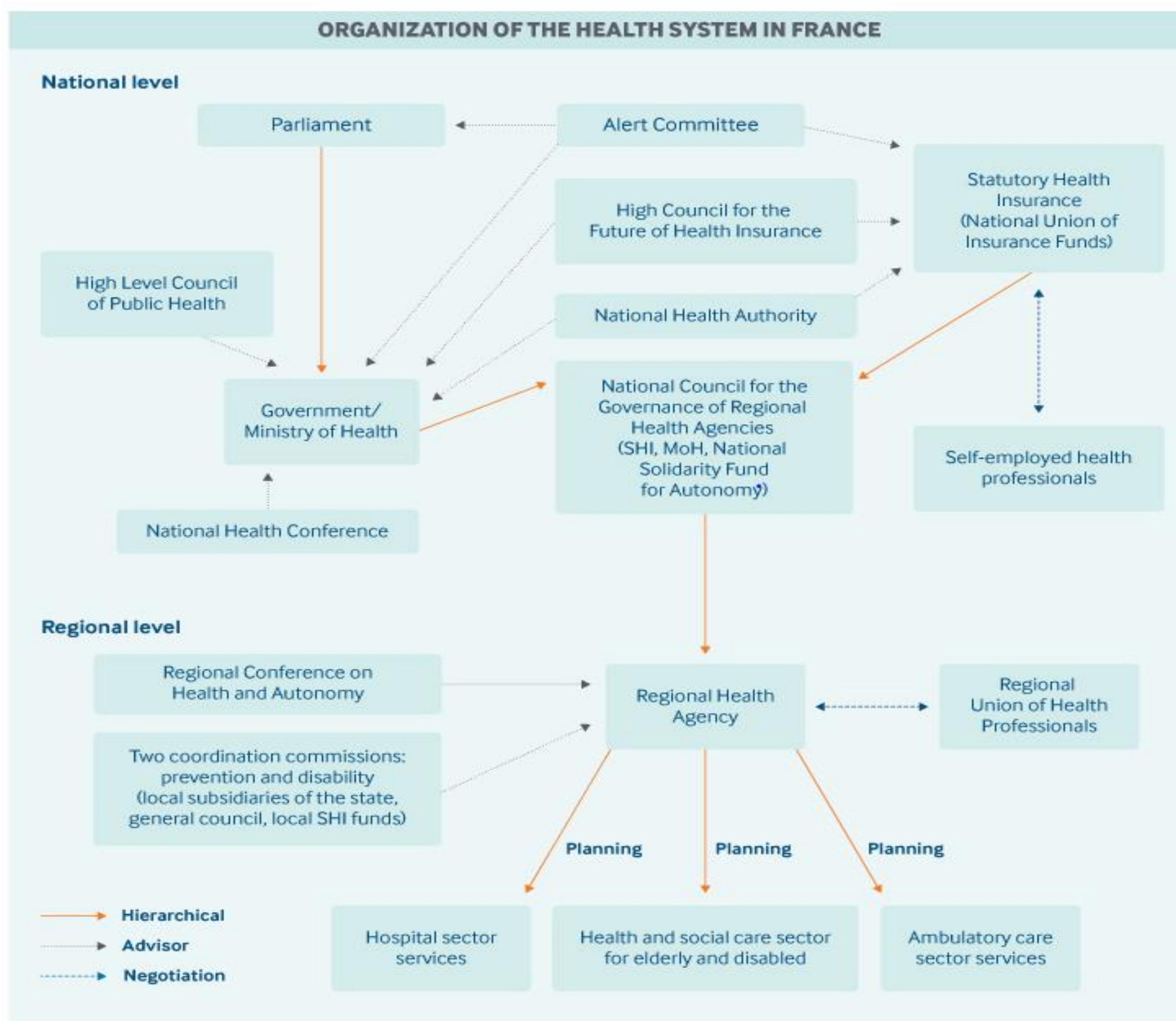

Figure 11-Source: The Commonwealth Fund[430]

[430] Commonwealth Fund, "France" <https://www.commonwealthfund.org/international-health-policy-center/countries/france> accessed September 20, 2021.

Agencies and Responsibilities

Agencies	Responsibilities
"The Ministry of Social Affairs, Health and Women's Rights	It is represented by the Regional Health Agencies throughout the regions, which coordinate population and health care including preventive, health care, and social care.
The French Health Products Safety Agency	Supervises the safety of health products, from manufacturing to marketing
The Agency for Information on Hospital Care	Manages the information systematically collected from patients and uses for hospital planning and financing
The National Agency for the Quality Assessment of Health and Social Care Organizations	Promotes patient rights and develops preventive measures to avoid mistreatment. The agency issues guidelines for the sector and also monitors and evaluates organisations and services.
The National Health Authority	It is the health technology assessment body. It evaluates drugs, medical devices and procedures. It accredits healthcare organisations, publishes guidelines and monitors the certification of doctors.
The French Agency for numerical health	It attempts to extend existing health information systems' adoption and interoperability".

(Table:15)

4.4.2. Role of Insurance in Healthcare of France

A. Public Insurance: In 2017, total health spending was 11.5% of GDP, which amounted to EUR 266 billion (USD 337 billion), of which 77% were supported by the government.[431]

SHI financing: Employers pay 80% of the tax and employees pay the rest; contributions are calculated from actual salaries and are capped at EUR 3,311 (USD 4,191) per month; A national designated income tax accounts for 34% of total financing; Tobacco and alcohol taxes, pharmaceutical sector taxes, and voluntary health insurance (VHI) firms supply 12% of the financing, while state subsidies provide 1%[432].

The coverage is mandatory; non-competitive statutory health insurance funds are supplied to every citizen; formerly, there were 42 funds. Parliament determines annual contributions. The system for SHIs where employees are registered is dependent on the job type. The SHI programme of their company and then universal health care law covers unemployed individuals for one year following the employment termination. Citizens can only opt-out of SHI on a rare basis, for example when foreign firms are employed.

The Government funds health care for illegal immigrants who have requested a residency. The EU insurance card covers visitors from elsewhere in the European Union (EU). Visitors from outside EU countries are only insured for emergency care.[433]

B. Private Health Insurance: Most voluntary health insurance (VHI) is supplementary and largely covers co-payments and balance billing, as are vision and dental treatment that is not covered by SHI. Complimentary insurance generally comes from non-profit organisations or institutions based on work. Private, but not

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[431] OECD Data, Health Spending (2017), https://data.oecd.org/healthres/health-spending.htm; accessed May 2021.
[432] Securité Sociale (2017), http://www.securite-sociale.fr/IMG/pdf/ccss-juillet2017.pdf; accessed May 2021.
[433] Victor Rodwin, "French Healthcare System" (2018) 54 49.

limited to firms offer both supplementary and supplemental medical insurance. Voluntary health insurance funds 13.5% of overall health spending.[434] The VHI covers 95% of the population through employers or means-tested vouchers. As of 2016, all employees are paid at least 50% of the cost of employer-funded VHI.

The coverage is very different, but the difference between the refund rate for the SHI and the national fee schedule is covered by every contract for VHI. Balance account coverage is also frequently given. Standards were set by legislation in 2013 for VHI funded by the employer to eliminate inequalities due to differences in access and quality.

C. **Services Covered:** Covered benefits under SHI are defined at the national level by the Ministry of Social Affairs, Health, and Women's Rights, as well as the SHI funds, which are organised in the National Union of Health Insurance Funds. It covers hospitalisation, treatment in public or private rehabilitation or physiotherapy facilities, outpatient care provided by general practitioners, specialists, dentists, physical therapists, and midwives, all maternity care services from the 12th week of pregnancy to six months after delivery, newborn care, and children's preventive health care up to the age of four; prescription drugs; and maternity care services provided by general practitioners, specialists, dentists, physical therapists, and midwives[435].

SHI also covers a portion of hospice, long-term mental health, and provides minimal coverage for vision, hearing aids, and dental care. Preventive care is generally underfunded; nevertheless, priority treatments, immunisation, mammography, and colorectal cancer screening are all completely covered. In 2015, SHI approved the treatment of severely vulnerable addicts at injection sites under the supervision of healthcare professionals, which will be fully supported by SHI until 2021[436].

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[434] OECD, "Health at a Glance: Europe 2020" (November 19, 2020) <https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2020_82129230-en> accessed September 20, 2021.

[435] Commonwealth Fund, "France" (n 431).

[436] Olivier Nay and others (n 430).

D. Out-Of-Pocket Spending (OOP) in Healthcare: There are no out-of-pocket expenses. The three forms of cost-sharing for the general and speciality treatment are coinsurance, co-payments and accounting. Some medical professionals are allowed to charge at rates greater than the national fee schedule. OOP accounted for 8% of medical spending in France in 2015[437].

Dental and eye services are the most out-of-pocket expenditure. These services are subject to extremely low official charges, not more than EUR a few for glasses or audio support, and the maximum charge for dentures is EUR 200. (USD 253). However, providers generally pay more than 10 times the stated cost for these services. However, due to the greater voluntary health coverage, the proportion of out-of-pocket expenditures on dental and optical care has fallen.

Meanwhile, because more prescription medicines are being removed from the national formulary, out-of-pocket drug spending has been gradually increasing. Over-the-counter medicines have also increased in popularity.

Hospital coinsurance is only available for the first 31 days at the hospital, and some operations are excluded from the same. Low-income people can receive free or reduced health insurance, complimentary eye and dental treatment. Individuals who make EUR 8,723 (US$ 11,040) or less per year are considered low incomes. In the case of households, with each member the qualification level increases. The overall number of low-income users is estimated at around 9%. The average of 6% is VHI vouchers tested and the state-sponsored coverage is free of charge[438].

4.4.3 Strategies to Ensure Quality and Accessible Healthcare System in France

A. Medical Education and Healthcare Workforce: The Ministry of Social Affairs, Health, and Women's Rights establish the maximum number of students who can be

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[437] Gregoire Mercier Id and others, "Out-of-Pocket Payments, Vertical Equity and Unmet Medical Needs in France: A National Multicenter Prospective Study on Lymphedema" <https://doi.org/10.1371/journal.pone.0216386>.

[438] Sandier and others (n 426).

admitted to the public medical, dentistry, midwifery, and pharmacy schools once a year. The annual tuition costs around EUR 500 (USD 633). At the moment of entry into medical education, the number of medical professionals is regulated. Moreover, 12% of the present medical staff are foreign medical experts. To date, the number of practitioners by area is not limited. Since 2013, however, ambulatory physicians can reach contractual agreements guaranteeing a monthly income of €6,900 (US$8,734) provided they practice in an insufficient supply of physicians in an area and agree to restrict further billing. Approximately € 50,00 (USD 63,290) a year is a fixed wage for doctors who work full time at medical centers in under-served areas[439].

B. Primary care: There are around 102,299 general practitioners and 121,272 experts in France (a ratio of 3.4 per 1,000 population). Approximately 59% of doctors are self-employed, either full-time or part-time (67% of GPs, 51% of specialists).[440]

Over 50% of GPs are in group practices, mainly younger professionals. Two to three physicians are the usual practice. 75% of the practice includes doctors only, while the rest comprise nurses and a variety of allied health workers. The average size of the panel of patients for the GPs is around 900. There is a voluntary gatekeeping system that provides cash incentives for those 16 years old and older who wish to register with a GP or specialist. Approximately 95% of the people have selected GP as their gatekeepers but also as gatekeeper's experts can act.

Self-employed GPs shall be compensated mostly by the SSI funds and the Ministry for Social Affairs and Women's Rights, on a fee-for-service basis. The GP cost per consultation for 2018 amounted to EUR 25 (US$ 32). GPs can now get a EUR 40 (USD 51) capitalized yearly annual reimbursement for chronically affected patients. Moreover, GPs earn an average annual pay-for-performance objective of EUR 5,000 (USD 6,330). In 2014, primary care physicians' averages were EUR 86,000 (USD 108,860), 94% from consultation fees and the rest from financial incentives and

[439] Commonwealth Fund, "France" (n 431).

[440] Securité Sociale 2017< http ://www.securite-sociale.fr/IMG/pdf/ccss-juillet2017.pdf> accessed on May 2021.

salaries.[441]GPs may charge more than the national fees schedule, and 25%. On average, experts make 1.3 times more what the GPs do[442].

Experimental networks of GPs, who provide chronic care, psychiatric, dietetic and other treatments not covered by SHI, are being developed. These networks are supported by the Regional Health Agencies with allocated funding. More than 1.000 medical homes also provide multi-professional services and after-hours treatment (normally 3 to 5 physicians and about a dozen health workers)[443].

C. **Outpatient Specialist Care:** Approximately 36% of outpatient specialists are solely independent, either in offices or in private clinics; the remainder of the experts are either fully employed or have a mixture of sources of income. Public hospital experts may visit patients with an outpatient or an inpatient payroll, but have to pay the hospital a proportion of their earned fees. A 2013 study projected that 10% of the 46,000 hospital operators, radiologists, cardiologists and obstetrician specialists served private patients[444].

In specialties that need significant expenditures in technology and equipment to treat patients, such as nuclear medicine, radiation, pathology, and intestinal surgery, half of the specialists work in group practices, and this number is rising. SHI charges a specialized fee that ranges from EUR 25 (USD 32) to EUR 69 (USD 69). (USD 88).

Self-employed experts earn an average of EUR 140,610 per year (USD 177,800). Pay-for-performance schemes are available to all self-employed experts. In addition to the quality standards that apply to general practitioners, specialists must achieve disease-specific quality targets. Pay-for-performance generates average yearly revenue of

[441] DREES, Portrait des professionnels de santé, Série Etudes et Recherche, no. 134 (Ministère des Affaires sociales et de la Santé, Feb. 2016), http://drees.social-sante.gouv.fr/IMG/pdf/ouvrage; accessed May 2021.
[442] HITM Editorial Team, “The Healthcare System in France” (2010) 5 Health Management <https://healthmanagement.org/c/it/issuearticle/the-healthcare-system-in-france> accessed September 20, 2021.
[443] HITM Editorial Team (n 443).
[444] CLEISS, “The French Health Care System” <https://www.cleiss.fr/particuliers/venir/soins/ue/systeme-de-sante-en-france_en.html> accessed September 20, 2021.

EUR 5,480 (USD 6,937) per physician, accounting for less than 2% of overall financing for outpatient services[445].

D. After-hours care: After-hours care is coordinated by Regional Health Agencies and provided by contracted hospital emergency departments, self-employed physicians who work for emergency services, and medical homes funded by SHI and staffed by doctors and nurses on a volunteer basis. Providing after-hours treatment is not required of primary care physicians[446].

E. Long-term care and social supports: The General Councils, which are governing bodies at a local (departmental) level, have control for health and social care for aged and specially-abled persons. The overall fragile elderly population is estimated at around 1.25 million or 2% of the total population.[447] It was estimated that the total expenditures for long-term care would be EUR 30 billion (USD 37.9 billion) in 2015, which is 1.7% of GDP[448].

In retirement homes and long-term care facilities, around 10,000 institutions have a total of 728,000 beds. In all, there is long term institutional care. Of them, 54% are public, 28% are private non-profit and 18% profit-making organizations, but the proportion of the profit-making institutions is rising[449].

SHI pays the medical costs of medical treatment in institutions while the costs of housing are borne by families. The average cost for these bags is EUR 1 500 (USD 1 900), part of which may be reimbursed by VHI, each month. Final care is completely covered in hospitals. Home care and services for elderly and people with disabilities are funded under the SHI National Solidarity Fund for Autonomy and income from

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445 Commonwealth Fund, "France" (n 431).
446 Karine Chevreul and others, *Health Systems in Transition: France*, vol 17 (2015).
447 Cour des Comptes, Le maintien à domicile des personnes âgées en perte d'autonomie (Dec. 2016), https://www.ccomptes.fr/fr/publications/le-maintien-domicile-des-personnes-agees-en-perte-dautonomie.
448 Marie-Eve Joël and others, "European Network of Economic Policy Research Institutes Assessing Needs of Care in European Nations Long Term Care in France" (2010) <www.ceps.eu> accessed September 22, 2021.
449 OECD, "France Long-Term Care" (2011) <www.oecd.org/health/longtermcareandwww.oecd.org/health/longtermcare/helpwanted> accessed September 22, 2021.

unpaid work day solidarity. This fund is supported by SHI. One day a year, employers contribute daily salaries to the SHI. These kinds of care are also financed by local authorities, general councils and families.[450]

Meanwhile, the vulnerable elderly will be given a tested monetary benefit for non-medical in-kind assistance. The allowances are according to dependence level, living conditions and requirements of the person and may be used for any selected service and service provider. It is estimated that approximately 1.1% of the total population is eligible. Informal careers also benefit but do not receive a monetary allowance from tax deductions[451].

F. **Hospitals:** Around 65% of hospital capacity and operations are represented by public institutions. The remaining 25% are private, for-profit facilities and private, non-profit facilities. All Hospitals are compensated by the diagnostic group (DRG) system established by the Minister of Social Affairs, Health and Women's Rights, for all hospital and ambulatory hospitals, including all public and non-profit hospitals in the health services and healthcare workers. There is no bundled reward or incentive for performance.

Hospitals get compensated in addition to the DRG rate for some costly and novel medicines and appliances. The Ministry of Social Affairs, Health and Women's Rights updates annually its list of medications and devices covered, depending on semi-transparent inventive criteria, pricing and the proportion of DRG people who need the innovator[452].

Public hospitals are supported mostly through SHIs (80%), while the rest of their income is covered by optional insurance and direct patient payments. Public and

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[450] OECD Health data 2017, https://www.oecd-ilibrary.org/docserver/health_glance-2017-81-fr.pdf.
[451] DREES, Études et résultats, “728 000 résidents en établissements d’hébergement pour personnes âgées en 2015,” (Ministère des Affaires sociales et de la Santé, 2017), http://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/publications/etudes-et-resultats/article/728-000-residents-en-etablissements-d-hebergement-pour-personnes-agees-en-2015; accessed May 2021.
[452] Zeynep Or, “Implementation of DRG Payment in France: Issues and Recent Developments” (2014) 117 Health Policy 146 <https://reader.elsevier.com/reader/sd/pii/S0168851014001353?token=35B24E660984873A61DE7E56CB08C90EF13F93D9003C6443BA9AFCB2FE1248CEE5B78BD2D6EA029D1382A72CF57CFD50&originRegion=eu-west-1&originCreation=20210922051334> accessed September 22, 2021.

private non-profit hospitals also receive funding to provide research and educational support (up to 13% of hospital's budgets), delivering emergency services, collecting organisms and transplants (10%-11% of the budget on average).

Private, lucrative clinics owned by individuals or increasingly by major companies are funded in the same way as public hospitals but their proportion of payers varies. At addition to DRG in private clinics, medical fees are charged, and there are less DRG payments than in public or non-profit institutions[453]. The below figure depicts the number of hospitals in France between 2000-2018.

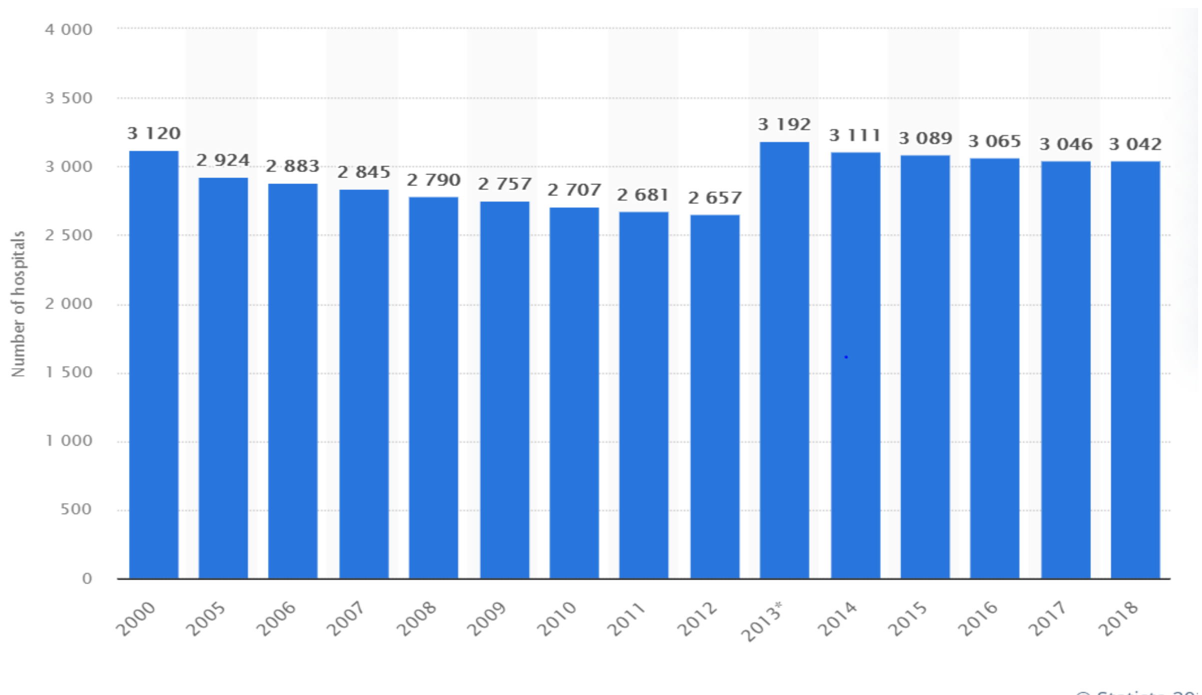

Figure 12-Source: Statista[454]

As per the data of Statista in 2018 France had 3042 Public Healthcare Hospitals.

[453] Chevreul and others (n 447).

[454] Statista, "Hospitals in France 2000-2018" <https://www.statista.com/statistics/557012/hospitals-in-france/> accessed September 20, 2021.

4.4.4 The Major Strategies to Ensure Quality Healthcare Care Accessible to Public

A. Quality of Care: achieve "quality in healthcare and pay-for-performance targets related to the use of computerized medical charts, adoption of electronic claims transmission, delivery of preventive services such as immunizations, compliance with guidelines for diabetic and hypertensive patients, generic prescribing, and limited use of psychoactive drugs for elderly patients, an average of EUR 5,000 (USD 6,330) per physician is provided annually."

Surveys of population groups such as infants, students, elderly etc are carried out on various indicators of health like diseases, nutrition etc and the records are maintained. The CONSTANCES Cohort is a sample of the 200,000 people who are examined annually with connections to the national claims database. There are published reports on national surveys that demonstrate regional differences in health and access to healthcare[455].

National plans exist for the treatment of chronic illnesses such as cancer and uncommon disorders, as well as prevention and healthy ageing. These strategies lay the groundwork for governance, tool development, and collaboration among the involved organizations. The national cancer strategy, as well as medical practice guidelines and minimum volume limits for complicated operations. In addition to enforcing compliance with standards and encouraging evidence-based practice, all of the plans stress the significance of assisting caregivers and guaranteeing patients quality of life[456].

Too far, 32 chronic illnesses have been listed by the National Health Authority in basic benefits based on evidence. All services required for individuals with certain chronic illnesses are described in these benefit packages. The suggested routes of care are

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[455] A Malone and others, "Population Health Management in France: Specifying Population Groups through the DRG System" [2021] BMC Health Services Research <https://doi.org/10.1186/s12913-021-06757-x>.

[456] CLEISS, "Quality and Safety of Healthcare in France" <https://www.cleiss.fr/particuliers/venir/soins/ue/qualite-securite_en.html> accessed September 21, 2021.

covered by chronic blockage, cardiac insufficiency, Parkinson's disease and end stage renal illness. The collaborating professional networks provide similar clinical guidelines and protocols, agree on best practices and have access to a shared record for patients. Furthermore, pilot telemedicine initiatives attempt to enhance the coordination of treatment and access for certain illnesses or groups, such as infants and older people.

Certification and revalidation for self-employed physicians is handled by independent authorities such as medical societies that have been recognized by the National Health Authority. Certification and revalidation of hospital physicians can be done as part of the accreditation procedure for the hospital. Continuous medical education activities, which are audited every fourth or fifth year, are required of doctors, midwives, nurses, and other professions. A handful of high-risk medical specialties, such as obstetrics, surgery, and cardiology, have optional accreditation. Physicians who are accredited can receive a discount on their professional insurance rates.

All four years, hospitals must be accredited. The national performance indicator programme CompaqH also publishes outcomes on chosen indicators. The Ministry of Social Affairs, Health and Women's Rights monitors quality assurance and risk management in hospitals, which publishes the rates for infections in hospitals and other online information. Individual doctors are not provided with information. The public reporting system does not yet include financial rewards or penalties; however, the subject remains disputed[457]. Care centers are also accredited to prevent elder abuse by the National Health Authority. The national health authority shall have public reporting available online for home care delivered by hospital subsidiaries[458].

[457] Commonwealth Fund, “France” (n 431).
[458] CLEISS (n 457).

B. Efforts to Reduce Disparities: It is national priority to reduce the gaps in health-related socioeconomic factors in access to care. There is a 6.3-year disparity in life expectancy for men of greatest levels of social security, and for the lowest, and for those with state-funded insurance and VHI with lower self-reported health.

The Public Health Act 2004 sets objectives for eliminating geographical and financial imbalances in access to prevention of obesity, cancer screening and vaccination services and inequalities in prevention treatment. To these objectives, differences are handled by physician contracts. Financial incentives, for example, promote medical practitioners in disadvantaged regions. In addition, SHI medical contracts restrict doctors from refusing treatment to state-sponsored insurance benefit recipients and putting a ceiling on balanced billing[459].

National statistics on nutrition, activity and use of tobacco are released and evaluated by socioeconomic class and kind of work. Differences in access to health care are measured by participation in systems and health outcomes screening programes. The Minister of Health announced a nationwide strategy to minimize incidences of health inequalities in March 2018, including a five-year investment of EUR 400 million (USD 506 million) and 25 initiatives including all age groups[460].

C. The Status of Electronic Health Records: At the end of 2018, the electronic health record (EHR) initiative has covered about 1,882,503 people and 731 institutions (one-third of all hospitals). Each stakeholder directly dealing with the hospitals and offices ie., the healthcare consumers and providers both have a unique electronic identity. The healthcare providers can access the record and enter information with the permission of the patient. Patients' health cards have a chip that ensures interoperability.[461]

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[459] Government of France, "The Guidelines of the Health Act" <https://www.gouvernement.fr/en/the-guidelines-of-the-health-act> accessed September 21, 2021.

[460] Olivier Nay and others (n 430).

[461] Ministère de la Santé, "Instruction N° SG/DSSIS/DGOS/DGCS/CNAM/2018/72 du 13 mars 2018 relative à l'accompagnement en région de la généralisation du dossier médical partagé (DMP)" (2018), http://circulaire.legifrance.gouv.fr/pdf/2018/04/cir_43291.pdf; accessed May 2021.

There are various delays in the attempt to completely integrate EHRs and there is little integration between healthcare practitioners and clinics of information systems[462]. Patients have complete access, either directly or through GP, to the information in their own documents, paper or electronic. In 2019 EHRs are scheduled to be used in nursing homes for exchanging information between health and social care personnel[463].

4.4.5. Recent Developments in Healthcare Sector of France

A contentious element of the 2015 Touraine legislation recommends that medical consultations should be completely free at the point of care: social security payments to practitioners and the SHI would be made immediately for all appointments. However, the extension of third-party payments to the whole patient group has been postponed indefinitely due to the significant opposition from medical workers. The increasing dissatisfaction with the excessive accounting disclosed in the press coupled with allegations of unfair competition from private clinics led to many public probes. Recommendations for more public oversight over these activities were made in the last survey.

Experiments with novel payment systems are still in their infancy. The development of accountable care groups sparked these trials. Bundled payments for orthopedic and colorectal operations will be explored at the national level in 2019–2020. Regional efforts, in addition to the national programme, are encouraged with the goals of integrating services and increasing quality, relevance, efficiency, and prevention. These five factors will be taken into account when deciding whether or not to authorize regional trials, which will operate for five years and receive financing for services not currently covered by SHI.

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[462] Zeynep Or et al., Évaluation d'impact de l'expérimentation Parcours santé des aînés (Paerpa) (Institut de recherche et documentation en économie de la santé (IRDES), 2018), https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/235-evaluation-d-impact-de-l-experimentation-parcours-sante-des-aines-paerpa.pdf; accessed May 2021.

[463] Assurance Maladie, Dossier medical partagé: Le service est désormais disponible pour tous (Nov. 6, 2018) https://www.ameli.fr/fileadmin/user_upload/documents/DP_DMP.pdf; accessed May 2021.

4.5 Right to Health and Public Healthcare in China

In 2001 China ratified the International Covenant on Economic, Social and Cultural Rights and as per the obligations under Article 12 of the covenant the country is under an obligation to implement suitable measures at the national level to realize the "right to health" in China. Through publicly-funded basic medical insurance, China obtains almost universal coverage. The urban workers are obliged to register for a programme based on employment, which is largely financed by payroll and employee taxes. Other residents can freely enrol in the Basic Medical Insurance Urban-Rural Resident, funded largely by central and local governments through individual primary subsidies. Public and private health organisations are organised by local health commissions to provide services. Primary, speciality, hospital, mental health and prescription and traditional Chinese medications are covered in the core medicine programmes. The ceilings for deductibles, co-payments and refunds apply. Annual expenditure ceilings are not available. Additional private health insurance provides for the protection of cost-share and coverage gaps.

4.5.1. Universal Health Coverage

China essentially achieved universal insurance in 2011 with three government insurance schemes, notably Urban Employee Basic Medical Insurance; compulsory for formally employed urban residents introduced in 1998; Rural people have received optional Newly Cooperative Medical Scheme in 2003, while voluntary Urban Resident Basic Medical Insurance was established in 2007 to cover urban residents who have no formal employment, including children, senior citizens and self-employed workers[464].

In 2016 Chinese central government, the State Council proposed a merger to extend its risk pool and cut administrative expenses, including a Newly Cooperative Medical Scheme, and Urban Resident Basic Medical Insurance[465]. This is currently undergoing consolidation. The joint public insurance scheme is currently named Basic Medical

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[464] HaoYu and Hao Yu, "Universal Health Insurance Coverage for 1.3 Billion People: What Accounts for China's Success?" (2015) 119 Health Policy 1145 <http://dx.doi.org/10.1016/j.healthpol.2015.07.008> accessed September 22, 2021.

[465] State Council, "Opinions of the State Council on Integrating the Basic Medical Insurance System for Urban and Rural Residents_Government Information Disclosure Column" (2016) <http://www.gov.cn/zhengce/content/2016-01/12/content_10582.htm> accessed September 22, 2021.

Insurance for urban and rural residents. Because the population in China is enormous, insurance coverage progressively expanded. Around 95% of Chinese people were insured by one of the three medical insurances in 2011. In China, insurance protection is not necessary.

4.5.2. Healthcare Governance in China

In China the National People's Congress, the Central authority has the principal authority for formulating national legislation, policies and administration on health. The basis of healthcare policies aims at 'right to basic services of healthcare for every individual'. These services are organised and provided by local governments such as provinces, prefectures, municipalities, counties, and towns. Health quality, safety, cost management, provisioning timings, health information technology, clinical guidelines and health equity are the responsibility of both national and local health institutions and authorities. The below figure depicts the organisational structure of China's public Healthcare System.

Figure 13-Source: The Common Wealth Fund[466]

[466] George A Wharton Roosa Tikkanen Robin Osborn Elias Mossialos Ana Djordjevic and Commonwealth Fund, "China" (*Commonwealth Fund*, 2020) <https://www.commonwealthfund.org/international-health-policy-center/countries/china> accessed September 17, 2021.

The State Council restructured the federal government's healthcare organisation in March 2018[467]. The following are some of the tasks of several agencies:

Government Agency	Responsibility
“The National Health Commission	The Commission formulates national health policies, organises and promotes reforms in the fields of health and medical services, and oversees and administers public health, medical services, emergency health and family plans. Traditional Chinese Medicine State Administration is associated with the agency.
The State Medical Insurance Administration	It supervises basic medical insurance programmes, catastrophic medical insurance, maternity insurance, pharmaceutical and health-care pricing, and a medical financial aid programme.
The National People’s Congress	It is in charge of enacting Health legislation. The State Council and the Communist Party's Central Committee, on the other hand, can launch major health programmes and changes, which are also considered legislation.
The National Development and Reform Commission	Plans for health infrastructure and competition among healthcare providers are managed by The National Development and Reform Commission.
The Ministry of Finance	provides financing for government health subsidies, contributions to health insurance, and health system infrastructure.

467“National Health Commission (NHC) (国家卫生健康委员会)” <https://uk.practicallaw.thomsonreuters.com/w-015-2140?originationContext=knowHow&transitionType=KnowHowItem&contextData=(sc.Default)&comp=pluk> accessed September 22, 2021.

State Market Regulatory Administration including China Drug Administration	Takes care of drug approvals and licenses
The China Centre for Disease Control and Prevention	Though not a government agency it has been administered by National Health Commission and is responsible for Disease Control and Prevention
The Chinese Academy of Medical Science	It is the Health Research Centre working under the National Health commission."

(Table 16)

Local governments (prefectures, counties, and municipalities) may have commissions, bureaus, or health departments of their own. Local commissions, bureaus, or health departments also run centres for disease control and prevention in their communities. The China Centre for Disease Control and Prevention only offers technical assistance to local centres at the national level.

4.5.3. Role Played by Judiciary in Recognizing the Right to Healthcare

China signed the ICESCR and other international treaties guaranteeing protection of people's right to health[468]. However, in Chinese courts, international rules on human rights cannot be cited directly but must be integrated into domestic law first[469]. In reality, therefore, the Chinese court has never used the international human right to health. The Constitution of the Peoples' Republic of China obliges the Government to provide the government with a comprehensive healthcare system to ensure access to healthcare for everyone at the national level[470]. There is no Constitutional court in

[468] Convention on the Elimination of All Forms of Discrimination against Women.
[469] Christina S Ho and Aeyal Gross, "Health Rights at the Juncture between State and Market : The People ' s Republic of China" [2014] Rutgers School of Law.
[470] Constitution of the People's Republic of China 1982.

China, however, and no right holders in any Chinese court have asserted Constitutional health rights.

However, this does not preclude the right to health from being litigated in Chinese domestic courts. In reality, the right to health can be broken down into individual rights such as health care, clean water, safe food, clean air, a healthy environment, and so on. As a result, in many cases across the world, the right to health is realized in practice through court victories over other legal rights. As a result, additional health-related rights may be used to justify the right to health in China.

Other legislation and regulations covering the health protection of various populations exist under China's legal system. Articles 53 and 54 of the Labour Law, for example, set health protection criteria for workplaces[471]. The Women's Rights Protection Law covers a wide range of health-related issues for women, including childbearing-related health benefits, workplace health and safety, and the prohibition of domestic abuse[472]. Quality air and water, which are fundamental determinants of health, are prioritized under the Environmental Protection Law[473]. Meanwhile, there are health-related laws in place at the provincial level. Although the initial intent of this legislation was not to safeguard health as a human right, via litigation, several components of the right to health have been indirectly protected in courts.

In recent years, the number of health-related legal issues has risen in China. The All-China Environment Federation filed the country's first public interest case on air pollution in July 2016. As per the facts of the case the defendant companies air emissions were not in accordance with the national safety requirements. It was proved before the court and the Dezhou Intermediate Court ordered the defendant to pay the government 21 million RMB (about $3 million) as compensation[474]. There are success stories where the court ordered in favor of parties who challenged the law quality healthcare provided by the healthcare units, malpractices and negligence by the hospitals and denial of benefits by the commercial insurers in relation to health

[471] Labour Law. 1995
[472] Women's Rights Protection Law. 2005
[473] Environmental Protection Law. 2015.
[474] Gillian Macnaughton, "Health and Human Rights Journal Mechanisms of Accountability for the Realization of the Right to Health in China" (2017) 19 Health and human rights journal 279.

insurance[475]. While courts have been effective in holding market participants accountable, they have been less effective in holding governmental actors accountable[476].

Furthermore, as Christina Ho points out, "in China, mitigation is a rather weak tool." People typically choose alternatives like mediation and arbitration because courts are expensive and responsible to governmental entities, among other reasons. In addition, in order to promote a "harmonious society," the government has favoured mediation over litigation, encouraging courts to "meet quotas for successfully resolved cases"[477]. People may be directed away from suing in the courts as a result of this pressure to pursue mediation.

4.5.4 Role of Insurance in Healthcare of China

A. Public Health Insurance: China's national medical security system is a tiered structure, with basic medical insurance (BMI) as the foundation and medical assistance as a backup, as well as commercial health insurance, charity donations, and medical mutual help activities as additional services[478]. In 2018, China spent CNY 5,912 billion on health care, accounting for around 6.6% of GDP (USD 1,665 billion)[479].

Employee and employer payroll taxes, together with a small amount of government money, are used to provide urban employees basic medical insurance. In metropolitan regions, employees are required to participate. Employee-based insurance accounted for 316.8% of the population in 2018[480]. Individual payroll over this amount is not taxed, as the employee payroll tax contribution is restricted at 300% of the average local salary. Individual tax rates in most provinces range between 2% and 3%. Employer tax rates vary depending on where you live.

[475] Ho and Gross (n 470).
[476] Ho and Gross (n 470).
[477] Philip D Chen and Di Wu, "China's Evolution in Progressively Realizing the Right to Health," *Advancing the Human Right to Health* (Oxford University Press 2013).
[478] Baokang Yi, "An Overview of the Chinese Healthcare System" (2021) 10 Hepatobiliary surgery and nutrition 93 <http://dx.doi.org/10.21037/hbsn-2021-3>.
[479] Baokang Yi (n 479).
[480] National Health Commission, China Health Statistical Yearbook 2019.

Employer contributions are calculated using the total payroll of all employees. Family members who aren't employed aren't protected.

Rural and urban inhabitants, self-employed persons, children, students, elderly folks, and others are covered under the Urban-Rural Resident Basic Medical Insurance[481]. At the household level, insurance is a choice. The two insurance plans that make up this programme (the rural plan and the urban non-employed plan) covered 897.4 million people in 2018. Annual fixed premiums are used to fund Urban-Rural Resident Basic Medical Insurance. Individual premium contributions are small, and government insurance premium subsidies provide for the vast bulk of insurer income. The central government gives a considerably higher percentage of subsidies than the provincial and prefectural governments in regions where the economy is less developed. Most subsidies are distributed locally in more developed areas (mainly by provincial governments).

The few permanent foreign immigrants get the same insurance advantages as citizens. Visitors and undocumented immigrants are not covered by government-funded health insurance. The local governments often define publically financed basic medical insurance. Inpatient hospital care; primary and specialist care; prescription drugs; mental health care; physical therapy; emergency care; traditional Chinese medicine are some of the expenses covered by such insurance. A distinct package of health benefits financed from the central and municipal governments includes prevention services, including immunisation and illness screening; every citizen has the right to these treatments, without co-payments nor deductibles. Coverage is personal; family or household benefit plans are not available[482].In addition, maternity care is covered by a distinct programme of insurance; it is presently fused into the basic health plan.

[481] John Strauss and others, "Healthcare and Insurance Among the Elderly in China: Evidence from the CHARLS Pilot" <https://www.ncbi.nlm.nih.gov/books/NBK109212/> accessed September 23, 2021.

[482] Jiahui Wang and others, "Can the Reform of Integrating Health Insurance Reduce Inequity in Catastrophic Health Expenditure? Evidence from China" (2020) 19 International Journal for Equity in Health 2020 19:1 1 <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-020-1145-5> accessed September 23, 2021.

B. Private Health Insurance in China: In China, private insurance can be used to cover deductibles, co-payments, and other cost-sharing, as well as offer coverage for expensive procedures not covered by public insurance. It is primarily purchased by higher-income people and by businesses for their employees. There are no statistics on the number of people who have private health insurance. For-profit commercial insurance firms are the most common providers of private health insurance[483].

Between 2010 and 2015, the overall value of private health insurance premiums increased by 28.9% each year[484]. Premiums for private health insurance amounted for 5.9% of overall health expenditures in 2015[485]. The Chinese government is supporting the growth of the private insurance sector, and some international insurers have lately entered the market.

4.5.5. Current Healthcare Delivery System in China

A. Primary care: Primary care in China is largely provided by village physicians and community health workers in rural clinics; general practitioners (GPs) or family doctors in the rural township and community hospitals; and medical professionals (doctors and nurses) at secondary and tertiary hospitals.

2018 witnessed 506,003 public primary care institutions and 437,636 private village clinics in operation in China. Village physicians who are not licenced general practitioners were allowed only to work in village clinics. 907,098 village physicians and health professionals also were employed in 2018. Township hospitals were set up to provide technical assistance to remote village clinics. As compared to secondary or tertiary hospitals the cost-sharing is lower at village clinics, township hospitals, or community hospitals hence the patients are encouraged to seek from the village hospitals. According to reports in 2018, China had 308,740 licensed and

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[483] Commonwealth Fund, "China" (*Commonwealth Fund*, 2020) <https://www.commonwealthfund.org/international-health-policy-center/countries/china> accessed September 23, 2021.

[484] Z. Song and Q. Hu, "Development Forecast of Commercial Health Insurance in the Period of the Thirteenth Five-Year Plan," China Insurance 5, no. 12 (2016): 12–15.

[485] National Health and Family Planning Commission, Statistical Communiqué of China Health and Family Planning Development in 2015 (2016), <http://www.nhfpc.gov.cn/guihuaxxs/s10748/201607/da7575d64fa04670b5f375c87b6229b0.shtml>; accessed May 10, 2021.

assistant General Practitioners, representing 8.6% of all licensed physicians and assistant physicians.[486]

Local health authorities and the Bureaus of Commodity Prices control primary care fee schedules in government-funded health institutions. In public hospitals and clinics, primary care doctors are not allowed to bill beyond the fee schedule. In 2014, China began permitting non-government clinics and hospitals to charge over the fee schedule in order to stimulate private investment in health care.[487]

Village doctors and health professionals at local clinics make money through refunds for clinical services and services such as vaccines and chronic disease screening. Revenues vary greatly from one location to another. GPs earn basic income at hospitals with business-oriented payments, such as registration fees for patients. Prescription medicines supplied to patients in hospitals accounted for 42% of outpatient expenditures and 28% of inpatient expenses in 2018.[488]

There is evidence in China that there are broad disparities in the quality of primary health care, which leads to poor population health and a significant economic effect. Inadequate training and educational opportunities for practitioners, the fee-for-service model that incentivizes unnecessary testing and treatments, a lack of integration between clinical care and the public health service as well as between different healthcare sectors, and insufficient continuity of care throughout the ent are all flaws in the primary health-care system[489].

B. Outpatient specialist care: China encourages practice by doctors in multiple settings. Through their hospital, patients can choose from a list of specialists. Outpatient specialists are paid on a fee-for-service basis by the hospitals where they

[486] National Health Commission, China Health Statistical Yearbook 2019.
[487] National Development and Reform Commission, National Health and Family Planning Commission, and Ministry of Human Resources and Social Security, "Announcement About Issues Related to Market Adjustment Prices of Health Care Services by Non-Government-Funded Health Institutions" (2014), http://www.gov.cn/xinwen/2014-04/09/content_2655189.htm; accessed May 10, 2021.
[488] National Health Commission, China Health Statistical Yearbook 2019.
[489] Xi Li and others, "Quality of Primary Health Care in China: Challenges and Recommendations" (2020) 395 Lancet (London, England) 1802 </pmc/articles/PMC7272159/> accessed September 23, 2021.

work, and public hospital specialists are not allowed to charge more than the fee schedule allows[490].

C. After-hours care: Since local physicians and health professionals typically reside in the same neighbourhood as patients, they provide after-hours care when necessary. Rural and secondary and urban emergency departments (EDs) have urban hospitals with both primary and special treatment and minimise the need for walk-in, after day-care centres[491].

D. Hospitals: China has majorly four types of hospitals namely public, private, for-profit and non-profit hospitals. Majority of the township hospitals and community hospitals arebelongs to public sector. No secondary and tertiary hospitals either private or public found in rural areas, they are concentrated in urban areas.

Table 1

The basic information of total public health resources from 2013 to 2018

Year	Population (10,000 persons)	Public health institutions		Public health technical personnel		Beds in public health institutions		Equipment in public health institutions	
		Number	Per 10,000 persons	Number	Per 10,000 persons	Number	Per 10,000 persons	Number	Per 10,000 persons
2013	136,072	31,155	0.23	608,560	4.47	214,870	1.58	481,148	3.54
2014	136,782	35,029	0.26	631,558	4.62	223,033	1.63	530,587	3.88
2015	137,462	31,927	0.23	639,189	4.65	236,342	1.72	572,371	4.16
2016	138,271	24,866	0.18	646,425	4.68	247,228	1.79	618,857	4.48
2017	139,008	19,896	0.14	661,616	4.76	262,570	1.89	686,572	4.94
2018	139,538	18,033	0.13	678,258	4.86	274,394	1.97	742,759	5.32

Table 17-Source: Current situation and distribution equality of public health resources in China[492]

E. Long-term care and social supports: In China long-term care and social supports are not covered by public health insurance. Usually, long term care is provided at home by family members. Intending to develop a formal National Policy framework

[490] Commonwealth Fund, "China" (n 484).
[491] Commonwealth Fund, "China" (n 484).
[492] Honghui Yao, Chaohong Zhan and Xinping Sha, "Current Situation and Distribution Equality of Public Health Resource in China" (2020) 78 Archives of Public Health </pmc/articles/PMC7507592/> accessed September 23, 2021.

on long term care insurance, the country has designated 15 cities as pilot sites. The government also encourage the incorporation of long-term care with other health care services.[493]

4.5.6. The Major Strategies to Ensure Right to Healthcare at China

A. **Quality of Care:** The National Health Commission oversees the Department of Health Care Quality, which is part of the Bureau of Health Politics and Hospital Administration and is responsible for national health care quality. Every five years (the most recent being in 2018), the National Health Service Survey for patients and providers is performed, and a report is issued after each survey emphasising data on chosen quality factors. Chronic illness management programmes are included in the Essential Public Health Equalization Program and are available to all Chinese citizens for free.

   A licence from the local health authority is required for hospitals to be accredited. Hospitals issue physicians with practice licences, which must be renewed regularly. Recertification and revalidation of physicians, as well as hospital accreditation, are the responsibility of local health authorities. Although there are no financial incentives for hospitals to fulfil quality standards, third parties publish several national hospital rankings. Clinical pathways are now controlled nationwide and utilised similarly to clinical recommendations in Western nations, after the issuance of the "Temporary Directing Principles of Clinical Pathway Management" by the previous Ministry of Health in 2009[494].

B. **Efforts to Reduce Disparities:** Although China has achieved great progress in this area over the last decade, there are still substantial discrepancies in access and quality of health care. Before the reform of the health insurance system more than ten years ago, income-related gaps in health care access were extremely severe, as most

[493] National Bureau of Statistics, China Statistical Yearbook 2017 (China Statistics Press, 2017).
[494] Li Wang and others, "The Development and Reform of Public Health in China from 1949 to 2019" (2019) 15 Globalization and Health 2019 15:1 1 <https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-019-0486-6> accessed September 23, 2021.

individuals did not have any coverage at all. Health insurance provided by the government is now almost universal, and there are safety nets in place for the poor. As a result, differences in income have narrowed significantly. There is, however, no monitoring organisation to monitor or report on health inequalities, and no focused efforts to eliminate disparities for specific populations.

The remaining access gaps are mostly attributable to differences in regionally defined insurance benefit packages, urban and rural characteristics, and economic disparity. Another difficulty is that the majority of good hospitals (especially tertiary institutions) with better-qualified health personnel are located in cities. Doctors in rural areas are mostly under-educated. The federal government and local governments provide training for rural physicians at urban hospitals and require new medical graduates to work as residents in rural health institutions to help bridge the divide between urban and rural health care[495].

C. **Efforts to Promote Delivery System Integration and Care Coordination:** Patients get primary care via medical alliances comprising regional hospital groups (which frequently include one tertiary and many secondary hospitals) and primary care institutions. The goal is to minimise healthcare expenditures and increase efficiency by reducing needless trips to tertiary institutions. Patients with significant health concerns, on the other hand, can be quickly referred to tertiary institutions and then returned to primary care after their condition improves. A medical alliance's hospitals use the same electronic health record (EHR) system, which makes lab data, radiological pictures, and diagnoses readily available.

There are three different types of medical alliances prevalent in China. Only one person owns a hospital in the Zhenjiang model (usually the local bureau of health). The Wuhan model does not have a single owner, but it does have a single tertiary hospital that is in charge of administration and financing. Only managerial and technical capabilities are shared between hospitals under the Shanghai model;

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[495] Yao, Zhan and Sha (n 493).

ownership and financial responsibilities are kept distinct. China is dominated by the Shanghai model[496].

D. Electronic Health Records (HER): Almost every healthcare provider now has their electronic health records (EHR) system. With unique patient identities, EHRs are also connected to health insurance systems within hospitals for claim payment (insurance ID or citizenship ID). EHR systems, on the other hand, differ greatly from institution to hospital and are seldom linked or interoperable. When visiting doctors at various hospitals, patients are frequently required to bring a printed health record with them. Different EHR systems may be utilised even if hospitals are controlled by the same local health department or connected with the same institutions[497].

E. Containment of Costs: Because of health insurance reform, an ageing population, economic expansion, and improvements in health technology, health expenditures have increased dramatically in recent decades. In 2004, health expenditures per capita grew from CNY 584 (USD 164) to CNY 4,237 (USD 1,194) in 2018.[498]

One major cost-cutting technique adopted by the state was the Provider Payment Reform. Fee-for-service was the primary payment system before the introduction of DRGs, global budgets, and capitation in 2009, and consumer and physician-induced demand drove up costs considerably. Many areas have utilised global budgets, which are very simple to implement for authorities.

As previously stated, the government prefers community and township hospitals to tertiary hospitals since community and township hospitals are less expensive. Quality, technological advancements, and co-payment rates are all factors in hospital competition. Another step to contain the cost of the drug was the introduction of

[496] Leyton Nelson, "Economics and Trade China's Healthcare System: Addressing Capacity Shortfalls before and after COVID-19" (2021).
[497] Jun Liang and others, "Adoption of Electronic Health Records (EHRs) in China During the Past 10 Years: Consecutive Survey Data Analysis and Comparison of Sino-American Challenges and Experiences" <http://www.jmir.org/2021/2/e24813/>.
[498] National Health Commission, China Health Statistical Yearbook 2019.

"zero markups" for prescription medications launched in the township, community, and county hospitals in 2013. Many areas expanded the programme to include secondary and tertiary hospitals.

Furthermore, the National Development and Reform Commission and the National Health Commission impose strict supply limits on new hospital structures and hospital beds, as well as restricting the acquisition of high-tech equipment like MRI scanners[499].

4.6 Right to Health and Public Healthcare in Myanmar

Myanmar's civilian administration took power in March of 2011. Even though the democratic process has progressed since then, there are still numerous issues in the healthcare area. Because there is a lack of information on Myanmar's healthcare system, this page will provide a quick review of the present state of affairs. The Republic of the Union of Myanmar had 51,410,00 people according to the 2014 Census. Between 2003 and 2014, the yearly population growth rate was 0.89%, based on the crude birth rate of 18.9 per 1,000 for the preceding year.

The Ministry of Health was restructured into six different departments. International non-governmental organizations, as well as national non-governmental organizations and community-based groups, promote healthcare. Because the government primarily collects data on public hospitals, there is little information on private hospitals. Even though there were insufficient medical professionals (61 per 100,000 population),to ensure quality in healthcare system the intake of medical students was lowered from 2,400-1,200. There is no information on the causes of mortality in the general population is found although the hospital statistics did provide some information.[500]

Despite the significant improvement, the results fell short of the targets established by

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[499] Commonwealth Fund, "China" (n 484).

[500] Nyi Nyi Latt and others, "Healthcare in Myanmar" (2016) 78 Nagoya J. Med. Sci <http://www.moh.gov.mm>.

Millennium Development Goals 4 and 5. In July 2015, a prepaid health insurance system went on trial, with an evaluation one year later. Many overseas contributors assist Myanmar's health, notably the Japan International Cooperation Agency. With these efforts and assistance, a significant development in the field of healthcare is predicted.

4.6.1. Administrative Structure of Healthcare in Myanmar

With recent changes in Myanmar's political and administrative institutions, the healthcare sector has changed dramatically. Despite the fact that the healthcare systems are a combination of public and private in terms of financing and supply, the Ministry of Health continues to be the primary supplier of healthcare services. The Ministry of Health has six departments that assist the general public with all areas of health[501].

Figure 14: Burma/Myanmar Library[502]

[501] Ministry of Health. Myanmar Health Care System. *In: Health in Myanmar 2014*. pp. 6–8, 2014, Ministry of Health, Nay Pyi Taw, Myanmar.

[502] Burma Library, "Myanmar Health Care System" (2011) <https://www.burmalibrary.org/docs14/Myanmar-Health-Care-

In the country the Department of Public Health look after the Primary healthcare and basic health services, as well as nutrition promotion, environmental sanitation, maternity and child health, school health, and health education. Infectious illness prevention and control, disease surveillance, outbreak investigations, and capacity building are taken care by the Department's Disease Control Division and Central Epidemiology Unit. Treatments and rehabilitation services are provided by the Department of Medical Services. Various types of health institutions under the Department's jurisdiction provide therapeutic services. The Department of Health Professional Resource Development and Management is primarily responsible for the training and production of all types of health except for conventional medicine professionals. For evidence-based medicine and policymaking, the Department of Medical Research conducts nationwide surveys and research. Food, medicines, medical equipment, and cosmetics are all regulated by the Food and Drug Administration (FDA). The Department of Traditional Medicine is in charge of traditional medicine-based healthcare as well as traditional medicine-related training. Food, medicines, medical equipment, and cosmetics are all regulated by the Food and Drug Administration (FDA). The Department of Traditional Medicine is in charge of traditional medicine-based healthcare as well as traditional medicine-related training. In 2014, there were 6,963 independent traditional healers. The majority of them received their education at the Institute of Traditional Medicine until 2001, and then at the University of Traditional Medicine beginning in 2002[503].

NGO's such as the Myanmar Maternal and Child Welfare Association and the Myanmar Red Cross Society are providing services in accordance with the national health strategy. Healthcare is also supported and provided by national non-governmental organisations, as well as locally active community-based groups and religious institutions.

System.pdf?__cf_chl_managed_tk__=pmd_Zw4S_0oTF7xwkRv2AmUD6FOqsWo1wCrvTOVn.YbH5Nk-1631889586-0-gqNtZGzNAtCjcnBszRE9>.

[503] Htay Win, Viroj Tangcharoensathien and Walaiporn Patcharanarumol, "The Republic of the Union of Myanmar Health System Review of the Union of Myanmar" (2014) 4 Health Systems in Transition.

4.6.2. Role of Health Insurance in Public Healthcare of Myanmar

As per reports out-of-pocket payments account for 73 percent of Myanmar's healthcare expenditures[504]. The Myanmar Ministry of Health reported in 2012 that government financing accounts for only 23% of overall healthcare costs. In comparison to neighbouring nations like as Thailand, Vietnam, and India, the government's healthcare spending is insufficient (Shobert 2014; WHO 2015a). The sole kind of health insurance available in Myanmar is the Social Security Scheme (SSS), which was established in 1956 by the Ministry of Labour. Because Myanmar has such a high percentage of out-of-pocket expenditures, the poor and other disadvantaged groups that utilise healthcare on a regular basis are more exposed to disastrous financial consequences when they require medical attention. To safeguard these populations, as well as middle-income groups, there is a strong desire to develop and execute a national health insurance system that ensures universal coverage[505].

Health insurance was exclusively given by the government for government employees in Myanmar, and private health insurance was only offered for employees of foreign organisations. In the 2014–2015 fiscal year, Myanmar's government spent 3.4 percent of its total budget on health care. Despite increasing funding for the health and education sectors, out-of-pocket spending remained high.[506]

In 2015 government of Myanmar formally declared that a single-year trial will be held to launch the nation-wide health insurance policy on 1 July 2015. Myanmar State Insurance and 11 private domestic businesses provide the same policies with a single unit giving the most basic level of coverage that is able to purchase from 1 to 5 units (one of which costs roughly $ 50). The same policies are available. Burma residents and foreign people residing in the country between the ages of 6 and 65 and can purchase insurance in good health. The insurers will pay about USD 15 per day per unit for the hospital. A policyholder can get an annual hospital expense of 30 days. If an

[504] World Bank, "Myanmar | Data" (*2015*) <https://data.worldbank.org/country/myanmar> accessed September 23, 2021.
[505] Marjolein van Rooijen and others, "Health Insurance in Myanmar: The Views and Perception of Healthcare Consumers and Health System Informants on the Establishment of a Nationwide Health Insurance System" (2018) 6 Risks.
[506] Khaing IK, Malik A, Oo M, Hamajima N. Health care expenditure of households in Magway, Myanmar. *Nagoya J Med Sci*, 2015; 77: 203–212.

insurance holder dies in the hospital, his beneficiary receives around USD 1.000 in compensation per unit insurance.[507]

Besides health insurance, Myanmar also has the Social Security Scheme, which is managed under the Ministry of Labour and Jobs and Social Security by the Social Security Board.

4.6.3. Steps Taken to Ensure Quality Healthcare

Although the rich have a large number of private amenities, the English documents are restricted. The "Law relating to private health care services" was published in 2007 by the government. As per the Private Health statistics 2015 there are 193 private hospitals, 201 private specialty clinics, 3,911 private general clinics and 776 private dentistry clinics in Myanmar. There are private non-profit clinics established by religious organisations and specific communities, they offer outpatient care to the needy. Some of them have emerged in recent years to provide hospitalisation some of the major cities, but the funding and care delivery are still scattered. Since official hospital statistics are confined to public institutions, information on both affluent and poor private facilities is limited[508].

Categories of public hospitals include general hospitals with bed to accommodate 2000 inpatients, specialized hospitals, educational institutions with 100-1200 beds; regional/state, and district with 200-500 beds and townships hospitals. In rural areas the public health units include sub-town and hospital stations with 16-25 beds, rural health centers with outpatient facility only and rural health centers with no beds or inpatient facility.

Rural regions are home to about 70% of the population. The primary healthcare professionals for them are basic healthcare workers. Each Rural Health Centre has 4 Sub-centers working under it. The human resource of the RHC include one RHC public health supervisor grade I, four RHC public health supervisor grade II (one at each sub-

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[507] The Global New Light of Myanmar Newspaper, Vol. II, Number 56, 16, Tuesday, June 2015.
[508] Department of Health Planning in collaboration with Department of Health. Annual Hospital Statistics Report 2012, 2014, Ministry of Health, The Republic of the Union of Myanmar, Nay Pyi Taw, Myanmar.

center), five midwives (one at the RHC and one at each sub-center), one woman health visitor at the RHC, and one health assistant. Maternal and child health (clinical and child care); school health; nutritional promotion, immunization; community education and Healthcare; environment Healthcare; surveillance and control of disease and diseases; treatment of common diseases; reference services; registration of births and deaths and training for volunteer workers; (community health workers and auxiliary midwives). These health professionals confront several obstacles with little resources and assistance in efforts to reach the furthest communities.

In 2013-2014, the number of doctors per 100,000 population was 61, infants surgeon per 100,000 population was 100 and parental surgeons per 100,000 population was 7 in the country. As per the WHO report the ratio was 59, 153 and 10 respectively in South East Asia. Despite a growth in healthcare workforce, skilled health workers are spreading unevenly between urban and rural locations.[509]

4.6.4. Education for healthcare professionals

The Ministry of Health, the Ministry of Education, and the Ministry of Defense are in charge of training and producing various types of health workers for the entire population. Myanmar does not have any private medical schools. 15 universities and 46 nursing and midwifery training schools work under the MoH and Ministry of Education to create health professionals. Under the Ministry of Defence, there is a medical school as well as an associated university. In medical and allied universities, there are now 39 doctoral programmes, 12 PhD programmes, 47 master's programmes, and 12 diploma programmes.[510]

The 9th seminar in Medical Education decided that the yearly admission of four schools in healthcare should be reduced from 2400 to 1.200 (300 in each institution) in 2012 and thereafter to producing competent medical physicians. In Taung-Gyi, Southern Shan State, the capital of Shan, a new medical school has recently been opened (150 students in 2015). The medical student study duration was also extended from six to

[509] WHO Global Health Observatory (GHO) data: Health System (Myanmar).WHO Health Statistics 2014. Available at: http://www.who.int/gho/publications/world_health_statistics/2014/en/.

[510] Ministry of Health. Health Statistics *In: Health in Myanmar 2014*. pp. 142–151, 2014, Ministry of Health, Nay Pyi Taw, Myanmar.

seven years[511]. Applicants from many fields have been selected for the capacity building and sent in for supervisory training in PhDs, M.A.s and other diplomas, and for short-term training. Doctors, dentists and nurses must join the civilian community.

The University of Traditional Medicine was founded in 2001 under the Department of Traditional Medicine and offers bachelor's and master's degrees. A bachelor's degree takes five years to complete, including a year of internship. Traditional medicine as well as the fundamental science of western medicine are covered in the curriculum. A total of around 100 applicants are accepted each year. There have previously been 1,139 graduates from the University. The University launched a Master of Myanmar Traditional Medicine programme and a Bachelor of Myanmar Traditional Medicine bridging programme in 2012.[512]

4.6.5. Healthcare Employees

Before this, the Union Civil Service Board of the central government employed members of the public sector health staff as civil servants (UCSB). For all public health facilities, employment norms and regulations were implemented. Health workers are being recruited not just by UCSB but also by state and regional governments. Furthermore, they are employed with public servant perks including permanent contracts, professional promotion, and postgraduate medical education possibilities, among others. The Ministry of Health (MoH) is a significant actor in Myanmar's public sector when it comes to health workforce generation, usage, and management.

In terms of employment, the private sector has greater flexibility. Each health facility develops its own recruitment processes and benefits packages for its employees. Although there are drawbacks in terms of postgraduate medical education, private health facility employment is more appealing than public health facility employment in terms of being located in metropolitan regions, giving higher pay, and providing better working circumstances.

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[511] Ministry of Health. Managing Health Workforces. *In: Myanmar Health Statistics 2014*. pp.126–130, 2014, Ministry of Health, Nay Pyi Taw, Myanmar.
[512] Ministry of Health. Managing Health Workforces. *In: Myanmar Health Statistics 2014*. pp.131, 2014, Ministry of Health, Nay Pyi Taw, Myanmar.

4.7 Table 18: Comparison of all the selected Countries

The below chart shows the comparison of some parameters of healthcare in the selected countries and India.

Sr. No	Identified Areas	India	USA	Australia	France	China	Myanmar
1	**Status of Federal/Central Legislation on Public Health**	Draft in Process-Right to Health and Healthcare Bill 2021 and National Public Health Act	No	Public Health Act 2016	Public Health Act 2004	No (The National Basic Public Healthcare Service Standard, promulgated in 2017)	No
2	**Universal Health Coverage**	No	No	No	Yes	Yes	No
3	**Budget Allocation (As per WB data)**	3.01% of GDP in 2019	16.77% of GDP in 2019	9.91% of GDP in 2019	11.6% of GDP in 2019	5.35% of GDP in 2019	4.68% of GDP in 2019

4	**Role of government**	In India Healthcare is a state subject however, the responsibility for the governance, financing, and operation of the health system is divided between the central and state governments. At the federal level, the Ministry of Health and Family Welfare has regulatory power over the majority of health policy decisions but is not directly involved in health care delivery.	Role of government: The federal government's responsibilities include setting legislation and national strategies; administering and paying for the Medicare program; cofounding and setting basic requirements and regulations for the Medicaid program; cofounding CHIP; funding health insurance for federal employees as well as active and past members of the military and their families; regulating pharmaceutical products and medical devices; running federal marketplaces for private health insurance; providing premium subsidies for private marketplace coverage. The U.S. Department of Health and Human Services is the federal government's principal agency involved with	Three levels of government are collectively responsible for providing universal health care: The federal government provides funding and indirect support for inpatient and outpatient care through the Medicare Benefits Scheme (MBS) and for outpatient prescription medicine through the Pharmaceutical Benefits Scheme (PBS). The federal government is also responsible for regulating private health insurance, pharmaceuticals, and therapeutic goods; however, it has a limited role in direct service delivery. The federal Department of Health oversees national policies and programs, including the MBS and PBS. States own and manage service delivery for public hospitals, ambulances, public dental care, community health (primary and	The provision of health care in France is a national responsibility. The Ministry of Social Affairs, Health, and Women's Rights is responsible for defining the national health strategy. It sets and implements government policy for public health as well as the organization and financing of the health care system. Over the past two decades, the state has been increasingly involved in controlling health expenditures funded by SHI.2 It regulates roughly 75 percent of health care expenditures on the basis of the overall framework established by Parliament. The central government allocates budgeted expenditures among different sectors (hospitals, ambulatory care,	China's central government has overall responsibility for national health legislation, policy, and administration. It is guided by the principle that every citizen is entitled to receive basic health care services. Local governments — provinces, prefectures, cities, counties, and towns — are responsible for organizing and providing these services.	In the country the Department of Public Health look after the "Primary healthcare and basic health services, as well as nutrition promotion, environmental sanitation, maternity and child health, school health, and health education. Infectious illness prevention and control, disease surveillance, outbreak investigations, and capacity building are taken care by the Department's Disease Control Division and Central Epidemiology Unit. Treatments and rehabilitation services are provided by the Department of Medical Services.

			health care services. The states cofound and administer their CHIP and Medicaid programs according to federal regulations. States set eligibility thresholds, patient cost-sharing requirements, and much of the benefit package. They also help finance health insurance for state employees, regulate private insurance, and license health professionals.	preventive care), and mental health care. They contribute their own funding in addition to that provided by federal government. States are also responsible for regulating private hospitals, the location of pharmacies, and the health care workforce. Local governments play a role in the delivery of community health and preventive health programs, such as immunizations and the regulation of food standards.	mental health, and services for disabled residents) and regions.		

5	**Health Insurance**	Total public and private health expenditures as a percentage of GDP are estimated at 3.9%, significantly lower than the world average of 9.9%.	92% of the population was estimated to have coverage in 2018	As of September 2021, around 54.5% of the entire Australian population had some form of general treatment cover.	Total health expenditures constituted 11.6% of GDP in 2019. Coverage is compulsory, and is provided to all residents by non-competitive statutory health insurance funds; historically, there have been 42 funds. Annual contributions are determined by Parliament. The SHI scheme in which workers enrol is based upon the type of employment. Unemployed persons are covered for one year after job termination by the SHI scheme of their employer and then by the universal health coverage law.	In 2018, China spent approximately 6.6 percent of GDP on health care, which amounts to CNY 5,912 billion (USD 1,665 billion).3 Twenty-eight percent was financed by the central and local governments, 44 percent was financed by publicly funded health insurance, private health insurance, or social health donations, and 28 percent was paid out-of-pocket.	The sole kind of health insurance available in Myanmar is the Social Security Scheme (SSS), which was established in 1956 by the Ministry of Labour.

6	**Public Health Insurance**	The public sector accounts for approximately one-quarter of health expenditures. (1) Ayushman Bharat Yojana, (2) Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), (3)	In 2017, public spending accounted for 45 percent of total health care spending, or approximately 8 percent of GDP. Medicaid is largely tax-funded, with federal tax revenues representing two-thirds (63%) of costs, and state and local revenues the remainder.	The federal government provides funding and indirect support for inpatient and outpatient care through the Medicare Benefits Scheme (MBS) and for outpatient prescription medicine through the Pharmaceutical Benefits Scheme (PBS). Medicare provides free public hospital care and substantial coverage for physician services and pharmaceuticals for Australian citizens, residents with permanent visas, and New Zealand citizens following their enrolment in the program and confirmation of identity. oral health expenditures in 2015–2016 represented 10.3 percent of the GDP, an increase of 3.6 percent from 2014–2015. Two-thirds of these expenditures (67%) were funded by the government.	Payroll taxes provide 53 percent of funding, with employers paying 80 percent of the tax and employees paying the rest; contributions are calculated from the actual salaries, capped at EUR 3,311 (USD 4,191) per month. A national earmarked income tax contributes 34 percent of funding. Taxes levied on tobacco and alcohol, the pharmaceutical industry, and voluntary health insurance (VHI) companies provide 12 percent of funding. State subsidies account for 1 percent of funding.	Medical aid ensures all citizens have fair access to basic medical services by supporting the section of the low-income populace to participate in the BMI by subsidizing the medical expenses that they cannot afford. Since 2018, medical aid has benefited 480 million low-income citizens, helped reduce their medical burden by approximately CNY ¥330 billion	Health insurance was exclusively given by the government for government employees in Myanmar

7	**Private Health Insurance**	36% of insured individuals in India have private coverage, which covers only hospitalizations. The Insurance Regulatory and Development Authority Act of 1999 allowed for private companies to enter the health insurance market. Private insurance now accounts for nearly 4.4 percent of total current health expenditures.	pending on private health insurance accounted for one-third (34%) of total health expenditures in 2018. Private insurance is the primary health coverage for two-thirds of Americans (67%). The majority of private insurance (55%) is employer-sponsored, and a smaller share (11%) is purchased by individuals from for-profit and non-profit carriers.	As of June 2020, almost 43.6 percent of the population in Australia had private health insurance hospital treatment coverage. The Australian Prudential Regulation Authority regulates private health insurance, and the Australian Competition and Consumer Commission promotes competition among private health insurers. Private health insurance may include coverage for hospital care, general treatment, or ambulance services. Government policies encourage enrolment in private health insurance through a tax rebate (8.5%–33.9%, depending on age and income) and an income-based penalty payment (1%–1.5%) for not having private insurance. This penalty, known as the Medicare Levy surcharge, applies only to singles with incomes above $90,000 and families with	Voluntary health insurance finances 13.5 ~~%~~ of total health expenditures. 95% of the population is covered by VHI, either through employers or via means-tested vouchers. Private for-profit companies offer both supplementary and complementary health insurance, but only for a limited list of services.	Purchased primarily by higher-income individuals and by employers for their workers, private insurance can be used to cover deductibles, co-payments, and other cost-sharing, as well as to provide coverage for expensive services not paid for by public insurance.	Private health insurance was only offered for employees of foreign organisations.

				incomes above $180,000.			
8	**Out of Pocket Spending**	out-of-pocket payments have been the primary means of funding health care, accounting for 65 percent of total health expenditures in 2015–2016. It has come down to 48.8% in 2017-18	10.81% of the total Healthcare Expenditure ($388.6 billion in 2020)	17.72% of the total healthcare Expenditure	9.25% of the total Healthcare Expenditure	35.75% of the total Healthcare Expenditure	76.45% of the total Healthcare Expenditure
9	**Primary Healthcare**	Under the Health and Wellness Centres program, 150,000 subcentres (the lowest tier of the health system) across the country are being upgraded to provide comprehensive primary health care services, free essential medicines, and free diagnostic services. The PHC is the first point of contact between a village community and a medical officer. These centres provide curative and preventive services to 20,000–30,000 people and serve as a referral unit for six subcentres with four to six beds each.	Roughly one-third of all professionally active doctors are primary care physicians, a category that encompasses specialists in family medicine, general practice, internal medicine, paediatrics, and, according to some, geriatrics. Approximately half of primary care doctors were in physician-owned practices in 2018.	In 2015, there were 34,367 GPs, 49,060 practitioners registered as both generalists and specialists, and 8,386 providers registered as specialists. In 2015, there were 11,040 nurses or midwives working in a general practice setting.	There are roughly 102,299 general practitioners (GPs) and 121,272 specialists in France (a ratio of 3.4 per 1,000 population). About 59 percent of physicians are self-employed on a full-time or part-time basis (67% of GPs, 51% of specialists).	Primary care is delivered primarily by: Village doctors and community health workers in rural clinics General practitioners (GPs) or family doctors in rural township and urban community hospitals Medical professionals (doctors and nurses) in secondary and tertiary hospitals. In 2018, there were 506,003 public primary care facilities and 437,636 private village clinics.	The Department of Public Health is mainly responsible for primary healthcare and basic health services. There are 87 primary and secondary health centers.

10	**Outpatient Specialist Care**	Community health centres also provide outpatient specialist care and are required to have four medical specialists (surgeon, general practitioner, gynaecologist, and paediatrician) supported by paramedical and other staff. They must also have 30 beds, a laboratory, X-ray services, and other facilities. Each center covers 80,000 to 120,000 people. All outpatient specialized services not provided at community centers are referred to district hospitals.	Specialists can work both in private practices and in hospitals. Specialist practices are increasingly integrating with hospital systems, as well as consolidating with each other. The majority of specialists are in group practices, most often in single-specialty group practices.	Specialists deliver outpatient care in private practice (8,001 specialists in 2015) or in public hospitals (3,745). Patients are able to choose which specialist they see but must be referred by their GP to receive MBS subsidies. Specialists are paid on a fee-for-service basis.	About 36 percent of outpatient specialists are exclusively self-employed. Specialists working in public hospitals may see private-pay patients on either an outpatient or an inpatient basis, but they must pay a percentage of their earned fees to the hospital.	Outpatient specialists are employed by and usually work in hospitals. Most specialists practice in only one hospital, although practicing in multiple settings is being introduced and encouraged in China.	
11	**After Hours Care**	The India Public Health Standards determine which health care facilities are required to operate 24 hours a day, seven days a week.	Primary care physicians are not required to provide or plan for after-hours access for their registered patients. However, in 2019, 45 percent of primary care doctors had after-hours arrangements: 38 percent of these provide care in the evenings and 41 percent on the weekends.	GPs are required to ensure that after-hours care is available to patients, but are not required to provide care directly. They must demonstrate that processes are in place for patients to obtain information about after-hours care and that patients can contact them in an emergency.	After-hours care is organized by the Regional Health Agencies and delivered by contracted hospital emergency departments, self-employed physicians who work for emergency services, and medical homes financed by SHI and staffed by doctors and	Because village doctors and health workers often live in the same community as patients, they voluntarily provide some after-hours care when needed. In addition, rural township hospitals and urban secondary and tertiary hospitals have emergency departments (EDs) where both primary care doctors	

					nurses on a voluntary basis. Primary care physicians are not mandated to provide after-hours care.	and specialists are available, minimizing the need for walk-in, after-hours care centers.	
12	**Long term care and social support**	India doesn't have any foundation on long-term care so far	There is no universal coverage for long-term care services. Public spending represents approximately 70 percent of total spending on long-term care services, with Medicaid accounting for the majority. Private long-term care insurance is available but rarely purchased; private insurance represented only 7.5 percent of total long-term care spending in 2016.	Three out of four people receiving long-term care receive residential aged care (nursing home care). Three-quarters of older Australians receive informal care and 60% receive formal care. In 2015, 11 % of Australians were informal caregivers, and 32 % of these caregivers were the primary caregiver or carers. In 2013, the federal government, in partnership with states, implemented the pilot phase of the National Disability Insurance Scheme. Under the same which point around 460,000 Australians are expected to receive support.	Health and social care for elderly and disabled people come under the jurisdiction of the General Councils, which are the governing bodies at the local (departmental) level. The total number of frail elderly is estimated at about 1.25 million, or 2% of the population. Total expenditures for long-term care were estimated to be EUR 30 billion (USD 37.9 billion) in 2015, or 1.7 % of GDP.	Long-term care and social supports are not part of China's public health insurance. In accordance with Chinese tradition, long-term care is provided mainly by family members at home.	

13	**Hospitals**	In total there are 37,725 Public hospitals and 7,39,024 beds in the public sector in India. In addition to that number of private hospitals and private clinics are also functioning.	In 2018, 57 percent of the 5,198 short-term acute care hospitals in the U.S. were non-profit; 25 percent were for-profit; and 19 percent were public (state or local government–owned).27 In addition, there were 209 federal government hospitals.	In 2016–2017, there were 695 public hospitals (673 acute, 22 psychiatric), with a total of nearly 60,300 beds. Hospital beds have increased by an annual average of 1.5 percent, maintaining a consistent supply of 2.5 beds per 10,000 population. In the same period, there were 630 private hospitals (341-day hospitals and 289 others) with 33,100 beds.22 Private hospitals are a mix of for-profit and non-profit. Public hospitals receive a majority of funding (92%) from the federal government and state governments, with the remainder coming from private patients and their insurers.	Public institutions account for about 65 percent of hospital capacity and activity. Private for-profit facilities account for another 25 percent, and private non-profit facilities make up the remainder.	Hospitals can be public or private, non-profit or for-profit. Most township hospitals and community hospitals are public, but both public and private secondary and tertiary hospitals exist in urban areas. Rural township hospitals and urban community hospitals are often regarded as primary care facilities, more like village clinics than actual hospitals. In 2018, there were approximately 12,000 public hospitals and 21,000 private hospitals (excluding township hospitals and community hospitals), of which about 20,500 were non-profit and 12,600 were for-profit.	Public hospitals are categorized into general hospitals (up to 2,000 beds), specialist hospitals and teaching hospitals (100–1,200 beds), regional/state hospitals and district hospitals (200–500 beds), and township hospitals (25–100 beds). In rural areas, sub-township hospitals and station hospitals (16–25 beds), rural health centres (no beds), and sub-rural health centres (no beds) provide health services, including public health services. There were 1,056 public hospitals with 56,748 beds in total. These facilities mainly provide curative and rehabilitative services. There are 87 primary and secondary health

						centres, 348 maternal and child health centres, 1,684 rural health centres, and 80 school health teams. As per the Private Health statistics 2015 there are 193 private hospitals, 201 private specialty clinics, 3,911 private general clinics and 776 private dentistry clinics in Myanmar. "There are private non-profit clinics established by religious organisations and specific communities, they offer outpatient care to the needy.

14	**Medical Education**	Medical education is provided by both state-led institutions and private colleges. The Medical Council of India establishes standards for undergraduate medical education, accredits undergraduate and postgraduate medical education programs, determines equivalencies for foreign medical graduates, and maintains a general directory for all certified physicians.	Most medical schools (59%) are public. Median tuition fees in 2019 were $39,153 in public medical schools and $62,529 in private schools. Most students (73%) graduate with medical debt averaging $200,000 (2019), an amount that includes pre-medical education.	Physicians are trained primarily at public (but also private) universities, with their fees subsidized through the tax system. The federal government provides primary care doctors with financial incentives to practice in rural and remote areas. There is no cap on the number of physicians in Australia, and workforce shortages are addressed through internationally trained providers.	Once a year, the Ministry of Social Affairs, Health, and Women's Rights determines the maximum number of students that can be admitted to medical, dental, midwifery, and pharmacy schools, which are all public by law.	The number of physicians is not regulated at the national level, and the government is trying to encourage more people to complete medical school. All the medical schools are public.	The Ministry of Health, the Ministry of Education, and the Ministry of Defence are in charge of training and producing various types of health workers for the entire population. Myanmar does not have any private medical schools. 15 universities and 46 nursing and midwifery training schools work under the MoH and Ministry of Education to create health professionals.

15	**Strategies to Ensure Quality of Healthcare**	Quality of care is addressed through legal and policy measures defined by the central and state governments. Currently, there is no single entity that is responsible for measuring all aspects of quality of care at health care facilities. In 2017, a centralized tracking system for district hospital performance was introduced along with public rankings of hospitals in the system based on performance. The National Accreditation Board for Hospitals and Healthcare Providers is responsible for accrediting all types of health facilities. Other frameworks that are being used to support quality control and improvement include: India Public Health Standards (2008) My Hospital (Mera-Aspataal) (2016) Labour Room Quality Improvement Initiative (LaQshya) (2017)	U.S. Department of Health and Human Services established the National Quality Strategy, a set of national aims and priorities to guide local, state, and national quality improvement efforts, supported by partnerships with public and private stakeholders. The strategy includes annual reporting on a selected set of quality measures. Healthcare Effectiveness Data and Information Set is used to rate provider quality. The agency for Healthcare Research and Quality publishes the National Healthcare Quality and Disparities Report. Several federal agencies are tasked with monitoring and reducing disparities.	The overarching strategy for ensuring the quality of care is captured in the National Healthcare Agreement of the COAG (2012). The agreement sets out the common objective of Australian government in providing health care in a sustainable system with improved outcomes for all. The Australian Commission on Safety and Quality in Health Care (ACSQHC) is the main body responsible for safety and quality improvement in health care. The Australian Bureau of Statistics, the national government statistical body, undertakes an annual patient experience survey. The Australian Council on Healthcare Standards is the (nongovernment) agency authorized to accredit provider institutions. States license and register private hospitals and the	An average of EUR 5,000 (USD 6,330) per physician annually is provided for achieving pay-for-performance targets related to the following: use of computerized medical charts adoption of electronic claims transmission delivery of preventive services, such as immunizations compliance with guidelines for diabetic and hypertensive patients generic prescribing limited use of psychoactive drugs for elderly patients. There are national strategies for the treatment of chronic conditions like cancer and for rare diseases, as well as for prevention and healthy aging. These plans establish governance, develop tools, and coordinate participating organizations.	The Department of Health Care Quality, which is within the Bureau of Health Politics and Hospital Administration and is overseen by the National Health Commission, is responsible at the national level for the quality of care. The National Health Service Survey for patients and providers is conducted every five years (the latest was in 2018), and a report is published after each survey highlighting data on selected quality indicators. To be accredited, hospitals must obtain a license from the local health authority. Physicians get their practice licenses through hospitals; licenses are subject to renewal. Local health authorities are responsible for physician recertification and revalidation and for	Although there were not enough medical doctors (61 per 100,000 population), the number of medical students was reduced from 2,400 to 1,200 in 2012 to ensure the quality of medical education.

		National Patient Safety Implementation Framework (2018–2025).		health workforce, legislate on the operation of public hospitals, and work collaboratively through the National Registration and Accreditation Scheme to facilitate workforce mobility across jurisdictions while maintaining patient protections. States also ensure that the workforce maintains minimum hours and standards of continuing education to maintain accreditation.	Population health surveys are undertaken based on disease, population segment (such as new-borns, students, elderly patients), or theme (like nutrition).	hospital accreditation to ensure competency.	

4.8 Conclusion

Healthcare is one among the top challenge every country in the world is undergoing. Though WHO defines healthcare as the "complete physical and mental well being" in the majority of the nations the healthcare thinking has not raised above tackling diseases. The current pandemic was an eye-opener to the world and nations were able to understand their standing In terms of healthcare. The above analysis has proved beyond doubt that none of the healthcare systems is free of challenges, all countries, recorded by WHO as best performing and the worst performing, are facing issues like disparities based on region and financial ability, out of pocket payment, high healthcare cost etc. However, the best-performing countries have a more channelised approach and more attention is given to the healthcare of the public.

The Global Health Index findings demonstrate that the National Health Security is weak in all nations irrespective of the status of their development. The majority of the countries lack a foundational healthcare system and are not prepared to deal with health emergencies and all nations have some important gaps in their healthcare system to be bridged.

Figure 15: Healthcare Profile of selected Countries

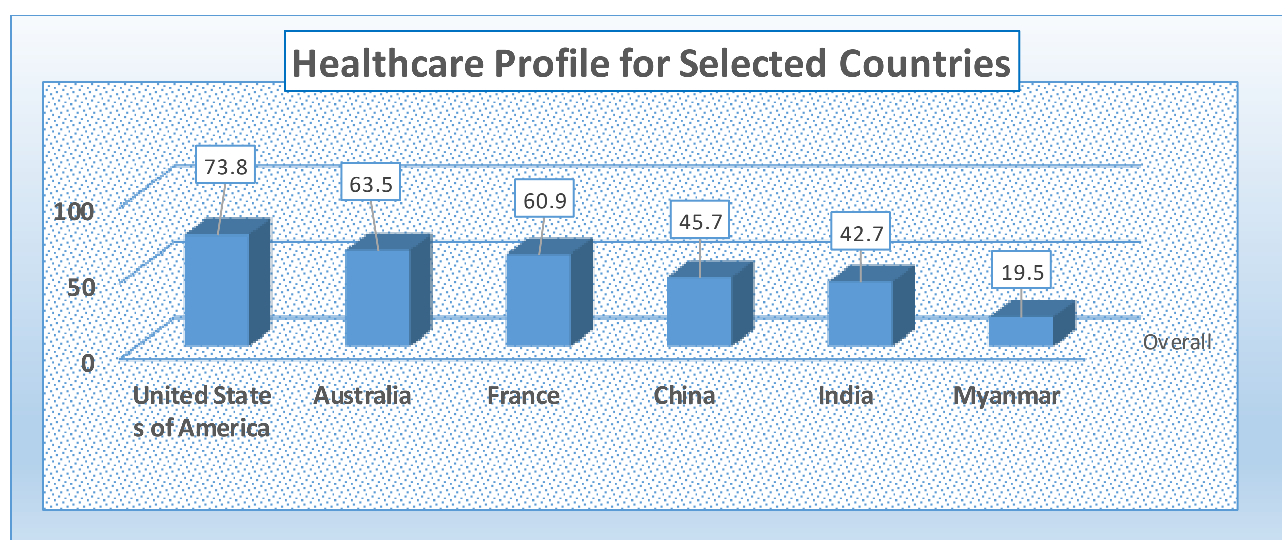

Figure 15-Source: GHS Index[513]

[513] Nuclear Threat Initiative; the Johns Hopkins Center for Health Security, "Global Health Security (GHS) Index" <https://www.ghsindex.org/> accessed September 18, 2021.

The study was conducted in all 196 countries and data was collected on 6 major criterias and one among them was healthcare. The USA topped this category with 73.8 points followed by Australia (63.5) in 6th position, then France (60.9) in 8th position. China ranked 30th position with 45.7 points. India with 42.7 points stood the 36th position. Myanmar is one of the lowest-ranked countries and got 111th position with (19.5).

The below table describes the indicator wise points of the selected countries in the category of healthcare.

Table 19: Analysis of healthcare system to treat the unwell

Health System	United States of America	Australia	France	China	India	Myanmar
"Health capacity in clinics, hospitals and community care centres	60.4	63.5	52.4	38.3	29.4	20
Medical countermeasures and personnel deployment	66.7	33.3	66.7	33.3	0	0
Healthcare access	25.3	43.8	46.2	31.4	29.6	24.5
Communications with healthcare workers during a public health emergency	100	100	100	0	100	50
Infection control practices and availability of equipment	100	50	50	100	50	0
Capacity to test and approve new medical countermeasures"	100	100	50	75	50	25

(Table 19: Source: GHS Index[514])

The below table shows the comparison of public healthcare expenditure and the status of out-of-pocket payment in each selected country. From the table 19 above, it is clear that the USA spends maximum on public healthcare and the USA stands first in health care

[514] Nuclear Threat Initiative; the Johns Hopkins Center for Health Security (n 514).

spending among all its peers and is one of the best-performing countries of the world in healthcare as per the Health Index of WHO. As per the findings of the CMS report in 2019 the national health care spending of the USA reached $3.81 trillion and they predicted an increase up to $4.01 trillion in 2020. It has been recorded by CMS the health care spending of the USA would reach $6.19 trillion by 2028 and would account for 19.7% of GDP. The reasons for the successful healthcare system of the USA can be the public healthcare spending and the effective implementation of the policies.

Table 20: Healthcare Expenditure and Out of Pocket payment in 2018 of selected countries

Healthcare Expenditure and OOP in 2018 of Selected Countries		
Country	**Health Expenditure (% of GDP)**	**OOP (% of current health Expenditure)**
USA	16.89	10.81
Australia	9.28	17.72
France	11.26	9.25
China	5.35	35.75
India	3.54	62.67
Myanmar	4.79	76.45

Table 20-Source: World Bank

In 2021–22, the Australian Government is expected to spend $98.3 billion on health, accounting for 16.7% of total government expenditures. This government has spent $16 billion during emergency health response to the Covid pandemic. Even after that, Australians pay for about 17 per cent of total health expenditure directly through out-of-pocket expenses. This adds up to $29.8 billion, or about $1,235 per person. The decentralised approach and effective implementation of policies including insurance are the key criteria for the success of Australian healthcare.

In 2020, France spent 209.2 billion euros on healthcare, or roughly 3,100 euros per person, down 0.4% from the previous year. In its draught budget for 2021, the French government forecasts fiscal deficits of 10.2% of GDP in 2020, followed by 6.7% in 2021 (up from 3%

in 2019). The government debt-to-GDP ratio is anticipated to climb over 20 points in 2020, to 117.5%, before falling somewhat in 2021, to 116.2%.

The amount spent on healthcare in China in 2018 was $501, up 14.59% from 2017. China is showing an upward trend in its healthcare spending however, the OOP is reported to be very high in the country due to the inefficient policies and insurance schemes.

The major drawback of India is that India's healthcare spending is very low as compared to many other developed and developing nations. As per the reports between 2008-09 and 2019-20, India's public health expenditure (the total of central and state spending) has stayed stable between 1.2% to 1.6% of GDP. The Health Ministry of India was given a budget of Rs 67,112 crore for 2020-21. This is a 3.9% increase above the 2019-20 updated projections (Rs 64,609 crore). There is a separate allocation of Rs 2,100 crore to the Department of Health Research.

From the above table, it is clear that Myanmar spends only 4.79% of its GDP on healthcare. Myanmar's health spending per capita was 59 dollars in 2018. Myanmar's health spending per capita grew from $7 in 2004 to $59 in 2018, rising at an average yearly rate of 17.89%.

The above analysis clearly established the reasons for good performance by few countries and poor performance by the others including India. India should improve its healthcare expenditure to bring quality in all levels of public healthcare. Systematic training of the healthcare practitioners and other staff, regular monitoring of the system through designated agencies, mandatory insurance for all, aged and long-term care are some of the areas that India can implement. To maintain uniformity a central law regulating quality, accessibility, availability and affordability of healthcare system is required. More power and responsibilities to local governments and each tier of the government like Australia can be a better strategy for effective implementation of the programmes.

CHAPTER 5

FINDINGS AND DISCUSSION BASED ON SURVEY CONDUCTED IN GUJARAT

5.1 Introduction

Over last two decades Gujarat showed rapid economic development[515]. In fact, the state's economic growth in last decade was faster than the country. Here arises the question whether this economic growth has contributed to the development of healthcare sector of the state or not? Like any other state healthcare has always been a challenge for Gujarat too. Even though the state has significantly improved some of the key health indicators, the issues in relation to access to quality healthcare continues to persist. The public healthcare infrastructure developed by Government of Gujarat is good as compared to majority of states in India[516]. The public health expenditure also has improved over time in Gujarat, it has recorded an increase of 18% from 2017-18 to 2020-21[517]. But there has been a decline of budget allocation from 5.7% of GDP in 2017-18 to 5% of GDP in 2021-22.

Some of the factors affecting the healthcare status of Gujarat include disparities based on income, gender and geographical region; unavailability of quality healthcare providers; underutilization of public healthcare by citizens; lack of awareness on the government initiatives; poor implementation of programmes and other initiatives of the government; etc. Disparity in healthcare facilities based on region still exist in Gujarat and the beginning of Millennium witnessed 16 times better facilities in urban areas than the rural areas[518]. Recently the state saw some reported cases of discrimination in access to healthcare based

[515] "GSDP of Gujarat, Economic Growth Presentation and Reports | IBEF" <https://www.ibef.org/states/gujarat-presentation> accessed November 13, 2021.
[516] Is It Achievable, "Health for All in Gujarat" 3193.
[517] Parth Shastri, "Budget for Health Spending: Gujarat Not in Top 10 | Ahmedabad News - Times of India" *Times of India* (2021) <https://timesofindia.indiatimes.com/city/ahmedabad/budget-for-health-spending-gujarat-not-in-top-10/articleshow/84741502.cms> accessed November 13, 2021.
[518] Achievable (n 517).

on Gender too[519]. Gap in income also has become a barrier in accessing quality healthcare to the impoverished. Low utilization of public healthcare is another issue the state's healthcare system is facing. Many of the studies found that citizens lack faith in public healthcare facilities and there is a tendency to opt private sector over public healthcare[520].

Gujarat has a three-tier healthcare system. The below figure 16 gives an illustration of three tier system implemented in Gujarat.

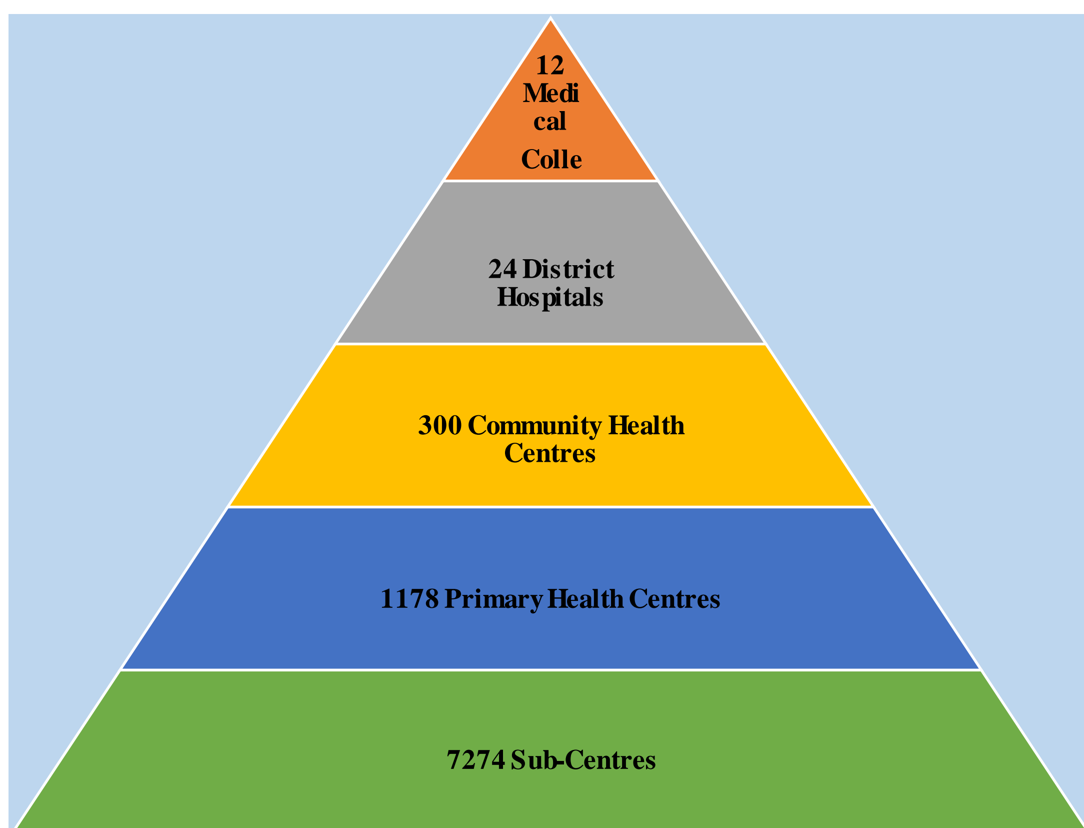

Figure 16: (Source- Health Pyramid of Gujarat[521])

There are three types of healthcare institutions in the primary level designed in accordance with the total population. First point is the Sub-Centre (SC) for a population of 3000 to 5000. Sub-Centres has one Auxiliary Nurse Midwife, One Male Health Worker, one

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[519] "Gujarat: Patriarchy Blocks Women's Access to Healthcare | Ahmedabad News - Times of India" <https://timesofindia.indiatimes.com/city/ahmedabad/patriarchy-blocks-womens-access-to-healthcare/articleshow/82923195.cms> accessed November 13, 2021.
[520] Achievable (n 517).
[521] National Health Misssion, "Health Pyramid of Gujarat | Citizen's Corner" <https://nhm.gujarat.gov.in/hospitals-gujarat.htm> accessed November 13, 2021.

Female Health Worker from PHC. The centres take care maternal and child health, nutrition, Diarrhea control, family welfare, immunization and control of communicable disease programme[522].

The second access point is the Primary Health Centre (PHC) for 20,000 to 30,000 population which renders services like outpatient services, indoor patients up to 4-6 beds, curative, preventive, promotional, and family welfare services. It has one medical officer, fourteen paramedical and other staff. Third category is the Community Health Centre (CHC) for every 1,00,000 populations. It has four specialist doctors in the areas of Medicine, Surgery, Pediatrics and Gynecologist and Obstetrician. CHC has facilities like outpatient services, indoor patients up to 30 beds, operation theatre, labor room, X-ray machine and pathological laboratory[523].

The second tier has District hospitals with facilities like General Medicine, General Surgery, Ear, Nose, Throat, Gynecology & obstetrics, Pediatrics and Neonatal services, Orthopedics, Ophthalmology, Dermatology, Dental Sciences, Imaging Services, Physiotherapy Services and also access to major health programmes. Finally, the third tier is the tertiary healthcare. In Gujarat the urban public health care units are managed by the local bodies like Municipal Corporation[524].

5.2 Healthcare in Tribal Region of Gujarat: Discussion and Findings

India has 705 tribes spread across different states of the nation constituting over 104 million. They account for 8.6% of the total population of the country[525]. Before getting in to the other details of this study it is essential to understand who is tribe. Indian Constitution defines tribe as *"such tribes or tribal communities or parts of or groups within such tribes or tribal communities as are deemed under Article 342 to be Scheduled Tribes for the purposes of this Constitution"*[526]. Article 342 imposes this right on the President of the

[522] Misssion (n 522).
[523] Misssion (n 522).
[524] Misssion (n 522).
[525] Expert Committee on Tribal Health, 'Policy Brief – Tribal Health Report, India' (2018) <http://tribalhealthreport.in/policy-brief/> accessed 12 November 2021.
[526] A.366(25),The Constitution of India [As on 1st April, 1950].

nation to specify the tribes or tribal communities or parts or groups within the tribal community through notification.

Healthcare for tribal population has always been a challenge for the country. As a step towards improving the healthcare infrastructure of tribal region the Ministry of Health and Family Welfare has allocated a significant portion of its budgetary allocation for the Scheduled Tribe and other vulnerable sections. The Ministry of Tribal Affairs contributes to the development of infrastructure in tribal-dominated areas and the provision of basic amenities to tribal people in the country, including medical facilities, through various schemes and programmes of concerned Central Ministries and State Governments, while the Ministry of Tribal Affairs supplements these initiatives by filling gaps. A designated source of funds for tribal development across the country is the Scheduled Tribe Component (STC) at the federal level and the Tribal Sub-Scheme (TSS) at the state level[527]. The government under National Health Mission has also implemented various initiatives to improve the tribal health and healthcare. Another initiative of Government of India to improve tribal health was the setting up of Expert Committee on Tribal Health under the leadership of Dr. Abhay Bang to launch a comprehensive roadmap to improve the health and healthcare in tribal regions of the nation. Yet, the tribal population undergo extreme deprivation, disparity and underdevelopment[528]. They are undergoing multiple socio-economic challenges especially health related issues. The health burden of tribal region is multifaceted; they are prey to malnutrition and nutrition related disorders and in addition to that both communicable and non-communicable diseases have found their ways to these regions. NFHS data recorded that in almost all health indicators, the performance of tribal areas are poor. As per the reports the tribal area lacks quality healthcare services too. The main reason reported for this lack of access to healthcare are mainly under development of the area. It has also been reported that healthcare workers including Doctors are reluctant to take up a job in tribal areas.

[527] Press Information Bureau, Government of India and Ministry of Tribal Affairs, "Free Medical Facilities in Tribal Areas" (2019) <https://pib.gov.in/Pressreleaseshare.aspx?PRID=1558965> accessed November 12, 2021.

[528] Dileep Mavalankar, "Doctors for Tribal Areas: Issues and Solutions" (2016) 41 Indian Journal of Community Medicine 172 <https://www.ijcm.org.in/article.asp?issn=0970-0218;year=2016;volume=41;issue=3;spage=172;epage=176;aulast=Mavalankar> accessed November 11, 2021.

To understand the status of healthcare in different regions of Gujarat the researcher has conducted a survey in to different regions of Gujarat namely tribal, rural and urban. This part of the study demonstrates the survey conducted in to the Panchmahal District of the state of Gujarat to understand the status and perceptions of tribal population on the healthcare provided by Government of Gujarat. As per the 2011 Census, the Tribal population in Gujarat accounts for 14.75% of the total population of the state[529]. Like all other state the healthcare of tribal region has always been a challenge for Gujarat too. Gujarat has 2519 sub centres, 203 PHC's, 259 HWC-SC, 218 HWC-PHC and 92 CHC's for the 89,17,174 (as per census 2011) tribal population. That means every 43927 people has access to one PHC, 3539.97 has access to one sub-Centre, 96925.80 has access to one CHC[530]. The below table illustrates the number of hospital staff and the shortfall of the doctors, nurses, midwives and other hospital staff in various public healthcare units in tribal Gujarat.

5.2.1 Table 21: Data of Healthcare Workers at Public Healthcare Centers at Tribal Areas

Data of Healthcare Workers at Public Healthcare Centres at Tribal Areas					
Category	**Required**	**Sanctioned**	**In position**	**Vacant**	**Shortfall**
Sub-Centres					
Auxiliary Mid Wife (ANM-Female)	2778	778	2112	666	666
Health Worker (Male)	2778	2778	1815	963	963
Primary Healthcare Units (PHC's)					
Health Worker (Female)	421	421	396	25	25

[529] GUJARAT STATE RURAL ROAD DEVELOPMENT AGENCY (GSRRDA) Roads and Buildings Department Government of Gujarat, "TRIBAL POPULATION PLANNING FRAMEWORK FOR GUJARAT RURAL ROADS (MMGSY) PROJECT Environmental and Socil Management Framework for MMGSY" (2017) <https://www.aiib.org/en/projects/approved/2017/_download/India/TPPF_MMGSY_Gujarat.pdf> accessed November 11, 2021.

[530] Ministry of Health and Family Welfare; Government of India, "Rural Health Mission Statistics 2018-19" (2019) <https://nrhm-mis.nic.in/SitePages/HMIS-Publications.aspx>.

Health Assistants (Female)	421	639	448	191	*
Health Assistants (Male)	421	421	333	88	*
Doctors	421	1030	531	499	*
Ayush Doctors	421	434	273	161	*
Dental Surgeons	421	0	0	0	0
Pharmacist	421	421	421	0	0
Lab Technician	421	421	421	0	0
Nursing Staff	421	1120	738	382	*
Community Healthcare Centres (CHC's)					
Doctors	92	*	*	*	*
Ayush Doctors	92	0	0	0	92
Surgeon	92	154	9	145	83
Obstetricians and Gynaecologists	92	62	20	42	72
Physicians	92	62	10	52	82
Paediatrician	92	62	19	43	73
Dental Surgeons					
Total Specialist	368	340	58	282	310
General Duty Medical Officers	184	340	181	159	3
Radiographer	92	92	14	78	78
Pharmacist	92	92	89	3	3
Lab Technician	92	92	84	8	8
Nursing Staff	644	644	509	135	135

(Table 20-Source: Rural health Statistics[531])

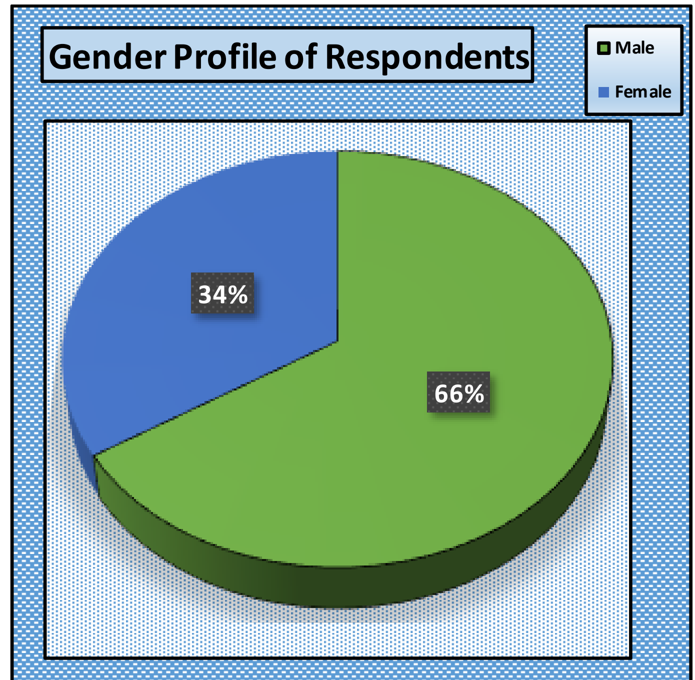
In the current study the data was collected by circulating a semi-structured questionnaire with 42 questions. The questionnaire had questions aiming to understand the personal and household profile of the respondent, the perception of respondent on the public and private healthcare in their area, status of healthcare in the surveyed area and the impact of governmental schemes.

[531] Ministry of Health and Family Welfare; Government of India (n 531).

The below tables 15 and figure 17 demonstrates the status of healthcare in surveyed tribal region.

5.2.2 Table 22: Gender Profile of the Respondents

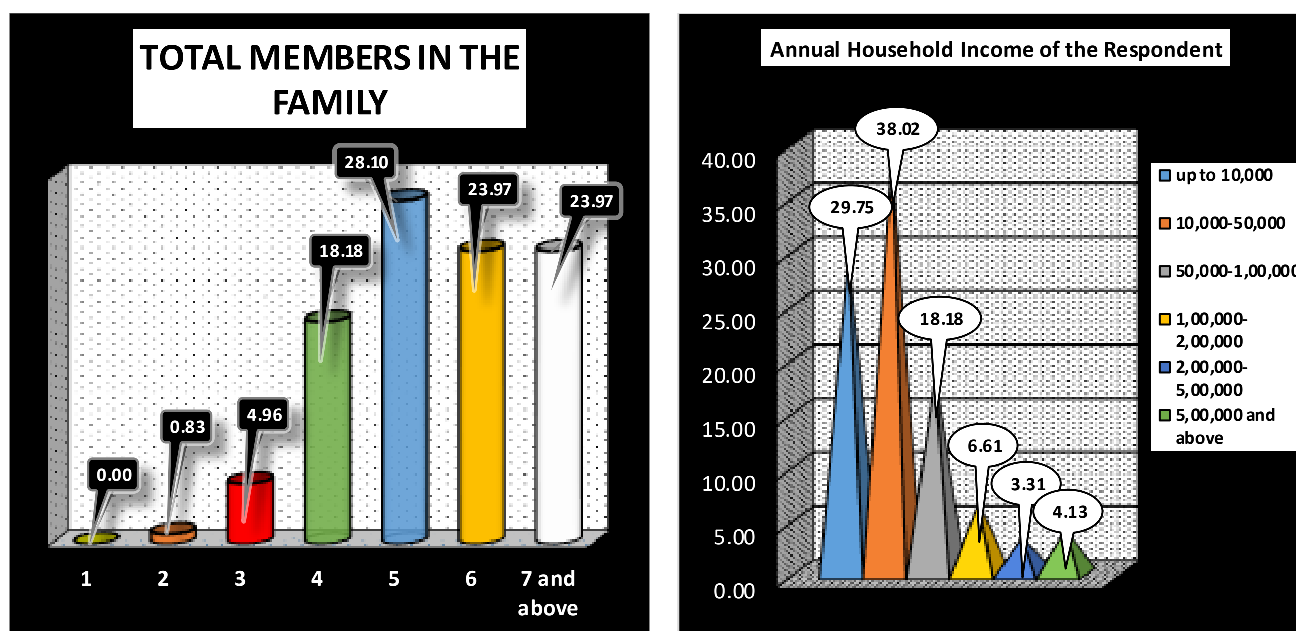
Gender Profile of Respondents		
Category	**Percentage**	**Frequency**
Male	66.12	80
Female	33.88	41
Third Gender	0.00	0
Prefer Not to say	0.00	0



(Figure 17-Source: Data collected by the researcher)

The table 21 above demonstrates the gender profile of the respondents from tribal region. Among the respondents' majority were male (66.12%) and only 33.88% females were willing to be part of the study.

5.2.3 Figure 18 and 19: Household Profile of the Respondent



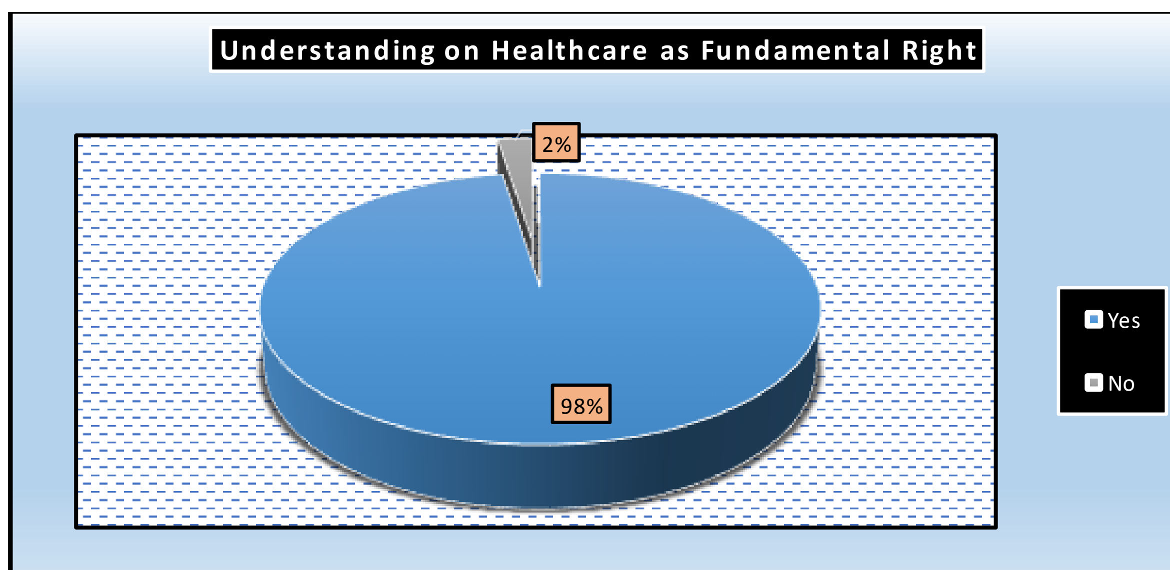
(Figure 18-Source: Data Collected by the researcher) **(Figure 19-Source: Data Collected by the researcher)**

The figures above illustrate that out of total respondents 28.10 % is having 5 members in the family followed 23.97% households having 6 and 7 and above respectively. Very less percentage i.e., 4.96% and 4.96% are having 2 and 3 members respectively in the family. On the other side the annual household income of the majority families (38.02%) are between Rs. 10,000-50,000 followed by 29.75% having only up to Rs. 10,000. Minority i.e., 3.31% and 4.13% are recorded to having an annual income of Rs. 2-5 lakhs and 5 lakhs and above respectively. It has been found that of all the respondents more than 29.75% belongs to BPL category.

5.2.4 Figure 20: Understanding of Respondent on Healthcare as a Fundamental Right

As mentioned in the previous chapter, though healthcare is not an explicitly guaranteed right under the Constitution of India, it has been recognized as a part of right to life under A. 21 by the Hon'ble apex court through its various judgements. Now the status of healthcare as a fundamental human right is an established right beyond any doubt.

Accordingly, the state has an obligation to provide quality healthcare to all its citizens without any discrimination. This question was included in the survey to understand the perception and understanding of the respondents on healthcare as a right.

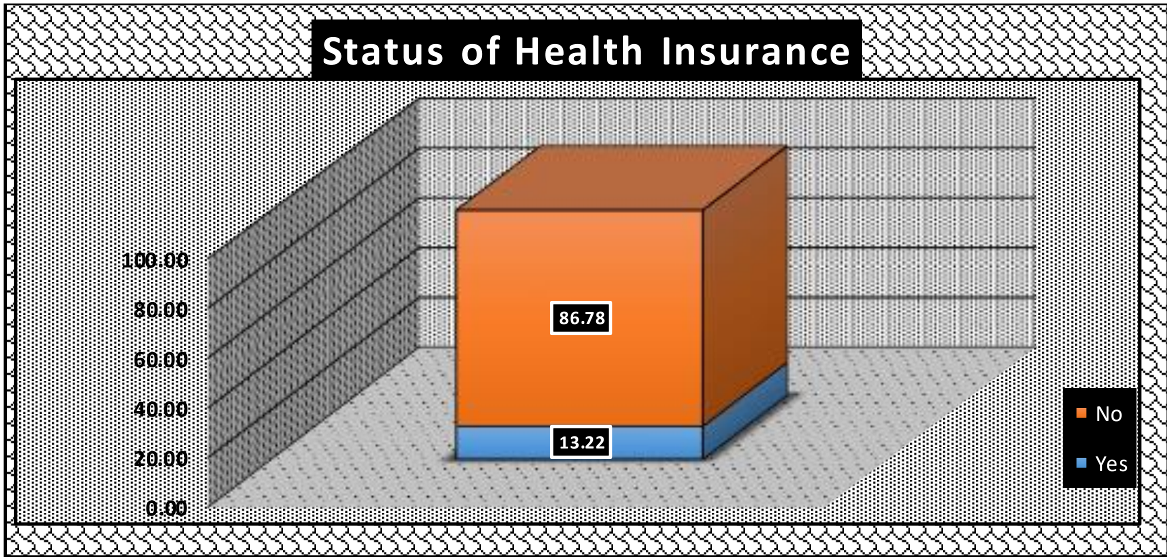


(Source: Data Collected by the researcher)

Surprisingly 98% of the total respondents believes that healthcare is a fundamental right though they are not aware about how to protect the same. Only 2% seems to be unaware of this fact.

5.2.5 Figure 21: Status of Health Insurance

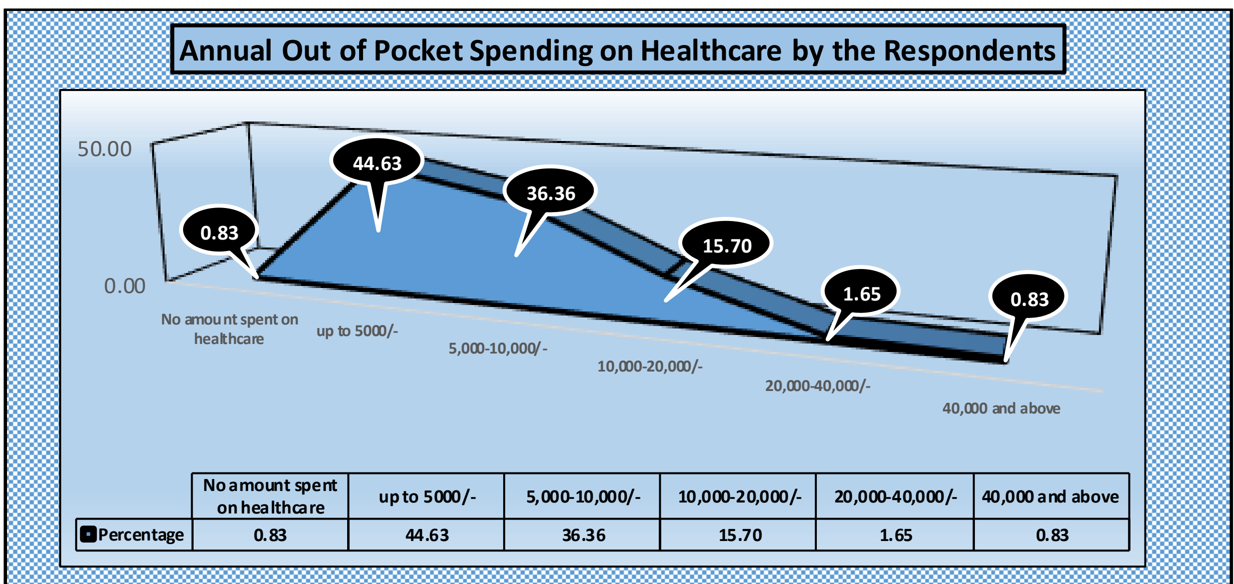
In India the total public and private health expenditures as a proportion of GDP are anticipated to be 3.9 percent, well below the global average of 9.9 percent. Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana has not been able to achieve its objective 'to provide cash less paper less access to healthcare to the public' even after 3 years of its implementation. The funding for the public health insurance scheme is divided between Central Government and State Government in 60:40 ratios respectively. As per the reports the private health insurance scheme covers 36% of the of the total insured in India.



(Source: Data Collected by the researcher)

It has been found in the study that out of the total surveyed respondents only 13.22% are having health insurance, majority i.e., 86.78% respondents were not having any insurance coverage.

5.2.6 Figure 22: Annual Out of Pocket (OOP) spending on healthcare by Respondents



	No amount spent on healthcare	up to 5000/-	5,000-10,000/-	10,000-20,000/-	20,000-40,000/-	40,000 and above
Percentage	0.83	44.63	36.36	15.70	1.65	0.83

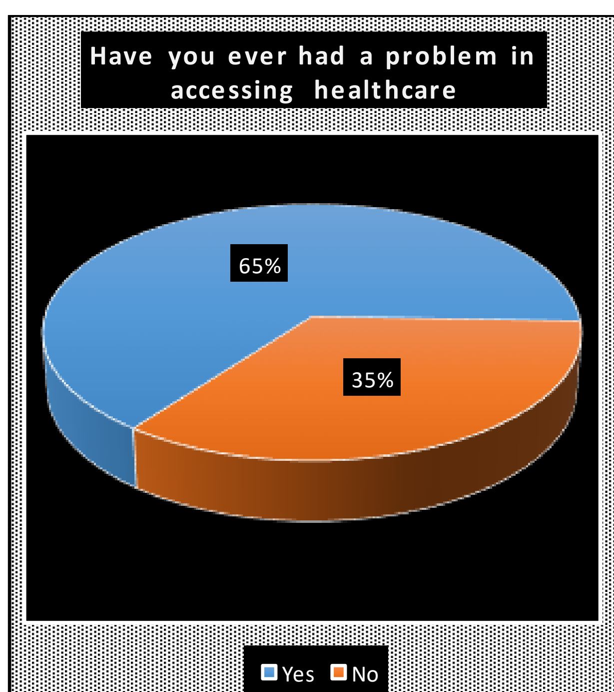
(Source: Data Collected by the researcher)

Out of Pocket payments are the payments directly made by the patients at the point of relieving healthcare. In India citizen can get free care in public healthcare units however

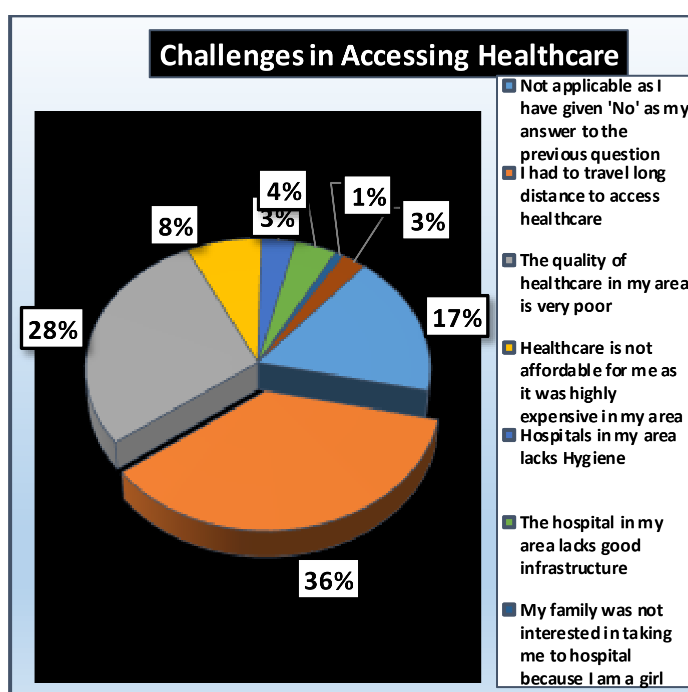
due to low healthcare funding by the government the coverage doesn't care medication, ambulance, in some cases bed and special cares by the private hospitals. The figure 22 above depicts that 44.63% of the respondents are spending around RS.5000/- per annum on healthcare followed by 36.36% spending RS.5000-10,000/-; 15.70% spending RS. 10,000-20,000/-; RS. 20,000-40,000/- and 0.83% spending RS.40, 000/- and above. Only 0.83% responded that they don't spend any amount on healthcare.

5.2.7 Figure 23 and 24: Responses on Problems Faced in Accessing Healthcare

The study found that 65% of the tribal population faced problem in accessing healthcare in their region. The reported challenges for non-accessibility are 36% of the respondents blaming the distance of healthcare units from their residents as barrier; 28% highlighting poor quality as the reason; 8% quoting affordability due to high cost as the issue; followed by 4%, 3% and 3% accusing poor infrastructure, lack of hygiene and lack of human resources respectively. 1% responded that they were not given access to healthcare by the family as they were females.



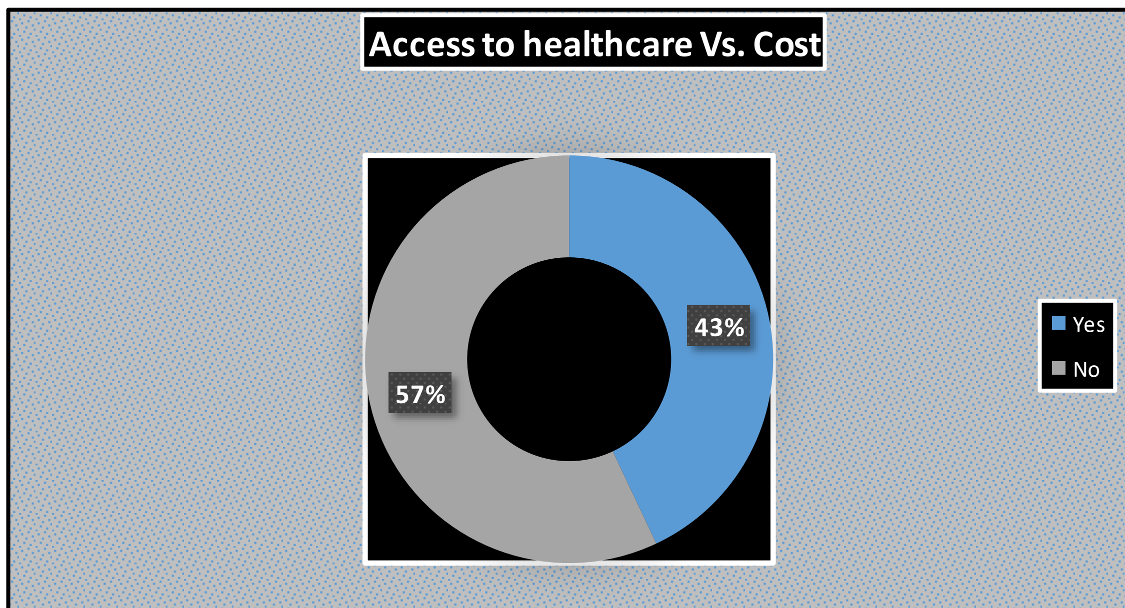
(Figure 23-Source: Data Collected by the researcher)



(Figure 24-Source: Data Collected by the researcher)

5.2.8 Figure 25: Have you ever had to forgo health care because of costs?

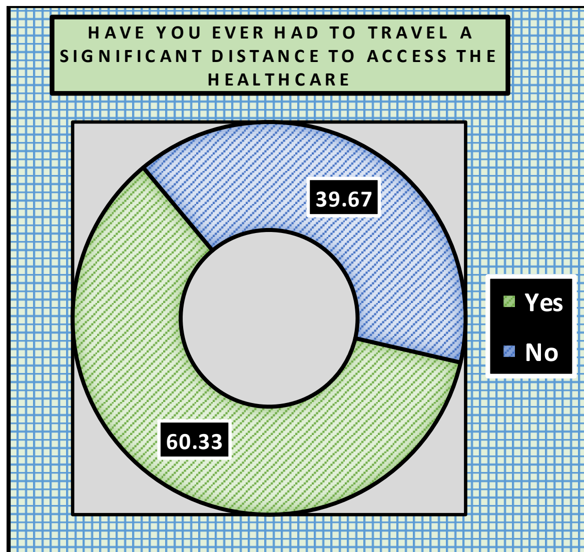
The relation between income and social status cannot have a one-to-one relation in developing nations like India. Income inequality plays a vital role in depriving millions of impoverished populations from accessing basic necessities which include healthcare too. The vulnerable sections are undergoing severe health issues due to poor standard of living, which leads them to spend more on healthcare and the same in turn forces them to embrace poverty.

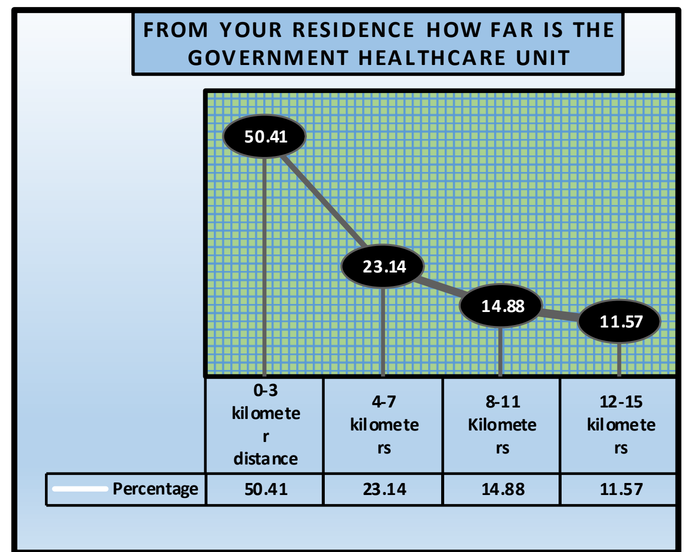


(Figure 25-Source: Data Collected by the researcher)

The 2013 Planning Commission report demonstrated that 48.6% of the Scheduled Tribe population in Gujarat were belonged to BPL category. In the present study also 29.75% belongs to BPL category. From the figure 25 above it is clear that majority (57%) of the total respondents never experienced income deficiency in accessing healthcare and 43% had to forgo healthcare due to cost.

5.2.9 Figure 26 & 27: Distance Vs. Access to Healthcare



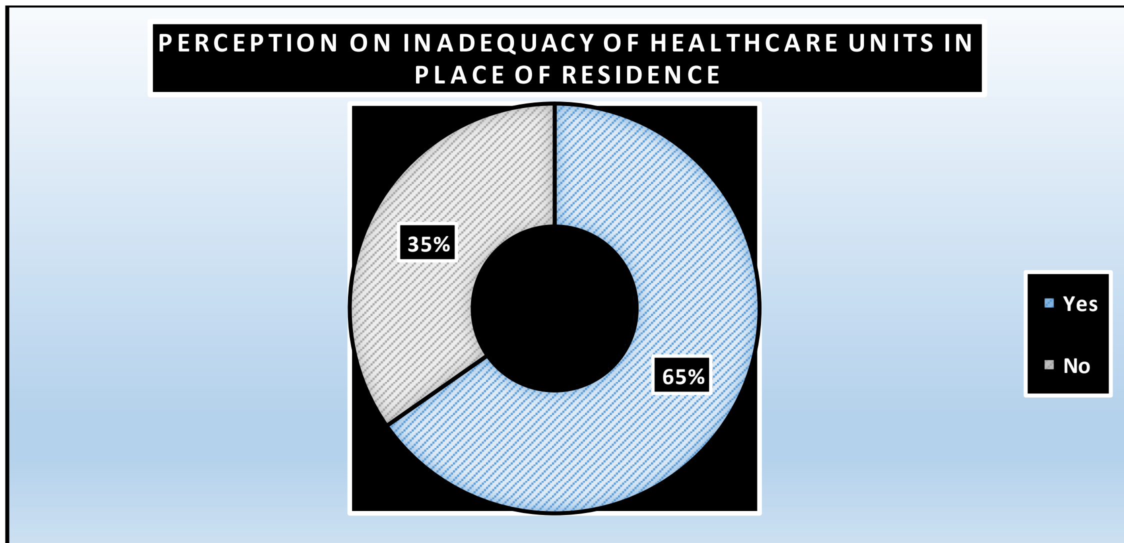


(Figure 26-Source: Data Collected by the researcher) **(Figure 27-Source: Data Collected by the researcher)**

This question was included in the questionnaire to understand whether the healthcare facilities are easily accessible to this vulnerable group or not. The figure 26 above shows that 60.33% of the respondents had faced challenges in accessing healthcare due to the distance where as 39.67% have not faced ant such issues. Figure 27 makes it clear that of the total respondent's half of the participants (50.41%) had access to healthcare within 3KM distance followed by 23.14 having it in 4-7 KM distance and 14.88 had healthcare units within 8-11 KM distance. It was 12-15 KM distance for 11.57% of the respondents.

5.2.10 Figure 28: Do you think that there are insufficient public healthcare units (Government) in the area of your residence?

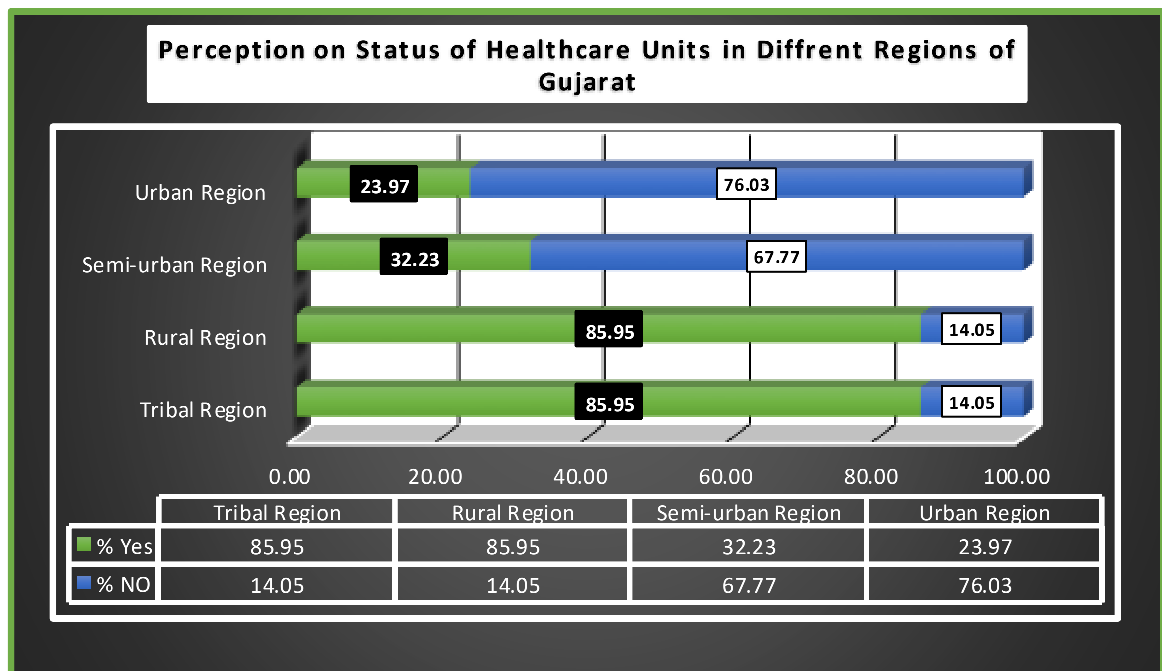
Though 50% of the participants said they have access to healthcare units within 3 KM of their residence, still 65% believes that there are inadequate number of healthcare units in their area. This opinion can be due to non-availability of quality healthcare units or special care services. Whereas 35% of the respondents were of the opinion that the number of hospitals are adequate in their area.



(Figure 28-Source: Data Collected by the researcher)

5.2.11 Figure 29: Do you think that there are insufficient public healthcare units in Tribal, Rural, Semi-urban and Urban areas of Gujarat?

The idea behind keeping this question was to record the understanding of respondents on the status of number of healthcare units in different regions of Gujarat.



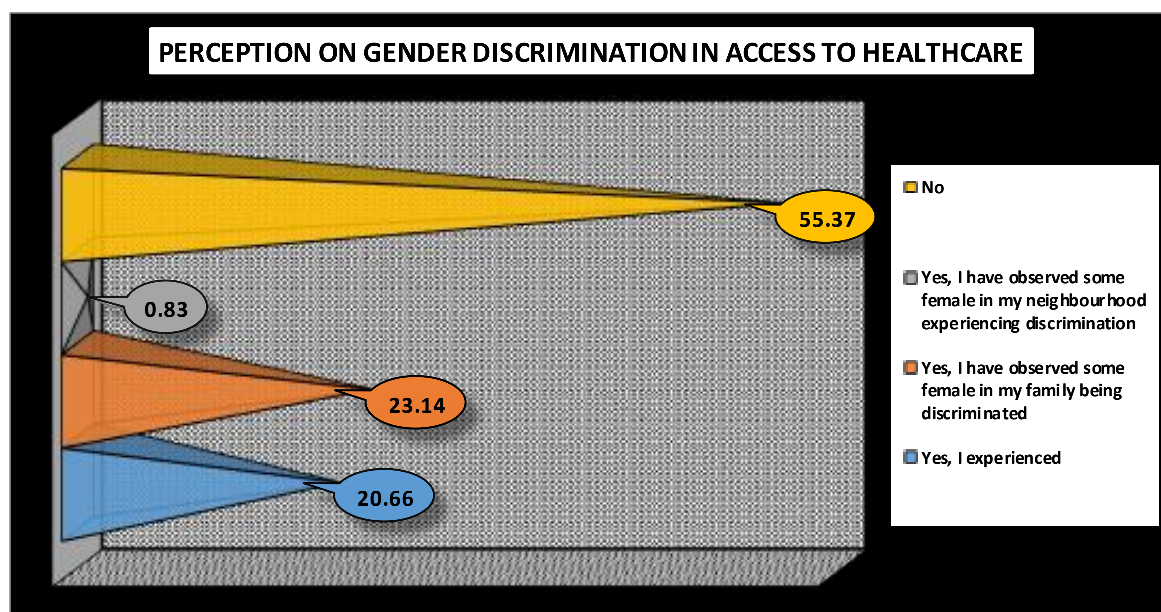
	Tribal Region	Rural Region	Semi-urban Region	Urban Region
% Yes	85.95	85.95	32.23	23.97
% NO	14.05	14.05	67.77	76.03

(Figure 29-Source: Data Collected by the researcher)

Against the thump rule of one Sub-Centre for 3000-5000 population, one PHC for 20,000-30,000 population and one CHC for 1,00,000 population Government of Gujarat has created 2519 sub-centers, 203 PHC's, 259 HWC-SC, 218 HWC-PHC and 92 CHC's. That means every 43927 people has access to one PHC, 3539.97 has access to one sub-center, 96925.80 has access to one CHC. Only number of PHC is less as compared to the standard set by the government of India.

Figure29 illustrates that 85.95% of the respondents think that there is inadequate public healthcare facilities in tribal and rural region, 32,23 % and 23.97% each believes it is inadequate in semi-urban and urban region too. Whereas majority 67.77% and 76.03% expressed that semi-urban and urban area has enough number of healthcare units.

5.2.12 Figure 30: Have you/someone in your family/neighborhood ever experienced discrimination based on gender while trying to access healthcare?

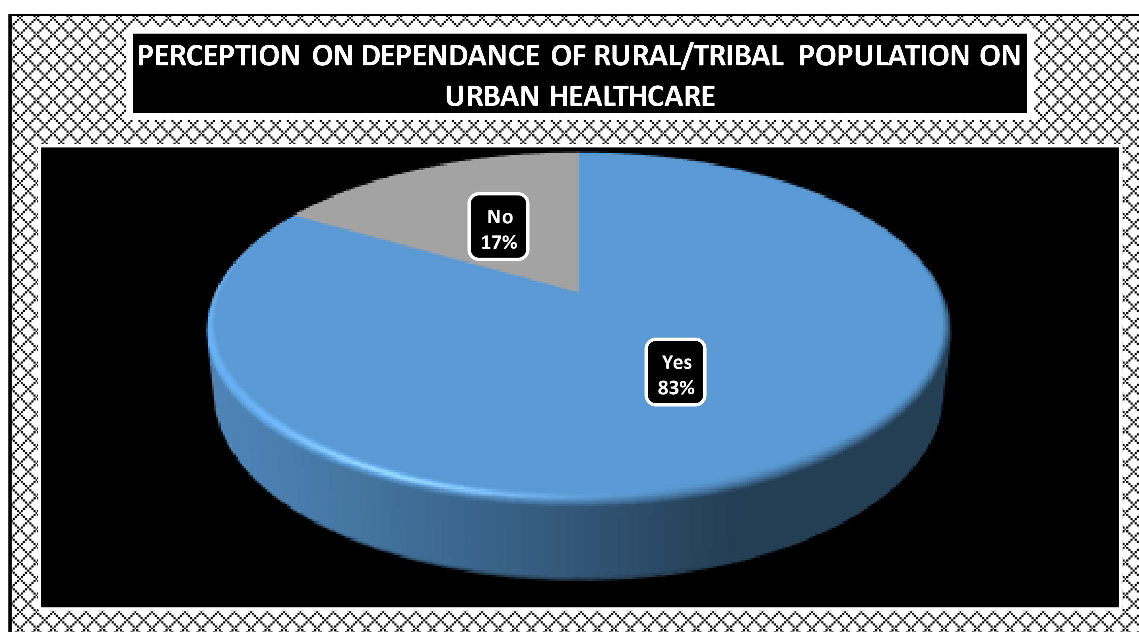


(Figure 30-Source: Data Collected by the researcher)

One of the objectives of the study is to understand the status of discrimination based on gender in accessing healthcare in the surveyed households. In India since time immemorial the society assigns women a subordinate position. This practice is the residue of the

'Patriarchal system' prevalent in our country. This gender-based discrimination has been a barrier in development of females in our nation. This has deprived a considerable percentage of female population from accessing every basic right like education, food, healthcare etc. The above figure 30 depicts that 55.37% of the respondents disagreed to the query about gender discrimination in access to healthcare. As per their experience neither someone in their family nor in neighborhood ever has undergone such discrimination. Whereas 23.14% of the respondents expressed that they have observed females in their family being discriminated in case of access to healthcare, means they were not given the healthcare assistance by the family when they were in need of the same. Similarly, 20.66% of the participants expressed that they have experienced gender-based discrimination in their family while trying to access the health care. 0.83% of the respondents said that they have observed women deprived of access to healthcare in their neighborhood.

5.2.13 Figure 31: Perception on Dependence of Rural/Tribal Population on Urban Health care



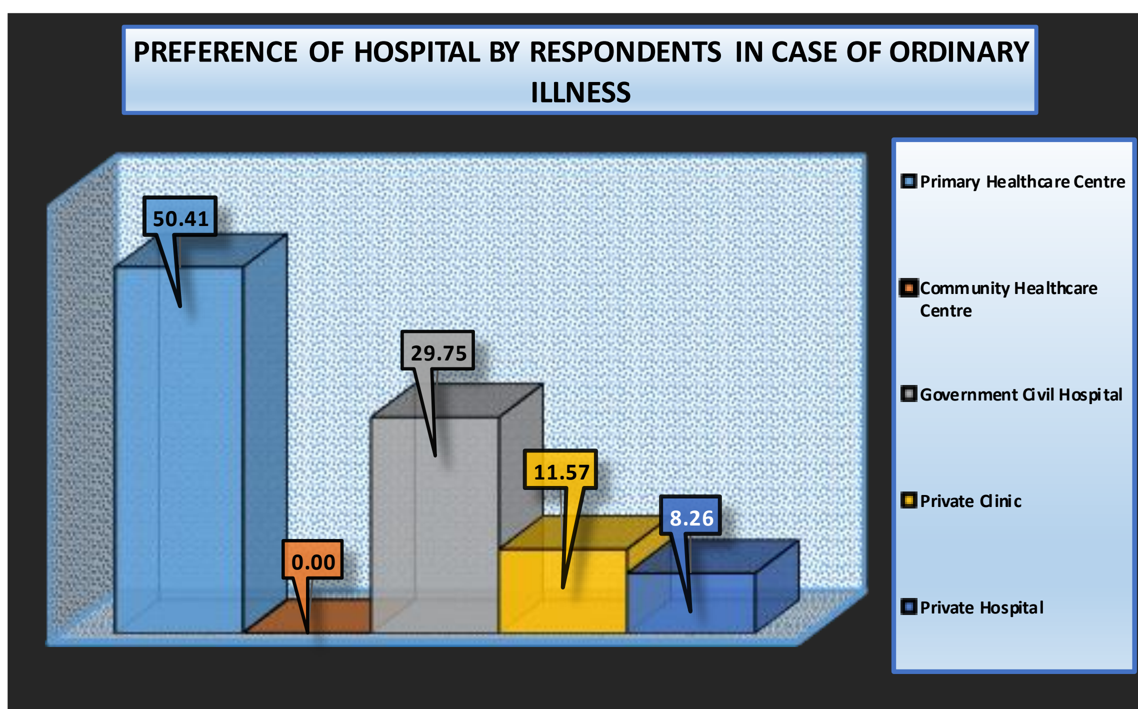
(Figure 31-Source: Data Collected by the researcher)

As per the findings majority (83%) of the respondents believe that rural/tribal population are dependent on urban healthcare whereas only 17% think otherwise. As per the

observation of the researcher from the field there are more options with all modern facilities are available in urban areas as compared to rural or tribal areas. In case of any serious illness, urban hospitals, both public and private are the only answers to the patients and their family.

5.2.14 Figure 32: Preference of hospitals by the respondents in case of Ordinary Illness

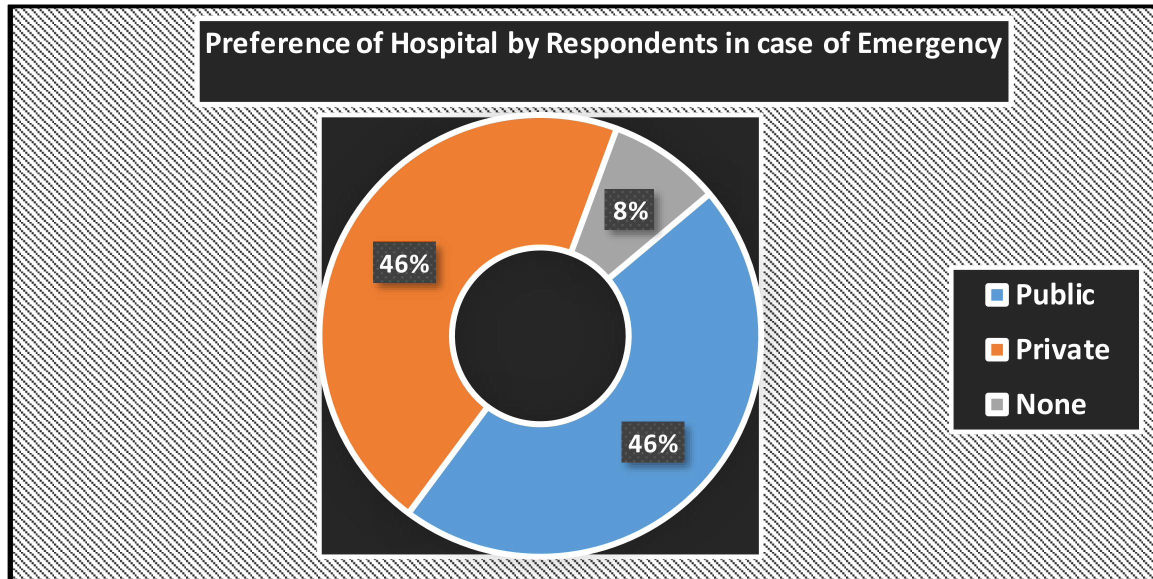
The figure 32 elucidates that majority (50.41%) of the participants were of the opinion that they would prefer primary healthcare in case of ordinary illness; 29.75% voted for government civil hospital; 11.57% opined that they would prefer private clinic and 8.26% private hospital. Unfortunately, no one selected Community Healthcare Centre, this is mainly due to the unawareness of public about the services provided by CHC's.



(Figure 32-Source: Data Collected by the researcher)

5.2.15 Figure 33: Which system would you prefer in case of Emergency?

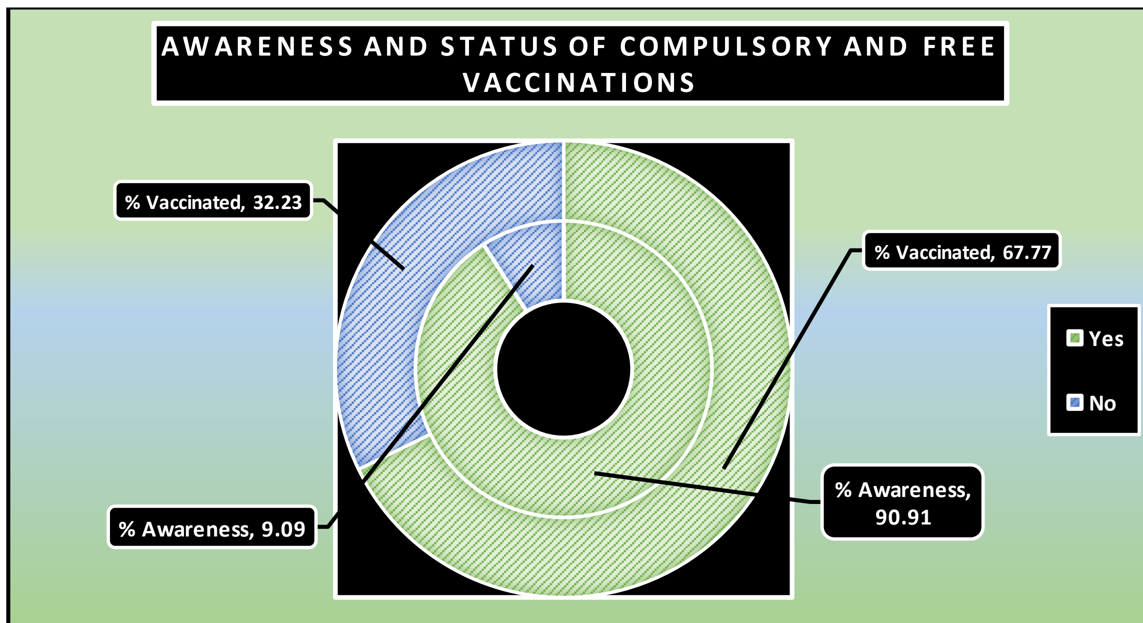
It has been found in the study that 46% of the respondents opined that they will prefer public healthcare system in case of emergency similarly 46% voted in favor of private healthcare system and 8% said they will neither prefer public healthcare system nor private but traditional method.



(Figure 33-Source: Data Collected by the researcher)

5.2.16 Figure 34: Awareness and Status of Compulsory and Free Vaccinations

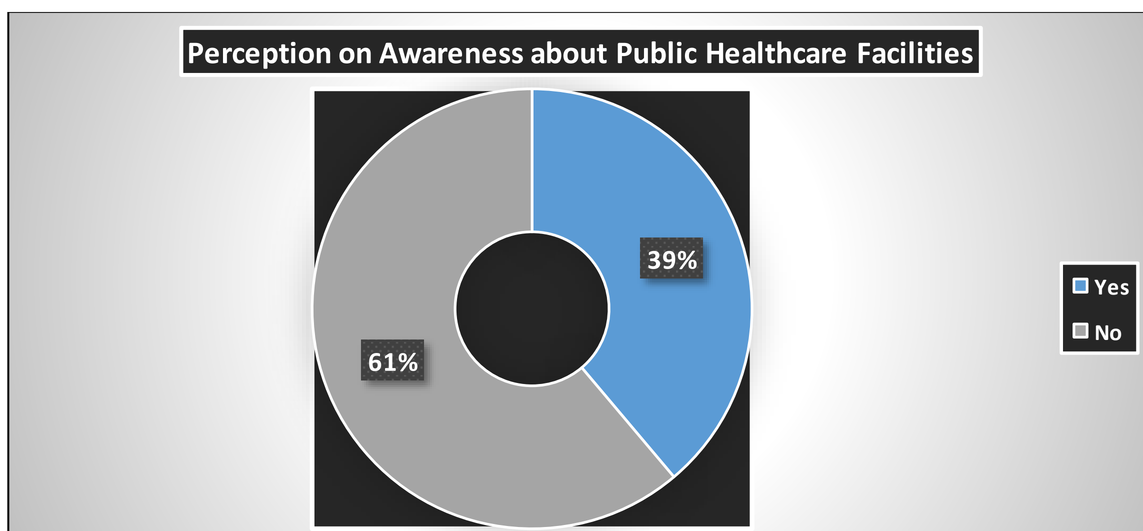
The figure 34 is the comparative analysis of both awareness and status of compulsory and free vaccination among the respondent's households. It has been found that this programme is one of the most successful programme of the government as the survey recorded 90.91% awareness and 60.77% households have admitted that they have completely vaccinated the children under the Universal Immunization Programme. However even after 36 years of its implementation there still exist a gap which is evident from the above data that even in the present day 9.09% of the participants were unaware of the same.



(Figure 34-Source: Data Collected by the researcher)

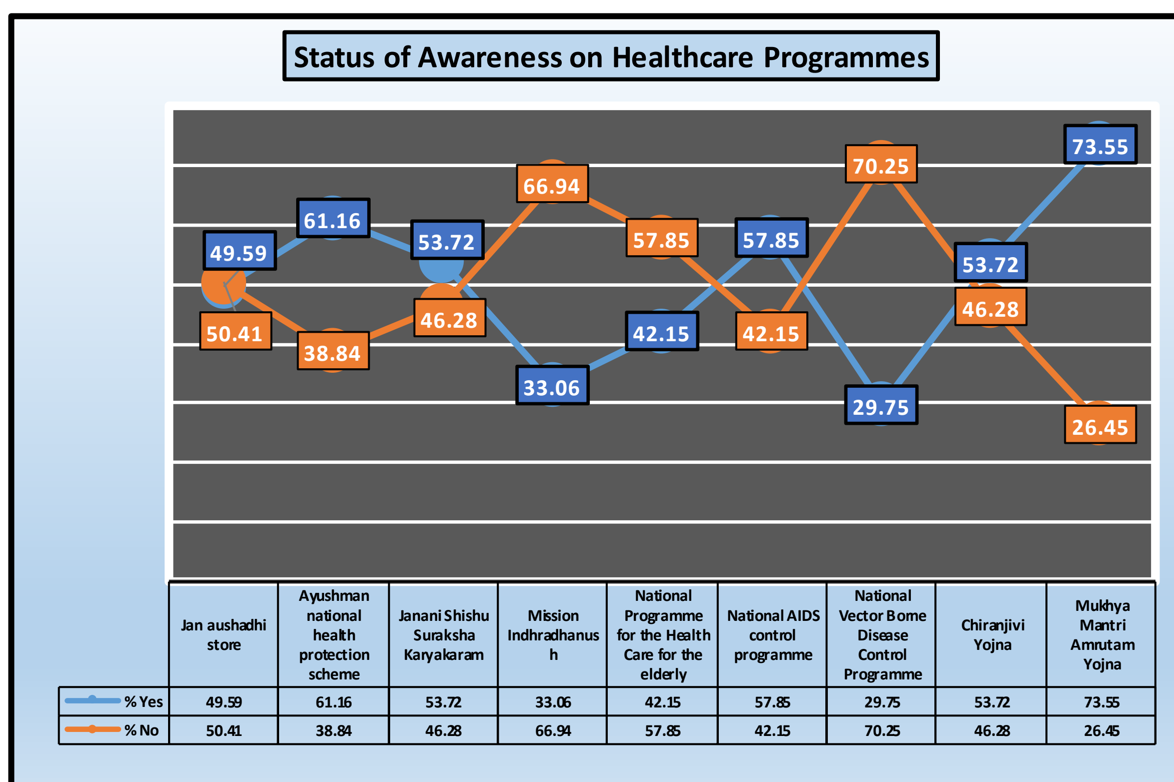
5.2.17 Figure 35: Do you think you have enough information about the healthcare facilities provided by the Gujarat government?

The question about awareness on the healthcare facilities provided by the Government of Gujarat yielded a mixed opinion. Majority of the respondents (61%) opined that there is lack of awareness on the same whereas 36% believes that they have awareness on the same.



(Figure 35-Source: Data Collected by the researcher)

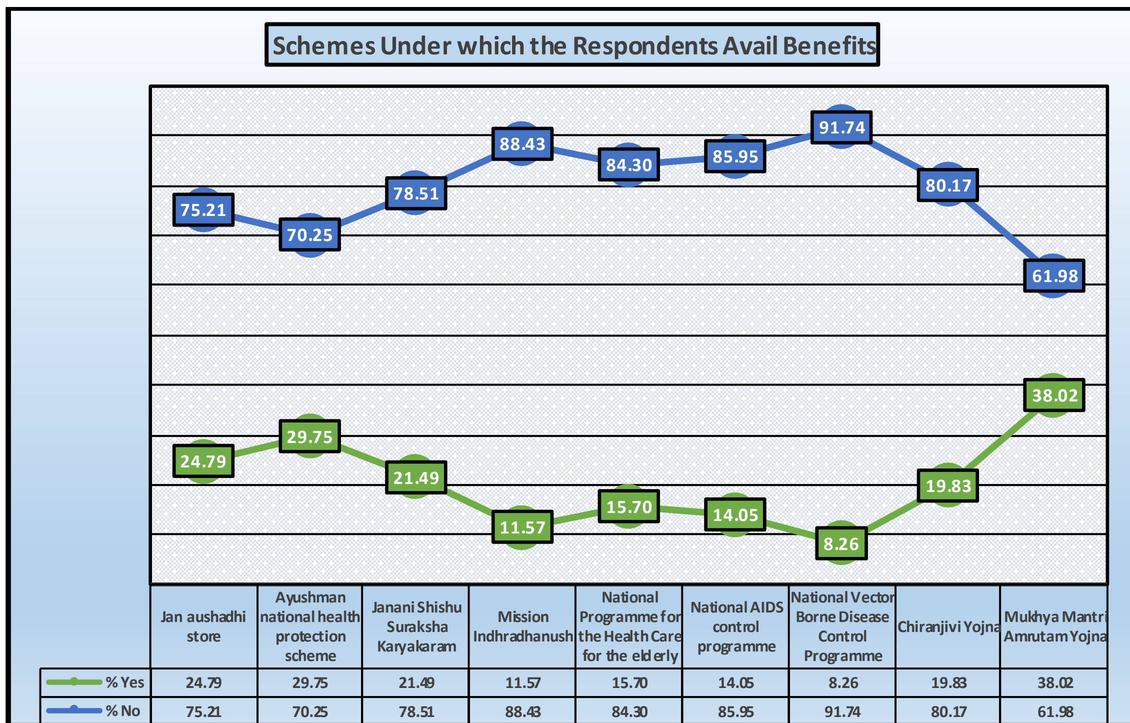
The below figure 36 depicts the responses on the specific question asked to understand the awareness of respondents on different government programmes implemented in state of Gujarat. The selected programmes for the survey were Jan Aushadhi store, Ayushman national health protection scheme, Janani Shishu Suraksha Karyakaram, Mission Indhradhanush, National Programme for the Health Care for the elderly, National AIDS control programme, National Vector Borne Disease Control Programme, Chiranjivi Yojna, Mukhya Mantri Amrutam Yojna. It has been found that above 50% of the participants were aware of all the above-mentioned government programmes. Majority (73.55%) of the respondents were aware of the Mukhya Mantri Amrutam Yojna followed by 61.16% respondents having awareness on Ayushman National Health Protection Scheme; 57.85 National AIDS control Programme; 53.72% each for Janani Shishu Suraksha Karyakram and Chiranjivi Yojna. National Vector Borne Disease Control Programme; Mission Indhradhanush, National Programme for the Health Care for the elderly and Jan Aushadhi Stores were the programmes having below 50% awareness.



	Jan aushadhi store	Ayushman national health protection scheme	Janani Shishu Suraksha Karyakaram	Mission Indhradhanus h	National Programme for the Health Care for the elderly	National AIDS control programme	National Vector Borne Disease Control Programme	Chiranjivi Yojna	Mukhya Mantri Amrutam Yojna
% Yes	49.59	61.16	53.72	33.06	42.15	57.85	29.75	53.72	73.55
% No	50.41	38.84	46.28	66.94	57.85	42.15	70.25	46.28	26.45

(Figure 36-Source: Data Collected by the researcher)

The findings depict that very less percentage of the respondents are availing benefits under the identified schemes. Only 38.02% are availing benefit under Mukhya Mantri Amrutam Yojna; 29.7% under Ayushman National Health Protection scheme, 21.49% under Janani Shishu Suraksha Karyakram (Refer Figure 36).

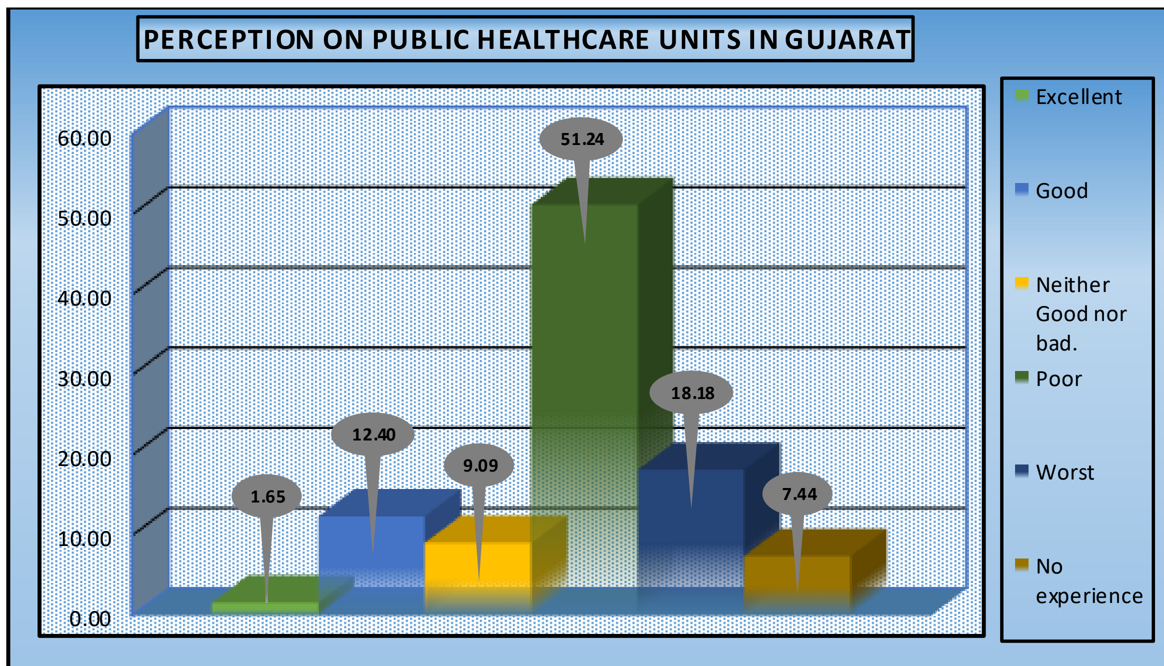


	Jan aushadhi store	Ayushman national health protection scheme	Janani Shishu Suraksha Karyakaram	Mission Indhradhanush	National Programme for the Health Care for the elderly	National AIDS control programme	National Vector Borne Disease Control Programme	Chiranjivi Yojna	Mukhya Mantri Amrutam Yojna
% Yes	24.79	29.75	21.49	11.57	15.70	14.05	8.26	19.83	38.02
% No	75.21	70.25	78.51	88.43	84.30	85.95	91.74	80.17	61.98

(Figure 37-Source: Data Collected by the researcher)

5.2.18 Figure 38: Perception of Respondents on Public Healthcare Units in Gujarat

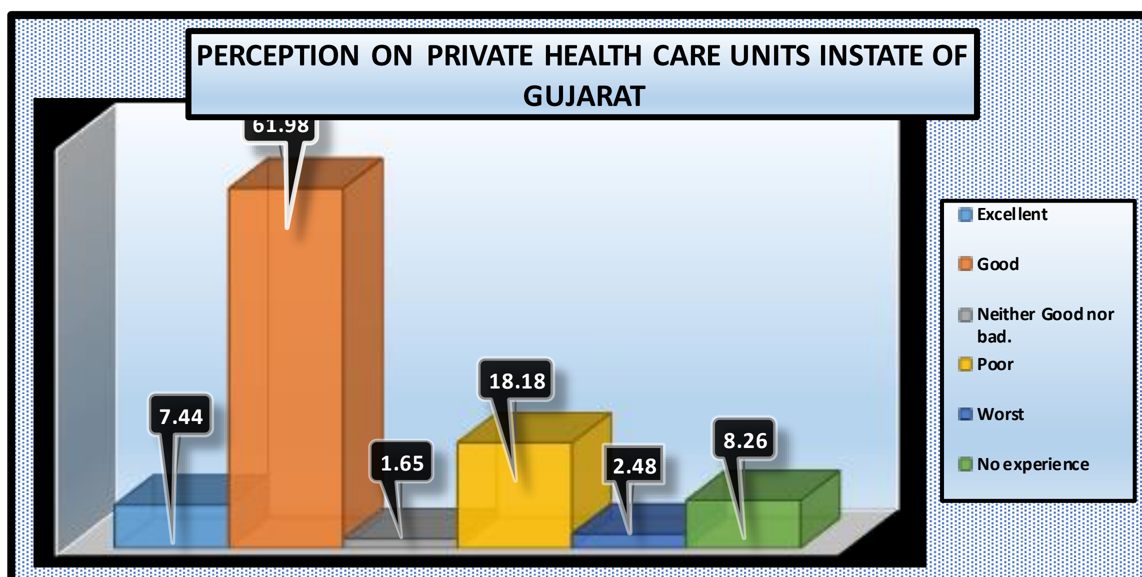
The below figure 38 illustrates that 51.24% of the respondent opined that the public healthcare system is poor followed by 18.18% rating it as worst; 12.40% voted it as good; 9.09 as neither good nor bad; 1.65% voted it as excellent.



(Figure 38-Source: Data Collected by the researcher)

In addition to rating the system they also have shared some of their concerns also regarding the system. Few among them include at least one district hospital should be there in each district; amenities and services are needs to be maintained regularly; should work on cleanliness infrastructure and quality. 24 X 7 services should be made available. It should be accessible, affordable and acceptable to public; should be upgraded expanded with latest equipment's and technology larger area and also rural areas with adequate staff and effective implementation of schemes not happening; number of beds in PHC's should be increased; special and emergency care with surgeon and anesthetist should be made available in PHC's of tribal regions. More awareness of the government schemes and programmes are required.

5.2.19 Figure 39: Perception of Respondents on Public Healthcare Units in Gujarat



(Figure 39-Source: Data Collected by the researcher)

Majority (61.98%) of the respondents were of the opinion that the private healthcare system is good. Unanimously everyone opined that it is not accessible due to the cost and due to which 8.26% expressed that they never had any experience with private healthcare system. 18.18% of the respondents rated it as poor.

There were concerns expressed by the respondents about the nature of the service providers in private healthcare system as they found them arrogant. 7.44% thought private healthcare system is excellent.

5.3 Findings and Discussion from Rural Regions of Gujarat

The population of Gujarat state in rural area accounts 57.40% of the total population. As per the census 2011 Gujarat state has 34,694,609 people living in villages of rural Gujarat[532]. As a result of implementation of two-tier healthcare system in rural areas in 1952, Gujarat also implemented the same with 6 bedded PHC and four Sub-centers. In 1978 following the concept of three tier system originated in Alma-ata-declaration, India

532 Census 2011, "Gujarat Population 2011-2021" (2011) <https://www.census2011.co.in/census/state/gujarat.html> accessed November 14, 2021.

being a signatory to the same executed the practice in our nation under Five-Year Plans. To conceptualize "Health for All" the country concentrated on making primary healthcare accessible affordable and acceptable to public without any discrimination.

Gujarat has 9166 Sub-centers, 1476 PHC's and 362 CHC's in Rural areas. Which means the state has one Sub-Centre for every 3,953 people, one PHC for every 24,549 people and one CHC for 1,00.097 people. The state has 6 SC's per PHC and 4 PHC's per CHC in the rural region. It has been reported that the state has 545 PHC's functioning with 2 Doctors, 92 with 1 Doctor and 67 without doctors. 104 of them are without lab technician, 122 functioning without pharmacist and 561 without lady Doctor. One main fact to be noted that none of the PHC's in rural areas of Gujarat are working 24X7. 841 of the 1476 PHC's are having Ayush facility.

The Deputy Director Rural Health organizes, implements and monitors rural healthcare under the guidance of Commissioner health and Additional Director health[533]. The below table illustrates the number of hospital staff and the shortfall of the doctors, nurses, midwives and other hospital staff in various public healthcare units in rural Gujarat as on 2019.

5.3.1 Table 23: Data of healthcare Workers at Public Healthcare Units at Rural Gujarat

Data of Healthcare Workers at Public Healthcare Centres in Rural Gujarat					
Category	**Required**	**Sanctioned**	**In position**	**Vacant**	**Shortfall**
Sub-Centres					
Auxiliary Mid Wife (ANM-Female)	9166	9166	8631	535	535
Health Worker (Male)	9166	9137	7940	1197	1226
Primary Healthcare Units (PHC's)					

533 "Rural Health | Commissionerate of Health | Health and Family Welfare Department" <https://gujhealth.gujarat.gov.in/rural-health.htm> accessed November 14, 2021.

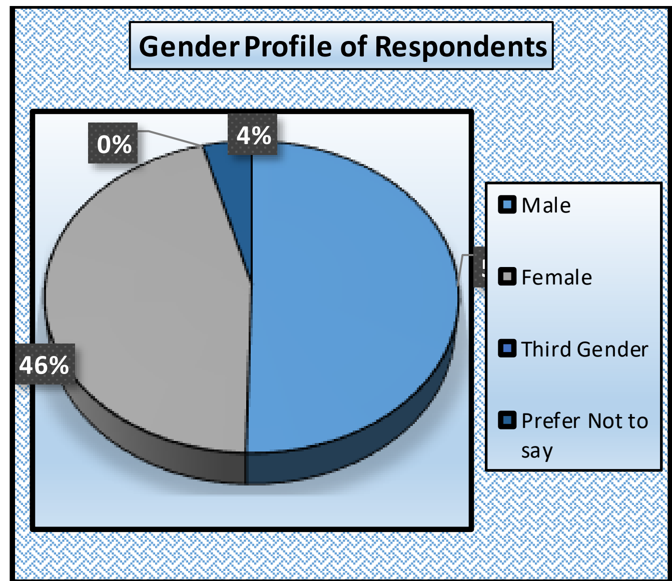
Health Worker (Female)	1476	1476	537	939	939
Health Assistants (Female)	1476	2165	1710	455	*
Health Assistants (Male)	1476	1396	936	460	540
Doctors	1476	2639	2186	453	*
Ayush Doctors	1476	1692	1273	418	*
Dental Surgeons	1476	0	0	0	0
Pharmacist	421	421	421	0	0
Lab Technician	421	421	421	0	0
Nursing Staff	421	1120	738	382	*
Community Healthcare Centres (CHC's)					
Ayush Doctors	362	0	0	0	*
Surgeon	362	363	31	332	331
Obstetricians and Gynaecologists	362	88	48	40	318
Physicians	362	62	9	53	353
Paediatrician	362	88	30	58	332
Dental Surgeons	724	362	265	97	459
Total Specialist	1448	601	118	483	1330
General Duty Medical Officers	724	1151	955	196	*
Radiographer	362	364	192	172	170
Pharmacist	1476	1476	1360	116	116
Lab Technician in	1476	1476	1358	91	91
Nursing Staff	1476	2554	1708	846	*

Source: Rural Health Statistics 2018-19[534]

[534] Ministry of Health and Family Welfare; Government of India (n 531).

5.3.2 Table 24: Gender Profile of Respondents

Category	Frequency	Percentage
Male	61	50%
Female	55	46%
Third Gender	0	0%
Prefer not to say	5	4%

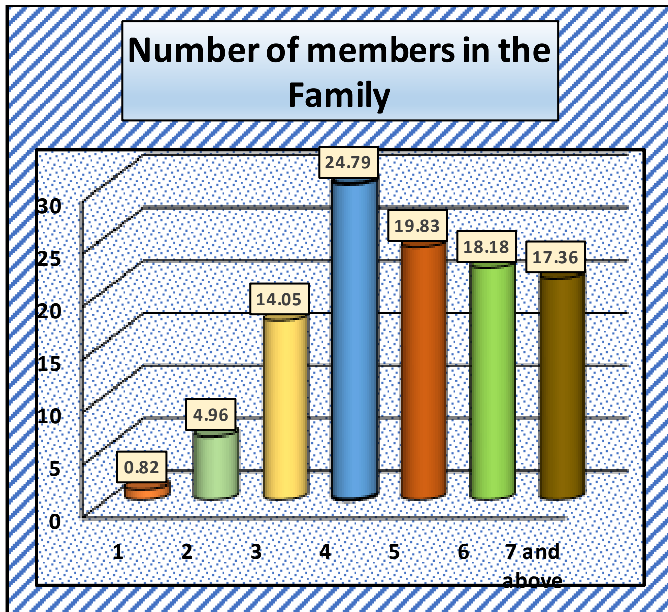


(Figure 40-Source: Data collected by the researcher)

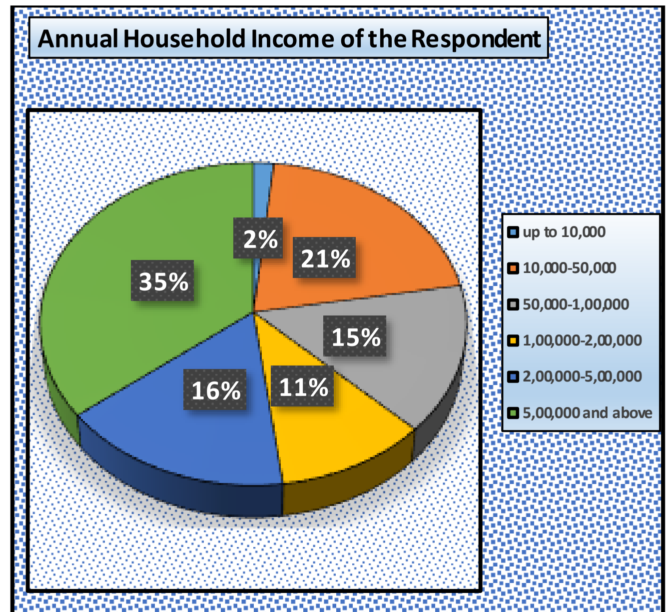
The female to male sex ratio in rural Gujarat 949 females per 1000 males as per the 2011 Census. The table 23 above demonstrates that in the current study out of the total participated respondents 50% were male; 46% female and 4% were not ready to disclose their gender.

5.3.3 Figure 41 & 42: Household Profile of the Respondent

The figure 41 below illustrates that out of total respondents 24.79% is having 4 members in the family followed by 19.83% households having 5 members. Very less percentage i.e., 4.96% and 14.05% households are having 2 and 3 members respectively in the family. On the other side the annual household income of the surveyed rural households found to be slightly on the higher side as compared to the tribal households. Majority (35%) were having more RS.5,00,000/- as annual income followed by 21% having between Rs. 10,000-50,000/-; 16% reported to having 2- 5 lakh per annum and 10.74% said 1-2 lakh. The study found that only 2 out of 121 respondents said to be having an income below RS. 10,000/- per annum. It has been found that of all the respondents only 2% belongs to BPL category.



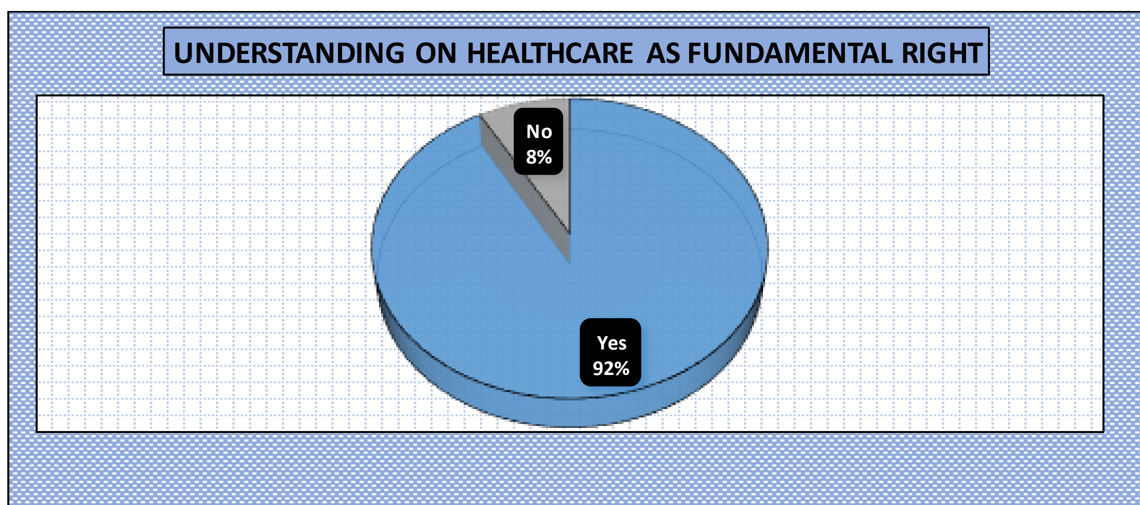
(Figure 41-Source: Data collected by the researcher)



(Figure 42-Source: Data collected by the researcher)

5.3.4 Figure 43: Do you think Healthcare is a Fundamental Right

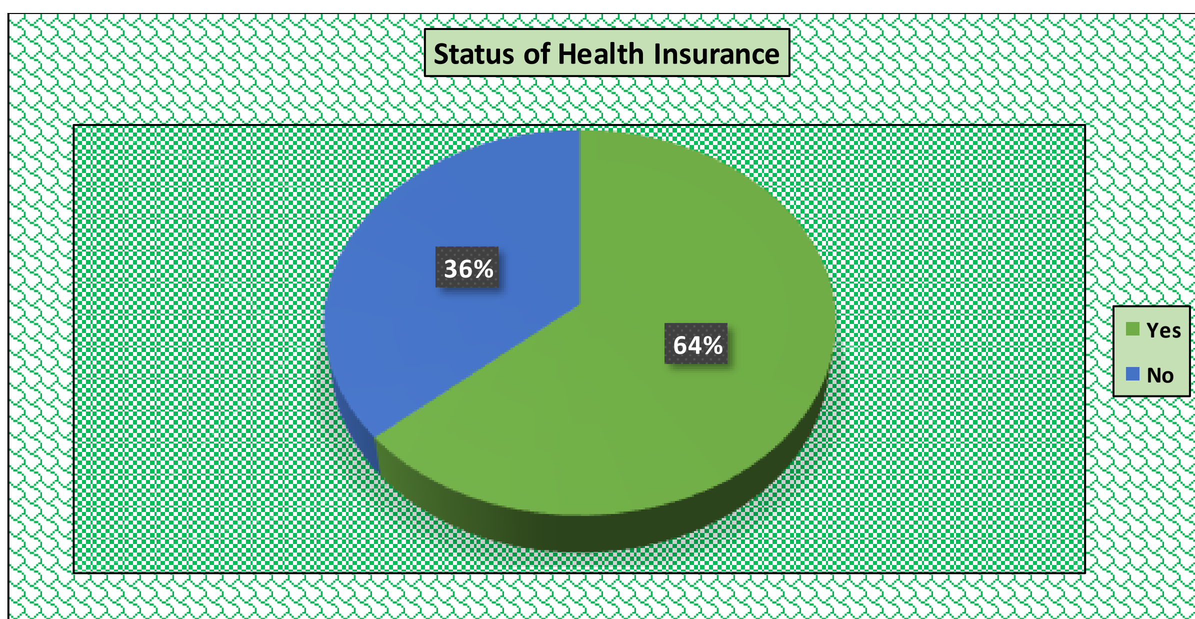
The above figure 43 makes it clear that majority of the rural population thinks that healthcare is a fundamental right. 92% of the participants answered as yes and negligible amount (8%) doesn't think it is a fundamental right. In the field investigation one fact observed by the researcher is that though majority is aware that healthcare is a fundamental human right, they don't have any clue on how this right can be protected.



(Figure 43-Source: Data collected by the researcher)

5.3.5 Figure 44: Status of possession of Health Insurance by the Respondents

Ministry of Labor and Employment, Government of India in 2008 launched Rashtriya Swasthya Bima Yojana (RSBY) with an aim to provides a wide range of hospital-based healthcare services to Below Poverty Line (BPL) families. However, under the public healthcare system the insurance coverage is only for the hospitalization services and expenses associated with inpatient care and they are expected to incur expenses on medicine, tests, post-treatment care, outpatient care etc. In addition to RSBY there is Mukhya Mantri Amrutam (MA) Yojna, Rogi Kalyan Samiti, Bal Sakha Yojna, Janani Suraksh yojna etc implemented by Government of Gujarat.



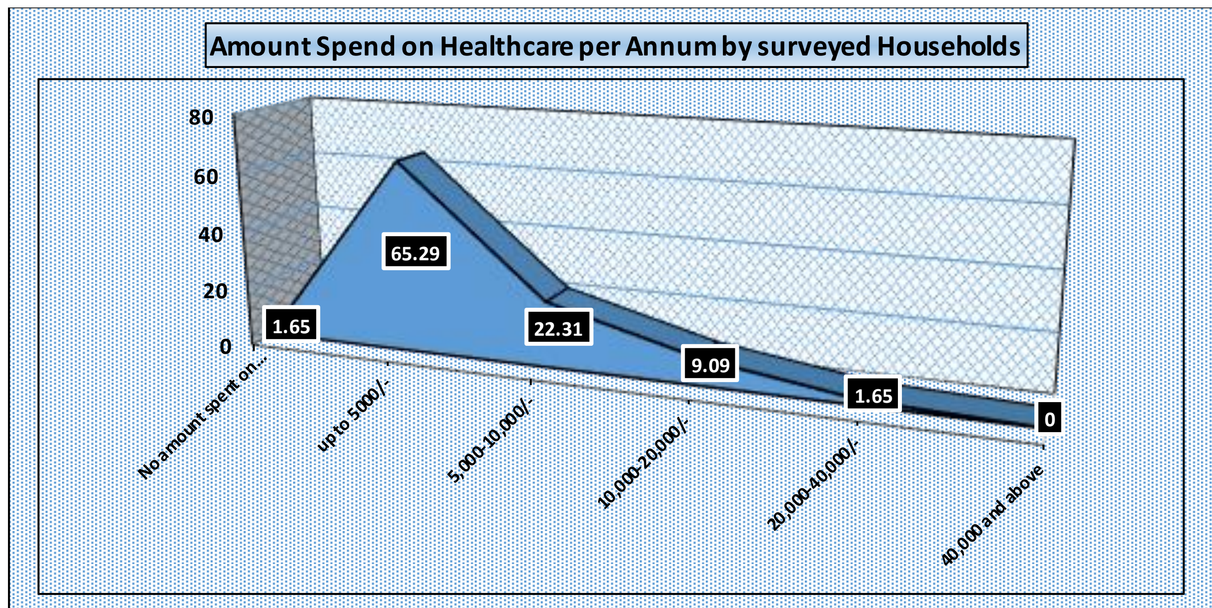
(Figure 44-Source: Data collected by the researcher)

The above figure 44 illustrates that of the total respondents 64% are having public health insurance coverage where as 36% are not having health insurance.

5.3.6 Figure 45: Out of Pocket (OOP) Spending on Healthcare by the Respondents

In the study it has been found that majority (65.29%) of the respondents are spending up to RS. 5,000/- on healthcare followed by 22.31% spending RS. 5,000-10,000/-; 9.09% spends between RS. 10,000-20,000/- and 1.65% between RS. 20,000-40,000/- annually.

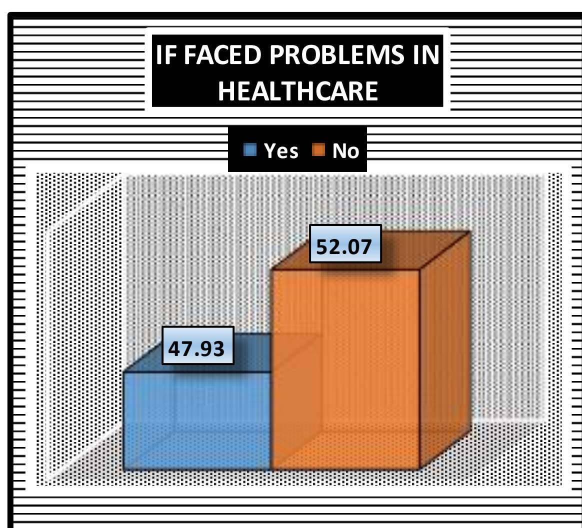
None of the participant responded to be spending more than RS. 40,000/- and a minority (1.65%) expressed that they don't spend ant amount on healthcare.

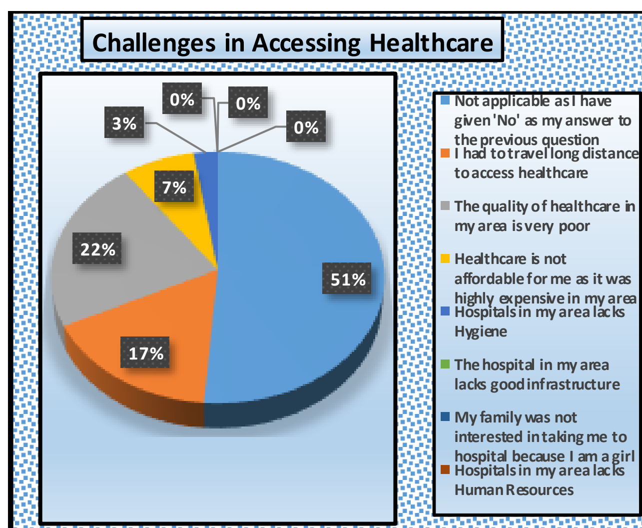


(Figure 45-Source: Data collected by the researcher)

5.3.7 Figure 46 & 47: Responses on Challenges Faced in Accessing Healthcare

The study found that 52.07% of the surveyed population didn't face any issue in accessing healthcare whereas 47.93% has answered that they had to undergo some challenges in accessing healthcare at their area of residence.

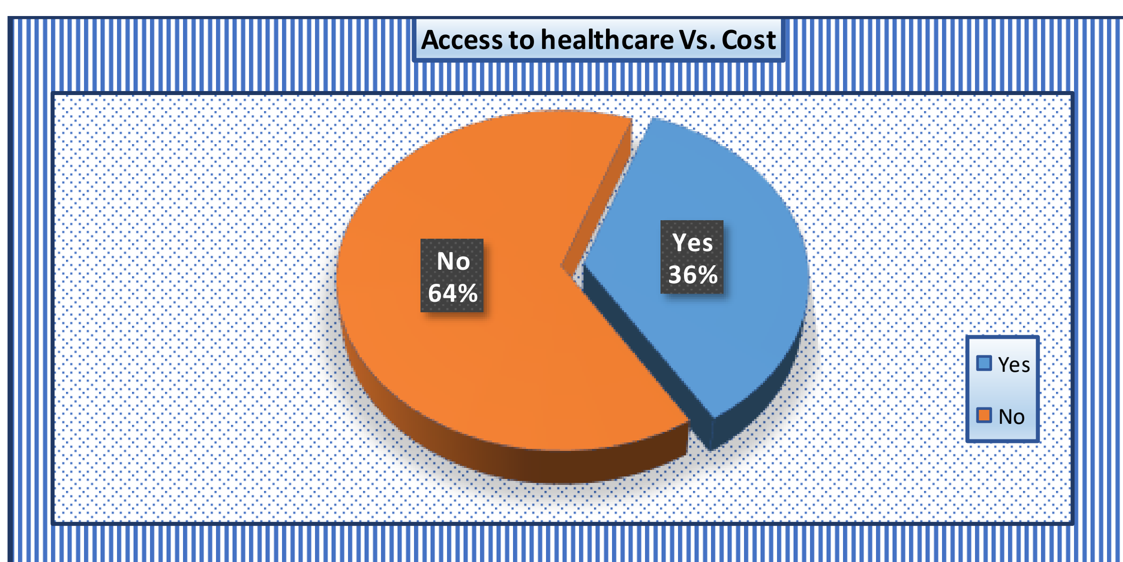




(Figure 46-Source: Data collected by the researcher) (Figure 47-Source: Data collected by the researcher)

The reported challenges for non-accessibility are 2236% of the respondents believes that the quality of healthcare in the public healthcare units at their area is poor; 16.53% highlighted distance as the barrier; 7.44% quoted affordability due to high cost as the issue; and 2.48% expressed lack of hygiene as the issue. However, 51.24% didn't face any issue in accessing healthcare.

5.3.8 Figure 48: Have you ever had to forgo health care because of costs?



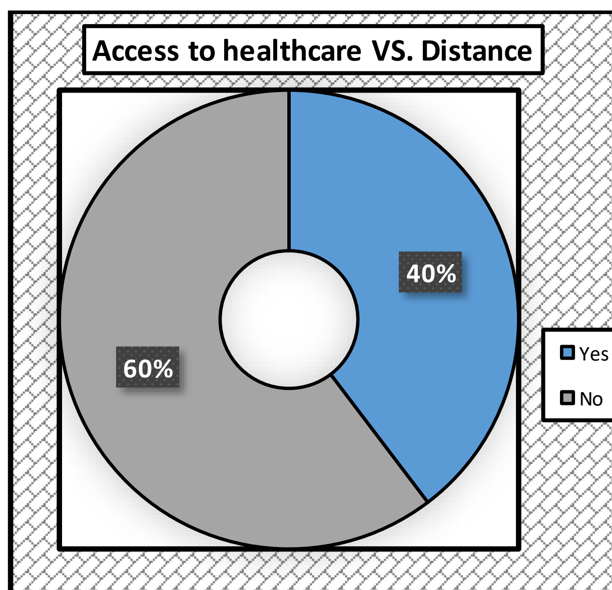
(Figure 48-Source: Data collected by the researcher)

It has been found in the study that majority (64%) didn't face any issue due to economic inefficiency where as 36% had to forgo healthcare due to cost. One of the objective of implementing health insurance schemes by the government was to encourage vulnerable sections to access hospitals in case of any illness, but this has not been very successful as the schemes give only limited coverage.

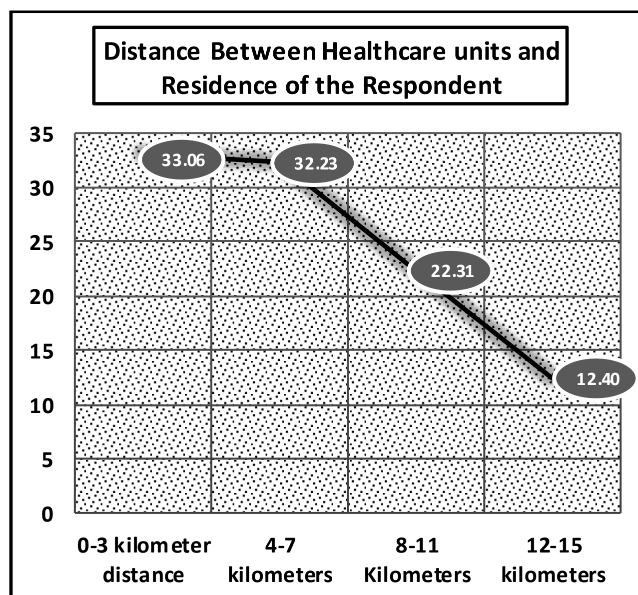
5.3.9 Figure 49 & 50: Status of Distance of Healthcare Units from the Residence of Respondents

The figure 49 below shows that 60 % of the respondents never had any issue in accessing healthcare due to distance whereas 40% opined that they had to travel a significant distance to access healthcare.

Figure 50 makes it clear that of the total respondent's 33.06% expressed that they have access to healthcare within 0-3 KM of distance from their residence; 32.23% having access to healthcare in 4-7 KM distance; 22.31% having in 8-11 KM distance and 12.40 % having healthcare providers in 12-15 KM distance. This is one of the reasons for less public (vulnerable section) accessing healthcare.



(Figure 49-Source: Data collected by the researcher)

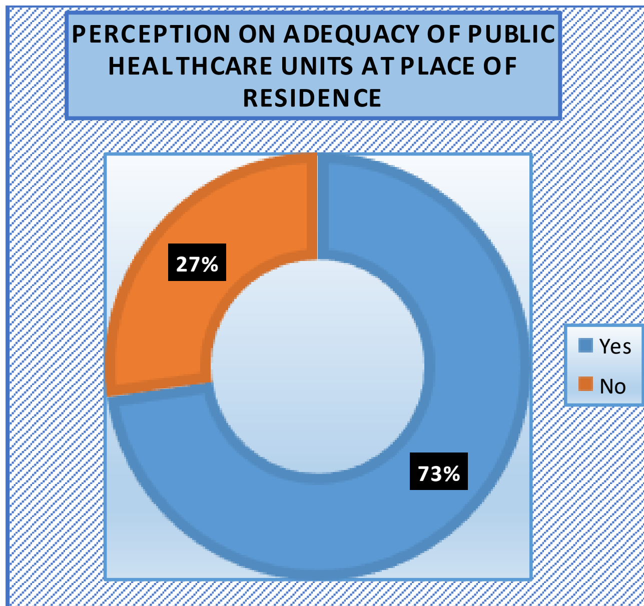


(Figure 50-Source: Data collected by the researcher)

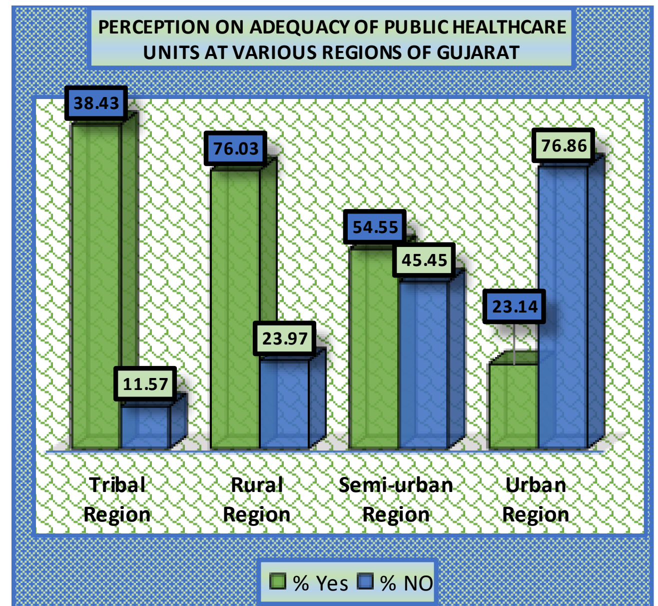
5.3.10 Figure 51 & 52: Perception on Adequacy of Public Healthcare units

Though Government of Gujarat has developed ample number of public healthcare units in the rural areas of Gujarat none of the sub-centres and PHC's are 24X7 functional. Also, the services available in such centres are also limited. Hence in case of emergency the rural population has to travel long distance to access healthcare. The present study found that 72.73% of the respondents expressed that there is inadequate number of healthcare units in their area of residence (refer figure 51 below).

The figure 52 (below) demonstrates the perception of respondents about the adequacy of healthcare units in different regions of Gujarat. It has been found that 88.43% opined that there is insufficient healthcare units in Tribal region; 76.03% respondents found that even rural area has inadequate number of healthcare units; 54.55% expressed even semi-urban region lacks hospitals and regarding urban healthcare system 23.14% feels the same.



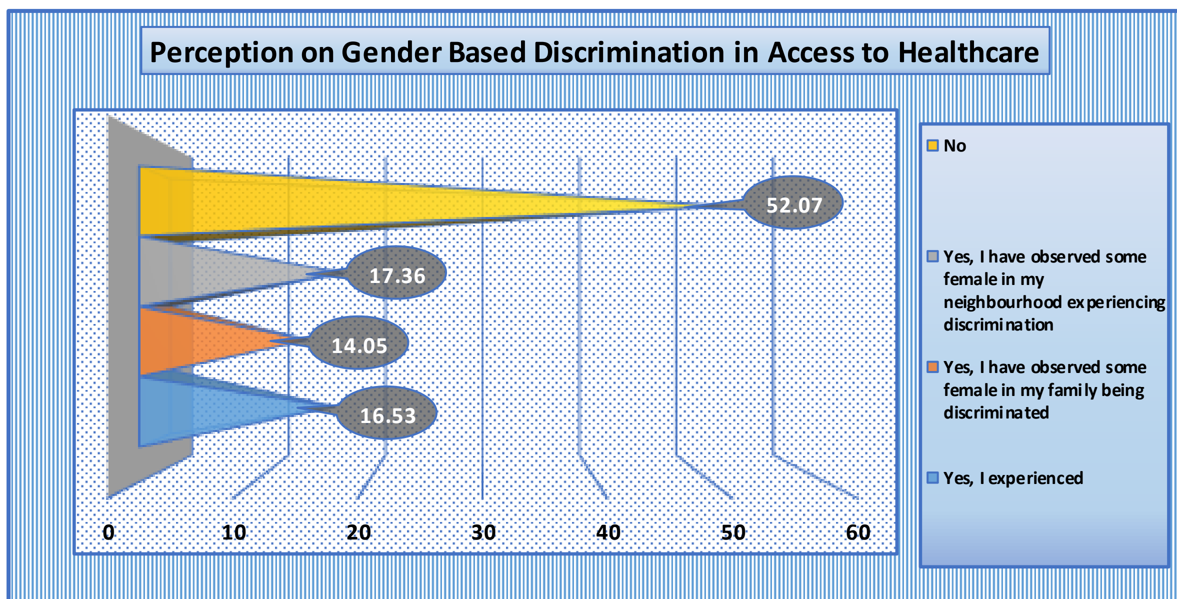
(Figure 51-Source: Data collected by the researcher)



(Figure 52-Source: Data collected by the researcher)

5.3.11 Figure 53: Have you/someone in your family/neighborhood ever experienced discrimination based on gender while trying to access healthcare?

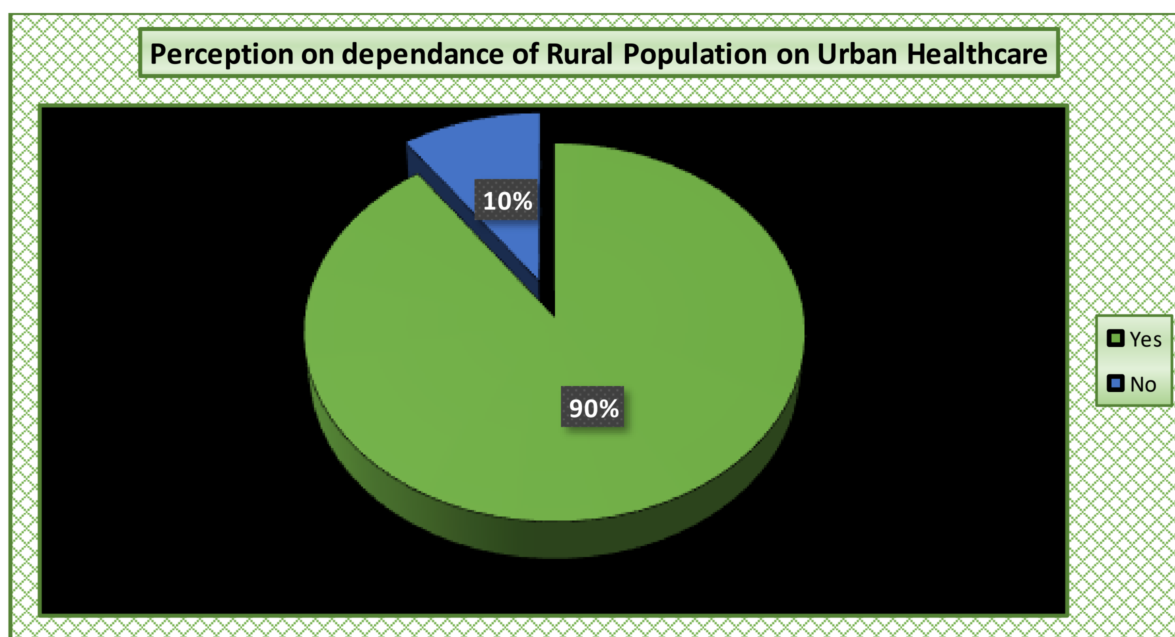
As mentioned above gender-based discrimination is an integral part of Indian society even after seven decades of independence.



(Figure 53-Source: Data collected by the researcher)

The above figure 53 depicts that 52.07% of the respondents disagreed to the query about experiencing gender discrimination in access to healthcare. As per their experience neither someone in their family nor in neighborhood ever has undergone such discrimination. Whereas 17% of the respondents said that they have observed women deprived of access to healthcare in their neighborhood followed by 16.53% expressing that they have undergone such discrimination from their own family and 14.05% observed females in their family being discriminated in case of access to healthcare.

5.3.12 Figure 54: Perception on Dependence of Rural/Tribal Population on Urban Health care

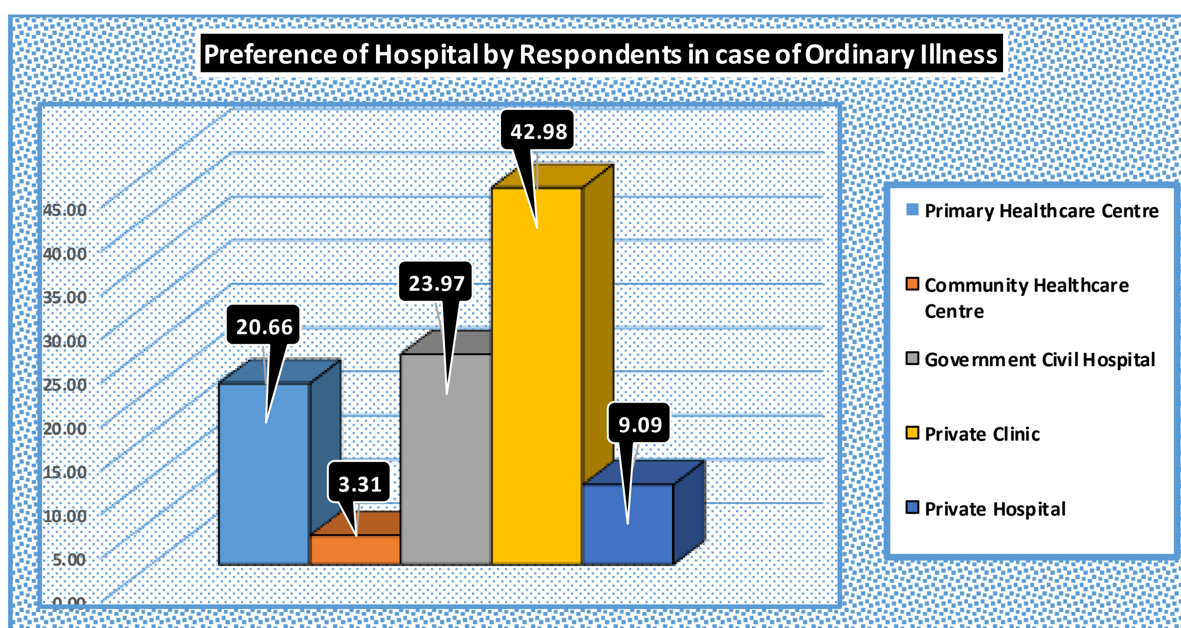


(Figure 54-Source: Data collected by the researcher)

As per the findings 90% of the surveyed population from the rural region agrees that the rural population is largely dependent on the urban healthcare whereas 10% differed in their views. Urban areas have healthcare system with more quality, in addition to the same the District Hospitals of the government are also situated in urban areas, hence the rural and tribal population have to travel to urban region for good care. Similarly, urban areas have got number of private multi-specialty hospitals and in case of serious and critical illness, people rather prefer them than the public healthcare units in their area.

5.3.13 Figure 55: Preference of hospitals by the respondents in case of Ordinary Illness

The below figure 55 elucidates that majority (42.98 %) of the participants were of the opinion that they would prefer private clinic in case of ordinary illness; 23.97% voted for government civil hospital; 20.66% opined that they would prefer Primary Healthcare Centre; 9.09% private hospital and very less percentage of population (3.31%) choose CHC's in case of general illness.

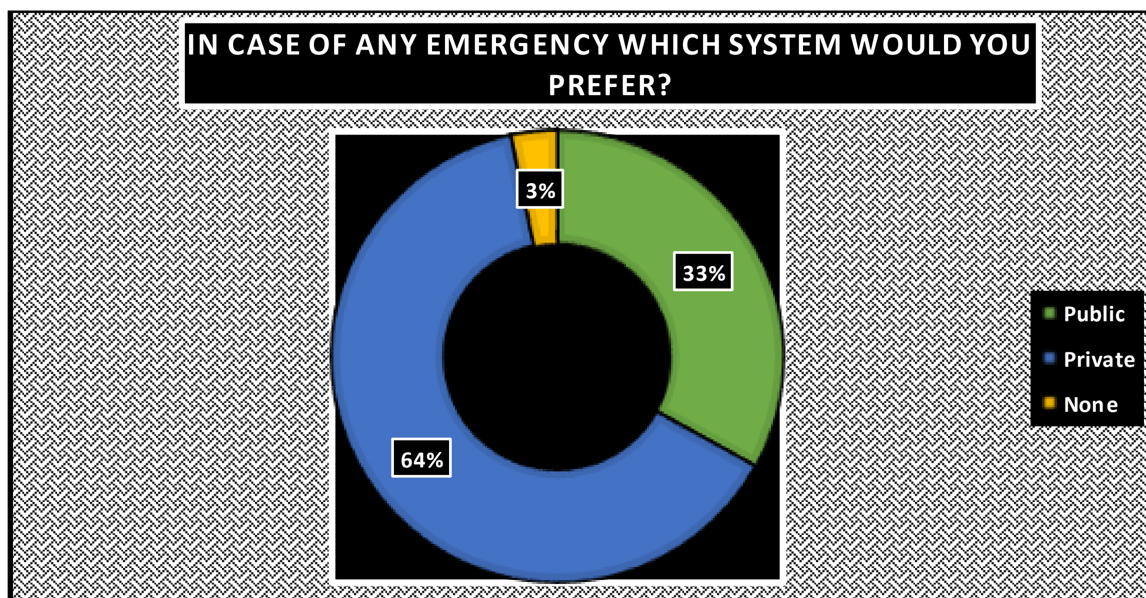


(Figure 55-Source: Data collected by the researcher)

5.3.14 Figure 56: Which system would you prefer in case of emergency?

One of the drawbacks of the healthcare system of our country is the lack of emergency care units in the rural and tribal areas. Kerala being the best performer in healthcare also lacks such facilities in rural/tribal areas. This has caused serious issues and took away the lives of many. The Hon'ble Apex court via its judgement dated 6th May 1996 has already directed the states that it is the Constitutional responsibility of the states to make

emergency healthcare available to public and the state-owned government hospitals are duty bound to provide timely emergency care to the ill[535].



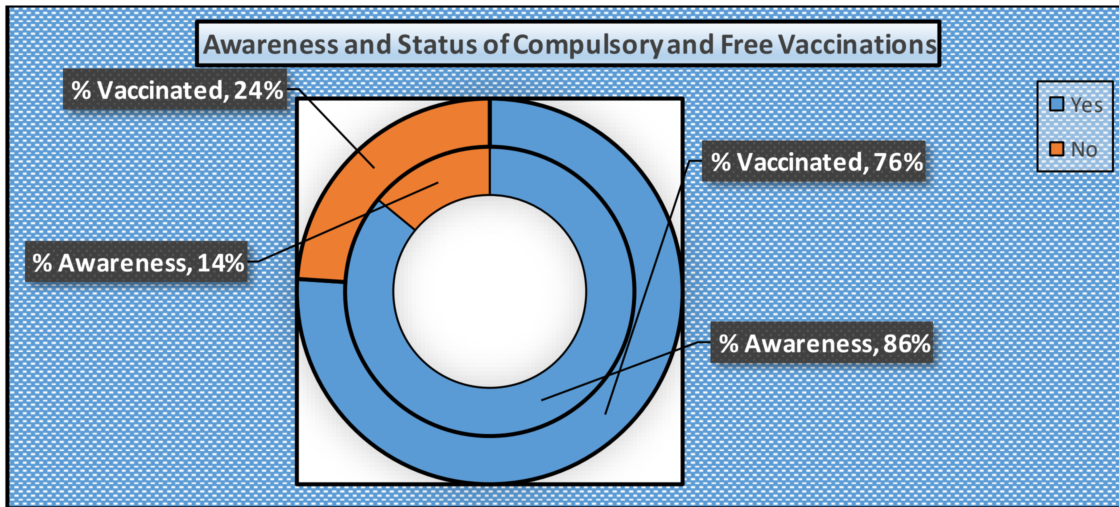
(Figure 56-Source: Data collected by the researcher)

It has been found in the study that 64% of the respondents opined that they will prefer private healthcare system in case of emergency similarly 33% voted in favor of public healthcare system and 3% said they will neither prefer public healthcare system nor private but traditional method.

5.3.15 Figure 57: Awareness and Status of Compulsory and Free Vaccinations

The comparative analysis of both awareness and status of compulsory and free vaccination among the surveyed households found that there is 86% awareness on the compulsory and free vaccination programme (Universal Immunization Programme) of the government and 76% of the households have admitted that they have completely vaccinated the children of their family. However even after 36 years of its implementation there still exist a gap which is evident from the above data that even in the present day 14% of the participants were unaware of the same and even after the awareness 10% have not vaccinated the children in their family.

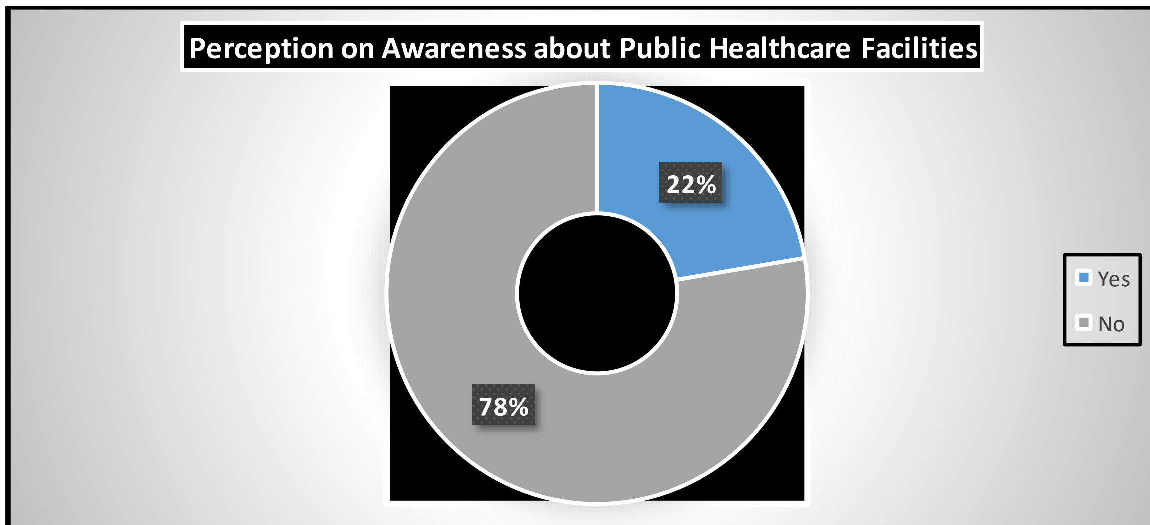
[535] *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (n 89).



(Figure 57-Source: Data collected by the researcher)

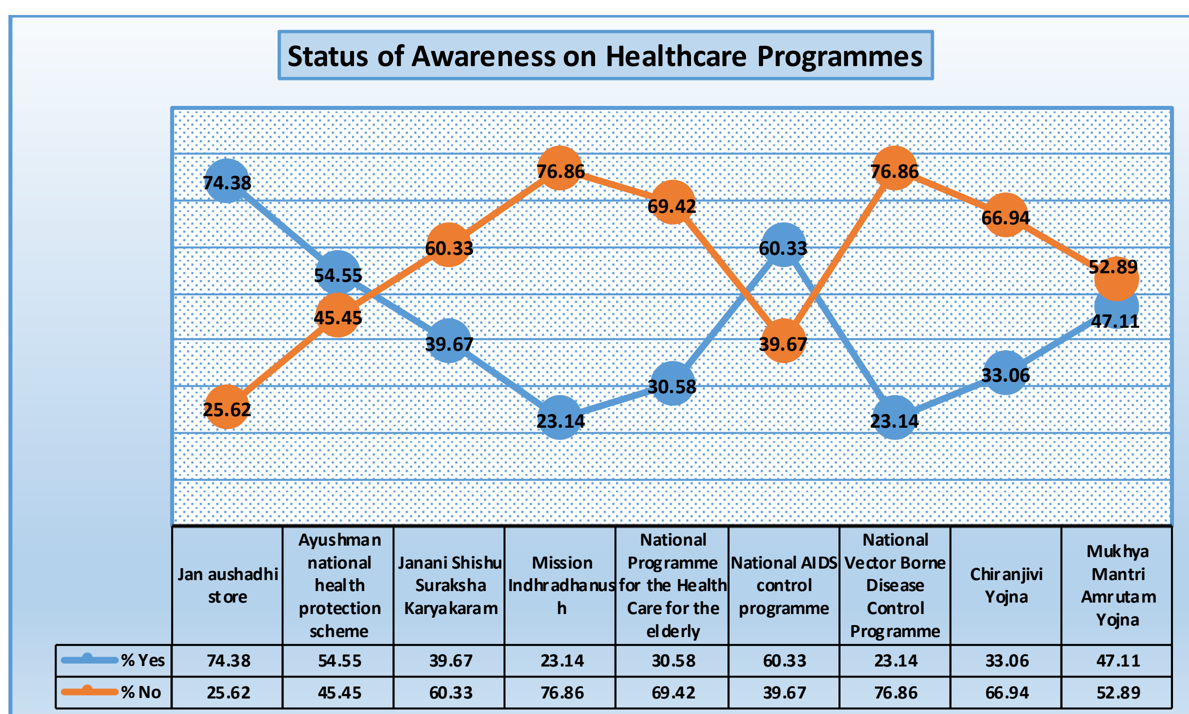
5.3.16 Figure 58, 59 & 60: Do you think you have enough information about the healthcare facilities provided by the Gujarat government?

Like any other governmental initiatives, the programmes and schemes on healthcare also requires better awareness so as to enable more public to access the same. In rural areas ASHA works and Anganwadi's are putting a lot os efforts to reach the public and spread the awareness on the same. However there exist a gap.In urban areas, the population seems to be less interested in government programmes on healthcare. There is also a missing group, which are the migrants, they usually are not aware of any such schemes due to the nature of their work and as they change their place of residence based on the work.



(Figure 58-Source: Data collected by the researcher)

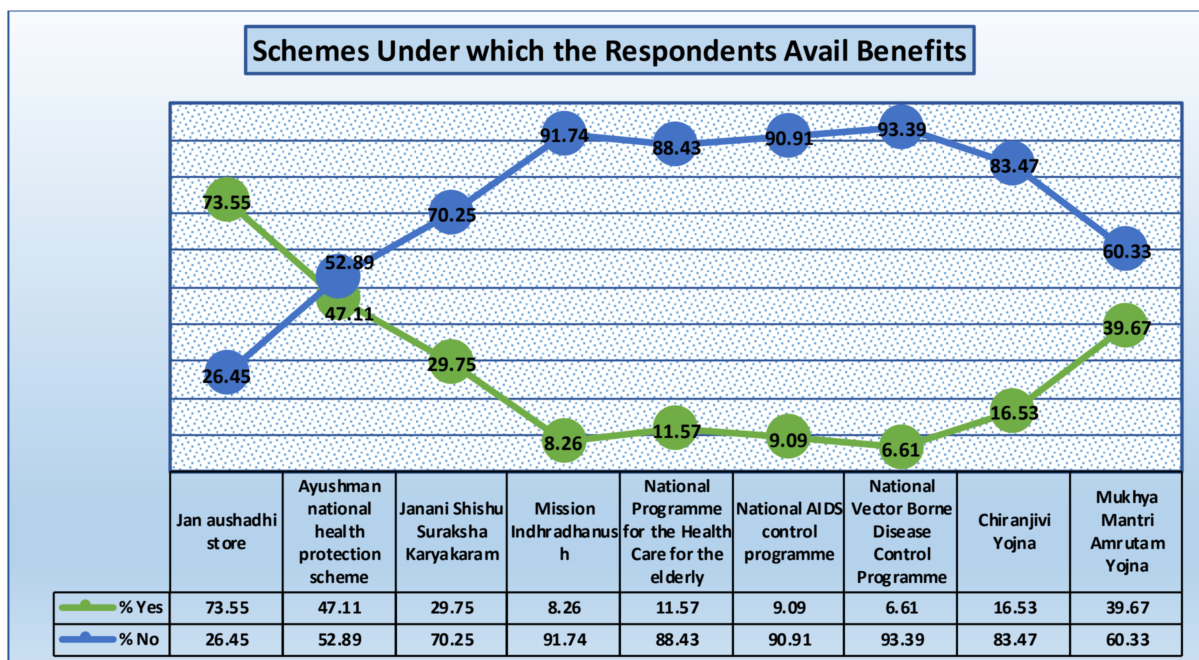
The question about awareness on the healthcare facilities provided by the Government of Gujarat found majority of the respondents (78%) giving the answer in negative whereas 22% believes that they have awareness on the same. This is an alarming situation as awareness plays a vital role in accessing the system. When the subjects are unaware of the schemes and facilities provided by the government, they will not avail the same. This is one of the reason for low utilization of public healthcare facilities by the public.



	Jan aushadhi store	Ayushman national health protection scheme	Janani Shishu Suraksha Karyakaram	Mission Indhradhanush	National Programme for the Health Care for the elderly	National AIDS control programme	National Vector Borne Disease Control Programme	Chiranjivi Yojna	Mukhya Mantri Amrutam Yojna
% Yes	74.38	54.55	39.67	23.14	30.58	60.33	23.14	33.06	47.11
% No	25.62	45.45	60.33	76.86	69.42	39.67	76.86	66.94	52.89

(Figure 59-Source: Data collected by the researcher)

The specific question on awareness of schemes yielded a mixed opinion. The Jan Aushadhi Stored bagged the maximum awareness as 74.38% of the population were aware of the same and 73.55% are availing benefits under the same.



	Jan aushadhi store	Ayushman national health protection scheme	Janani Shishu Suraksha Karyakaram	Mission Indhradhanush	National Programme for the Health Care for the elderly	National AIDS control programme	National Vector Borne Disease Control Programme	Chiranjivi Yojna	Mukhya Mantri Amrutam Yojna
% Yes	73.55	47.11	29.75	8.26	11.57	9.09	6.61	16.53	39.67
% No	26.45	52.89	70.25	91.74	88.43	90.91	93.39	83.47	60.33

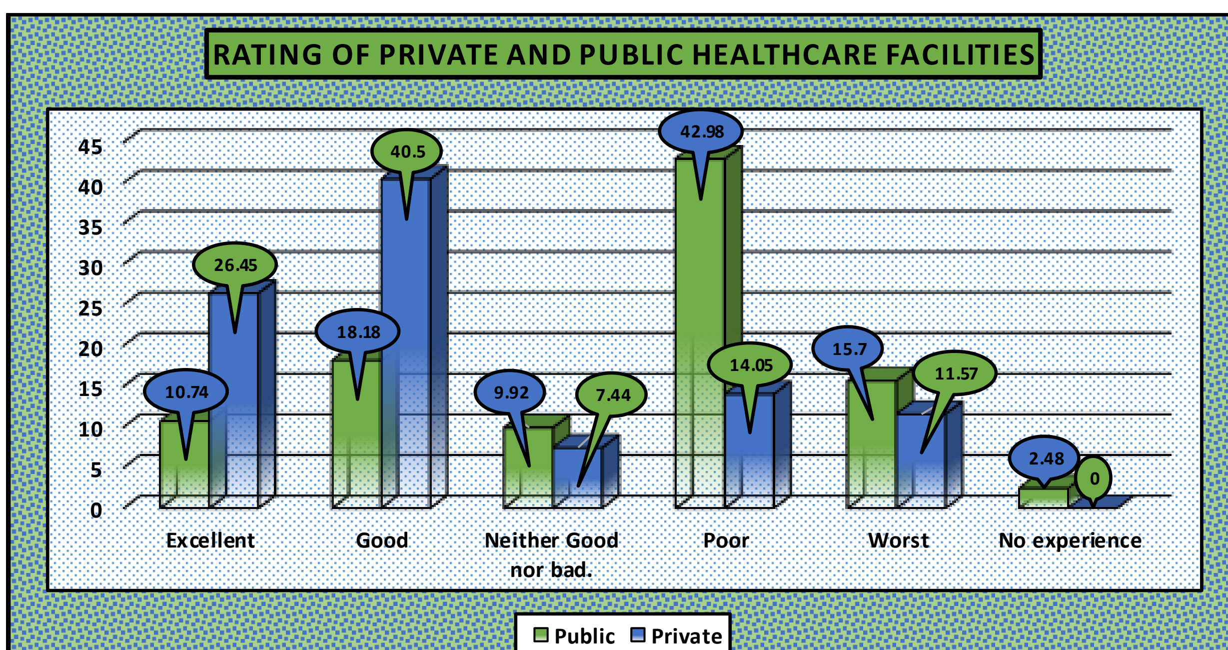
(Figure 60-Source: Data collected by the researcher)

60.33% of the respondents are aware about the National AIDS Control programme followed by 54.55% aware and 47.11% availing the benefits under Ayushman National Health Protection Scheme. The study recorded that 47.11% % has awareness and 39.67% availing the benefits under Mukhya Mantri Amrutam Yojna. It has been found that awareness about Janani Shishu Suraksha Yojna (39.37%) , Chiranjivi Yojna (33.06%), National Programme for the Healthcare of Elderly (30.58%), Mission Indradhanush (23.14%) and National Vector Borne Disease Control Programme (23.24%) are having more awareness among the rural population as compared to the tribal population though the consumption remains less.

5.3.17 Figure 61: Perception of Respondents on Public and Private Healthcare Units in Gujarat

It is evident from the figure 61 that the surveyed population in the rural area is very sure that the private healthcare system is better than the public healthcare system. The responses were taken in a 5-point Likert scale from Excellent to worst. As per the findings from the field 26.45% of the respondents expressed that private healthcare system is excellent followed by 40.5% rating it as good. 7.44% found it as neither good nor bad; 14.05% as

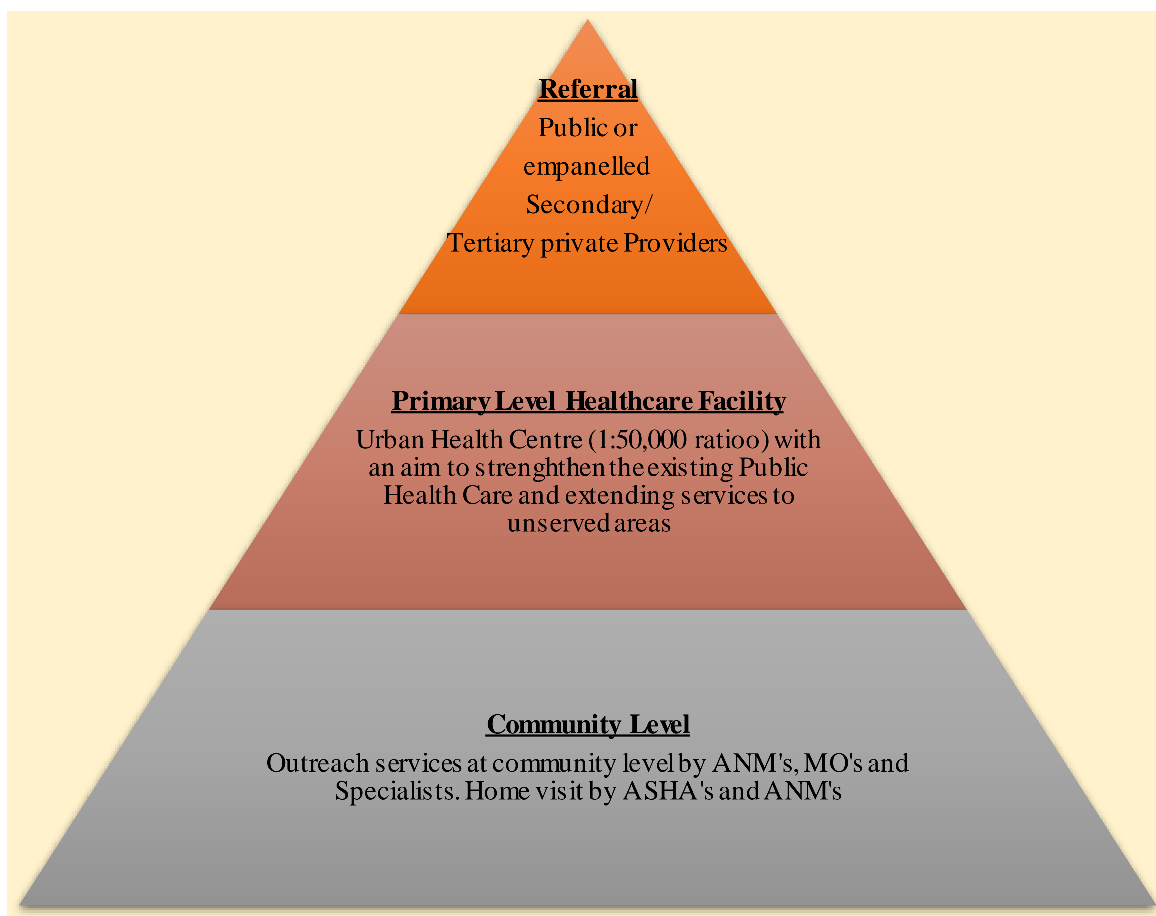
poor and 11.57% as worst. Whereas in case of public healthcare system only 10.74% rated it as excellent; 18.18% opined it as good; for 9.92% it is neither good nor bad; majority, 42.98% found it as poor and 15.7% as worst. 2.48% of the respondents expressed that they don't have any experience with the public healthcare system.



(Figure 61-Source: Data collected by the researcher)

5.4 Healthcare in Urban Region: Discussion and Findings from Gujarat

The Union Cabinet approved the National Urban Health Mission (NUHM) in 2013 as a sub-mission under the overarching "National Health Mission (NHM) with an aim to provide equitable and high-quality primary health care services to the urban population". The programme has a special focus on the slum and vulnerable populations. NUHM aims to promote people's health by providing access to high-quality primary care. NUHM covers all cities and towns with a population of more than 50000 people, as well as district and state headquarters with a population of more than 30000 people. Gujarat also has implemented NUHM under NHM. The below figure provides information on the urban healthcare model.



(Figure 62: Source[536])

Gujarat is one of the most urbanized states in India. Rapid industrialization has accelerated the urban growth. As per the Census 2011, the urban population of Gujarat has reached 42.6%. The Ministry of Health and family Welfare, Government of Gujarat has created good infrastructure to provide primary, secondary and tertiary healthcare to its citizens. The primary focus of the government is the marginalized and weaker sections of the society residing in tribal, rural and urban areas. Health and Family Welfare Department has its sub departments namely Commissionerate of Health, Medical Services, Medical Education and Research; Gujarat Medical Services Corporation Limited. (GMSCL); Food and Drug Control Authority (FDCA); Directorate of Indian System of Medicine and Homeopathy

[536] Ministry of Health and Family Welfare; Government of India (n 531).

(AYUSH) and Employee State Insurance Scheme (ESIS) working towards achieving 'Healthcare for All'[537].

Health Centres	Required	Existing	Difference	
			Extra	Shortfall
Sub-Centre	8008	9231	1223	-
PHC	1290	1477	187	-
CHC	322	348	26	-
Urban PHC	404	380	-	24
Urban CHC	56	40	-	16

Table 25: Source-Times of India[538]

In the study it has been found that the government has failed to pay equal attention to the development of healthcare in rural and urban areas. Recently the government of Gujarat has created excessive number of healthcare units in rural areas than the minimum requirement as per the policy. In urban areas there is shortfall of the same. The state has shortage of 13 District hospitals. It is clear from the above table that urban areas of Gujarat has shortage of 24 Urban PHC's and 16 urban CHC's.

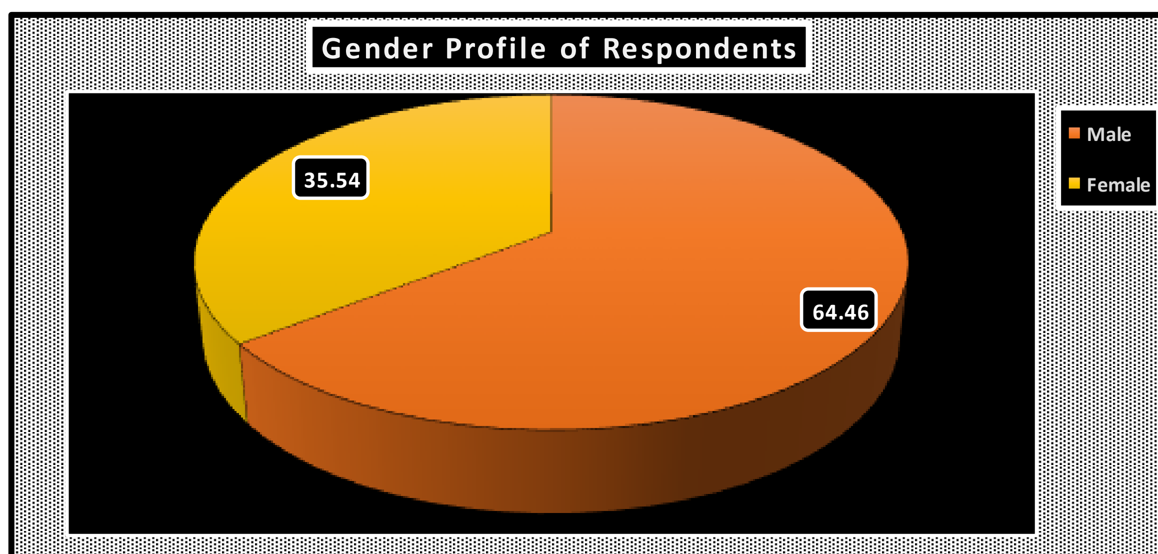
Data of Healthcare Workers at Public Healthcare Centres at Urban Areas					
Category	**Required**	**Sanctioned**	**In position**	**Vacant**	**Shortfall**
Urban Primary Healthcare Units (PHC's)					
Health Worker (Female)/ANM	1590	3064	1947	1117	*
Pharmacist	318	380	359	21	*
Lab Technician	318	344	221	123	97
Doctors	318	373	257	116	61
Nursing Staff	318	585	433	152	*

[537] Government of Gujarat, "Functions & Objective | Gujarat Health and Family Welfare Department" <https://gujhealth.gujarat.gov.in/functions-objectives.htm> accessed November 15, 2021.
[538] "'More Health Centres in Rural Areas, Fewer in Urban'" *Times of India* (2021) <https://timesofindia.indiatimes.com/city/ahmedabad/more-health-centres-in-rural-areas-fewer-in-urban/articleshow/81251056.cms> accessed November 15, 2021.

Urban Community Healthcare Centres (CHC's)					
Total Specialist	56	111	35	76	21
General Duty Medical Officers	28	75	21	54	7
Radiographer	14	7	0	14	14
Pharmacist	14	13	9	4	5
Lab Technician	14	13	11	2	3
Nursing Staff	98	255	76	176	22

(Table 26: Source[539])

5.4.1 Figure 63: Gender Profile of the Respondents

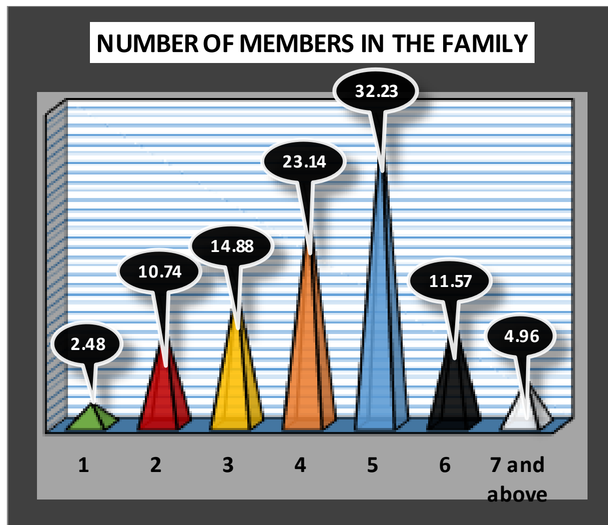


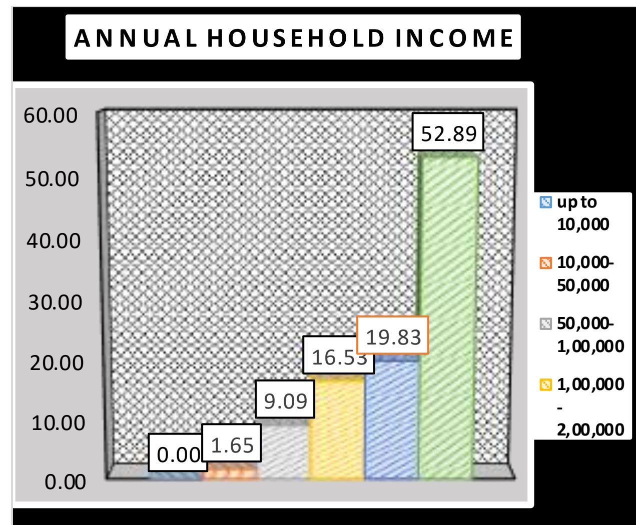
(Figure 63-Source: Data collected by the researcher)

Figure 63 makes it clear that out of approached 121 respondents 64.46% were male and 35.54% were female. Though the researcher tried to ensure equal participation by male and female in the survey from all the three regions, there was less cooperation from females.

[539] Ministry of Health and Family Welfare; Government of India (n 531).

5.4.2 Figure 64 and 65: Household Profile of the Respondent



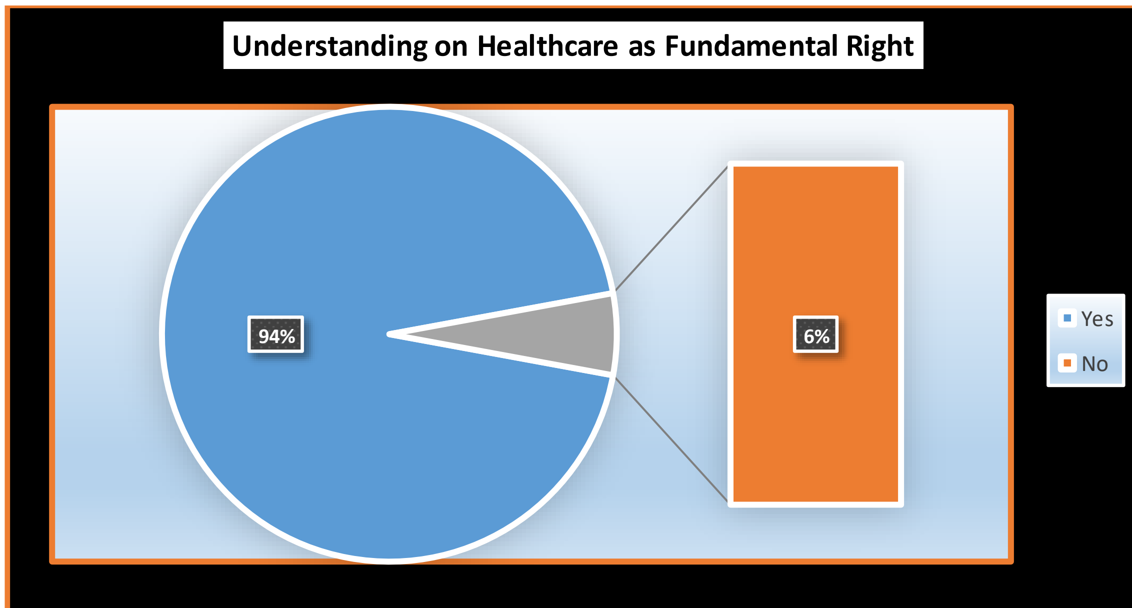


(Figure 64-Source: Data collected by the researcher) **(Figure 65-Source: Data collected by the researcher)**

The figures above illustrate that out of total respondents 32.23 % is having 5 members in the family followed 23.14% households having 4 members; 14.88% with 3 members; 11.57% with 6 members and 10.74% with 2 members in the family. Negligible percentage is having either one member or more than 7 members in the family. On the other side the annual household income of the majority families is on higher side as compared to the other two regions in urban region. The study recorded that 52.89% of the surveyed households are having annual income above RS. 5,00,000/- followed by 19.83% having income between RS.2-5 lakh; 16.53% earning between RS.1-2 lakh annually and very less people earning below RS 1,00,000/-. None of the respondents were earning below RS. 10,000/- hence the BPL category is very less in the considered sample.

5.4.3 Figure 66: Do you think Healthcare is a Fundamental Right

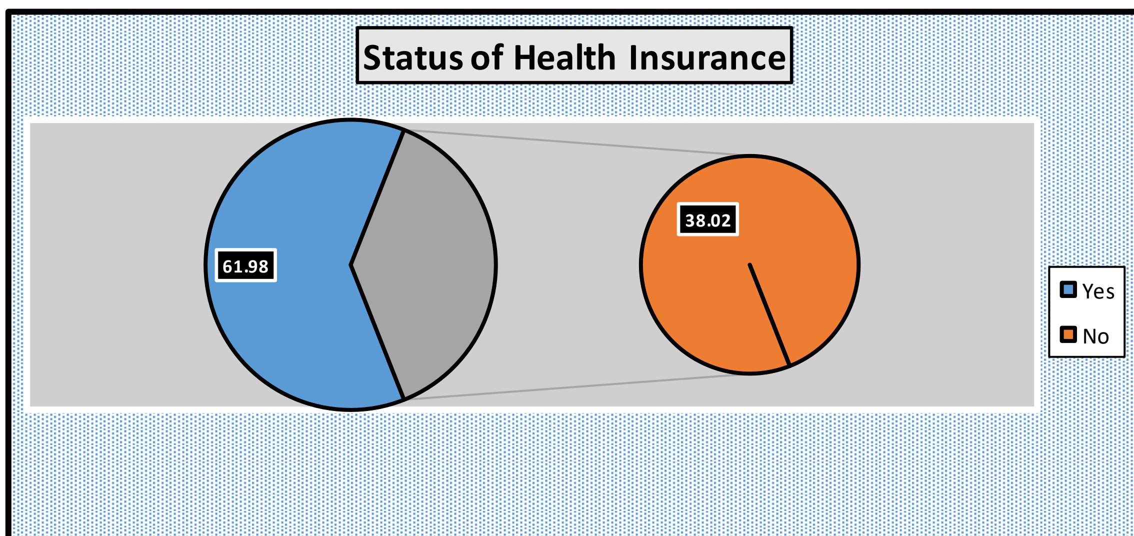
The below figure 66 (below) makes it clear that majority of the urban population thinks that healthcare is a fundamental right. 94% of the participants thinks that healthcare is a fundamental right whereas 6% gave a negative answer. Surprisingly, the study found that awareness on healthcare as fundamental right is more among the tribal population as compared to the rural and urban population.



(Figure 66-Source: Data collected by the researcher)

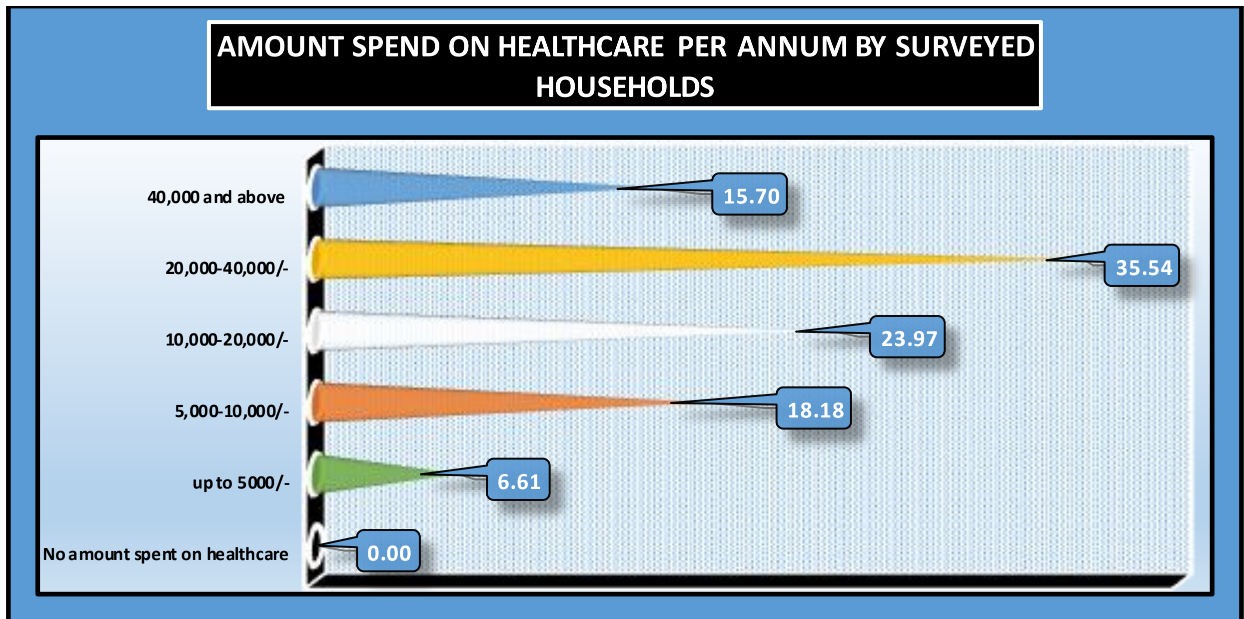
5.4.4 Figure 67: Status of possession of Health Insurance by the Respondents

The status of health insurance is less among the urban population as compared to the other two regions. In the present study, the figure 67 illustrates that majority (61.98%) of the surveyed population were covered by insurance scheme either private or public whereas 38.02% were not having any health insurance. One of the observations from the field is that majority of the urban respondents were covered by private/ employee insurance schemes not under the publically sponsored schemes.



(Figure 67-Source: Data collected by the researcher)

5.4.5 Figure 68: Out of Pocket (OOP) Spending on Healthcare by the Respondents

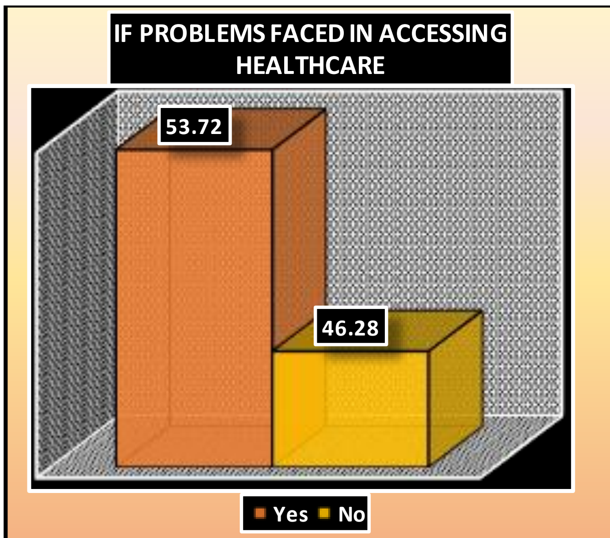


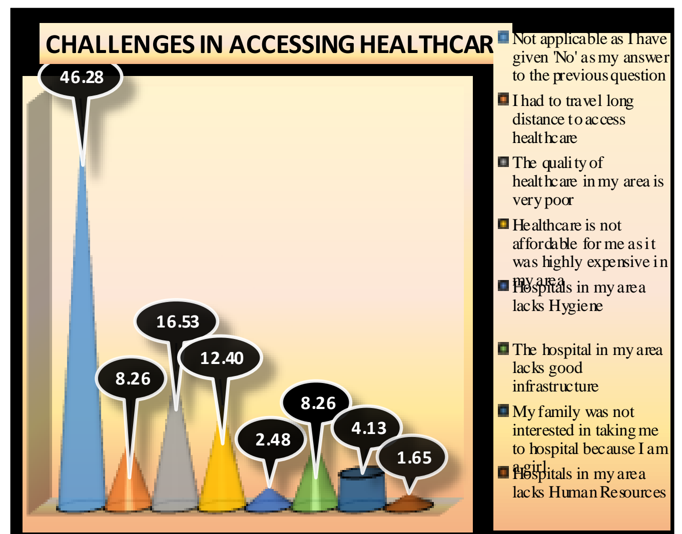
(Figure 68-Source: Data collected by the researcher)

This question yielded a mixed opinion from the respondents. The study found that urban population is spending more on healthcare as compared to people from other regions. It has been found that 35.54% of the surveyed households spend RS. 20,000/0-40,000/- on healthcare annually followed by 23.97% of them spending RS. 10,000-20,000/-; 18.18% spending RS. 5,000-10,000/-; 15.70% spending RS. 40,000/- and above and only very less percentage (6.61%0 spending below RS. 5,000/- for healthcare.

5.4.6 Figure 69 & 70: Responses on Challenges Faced in Accessing Healthcare

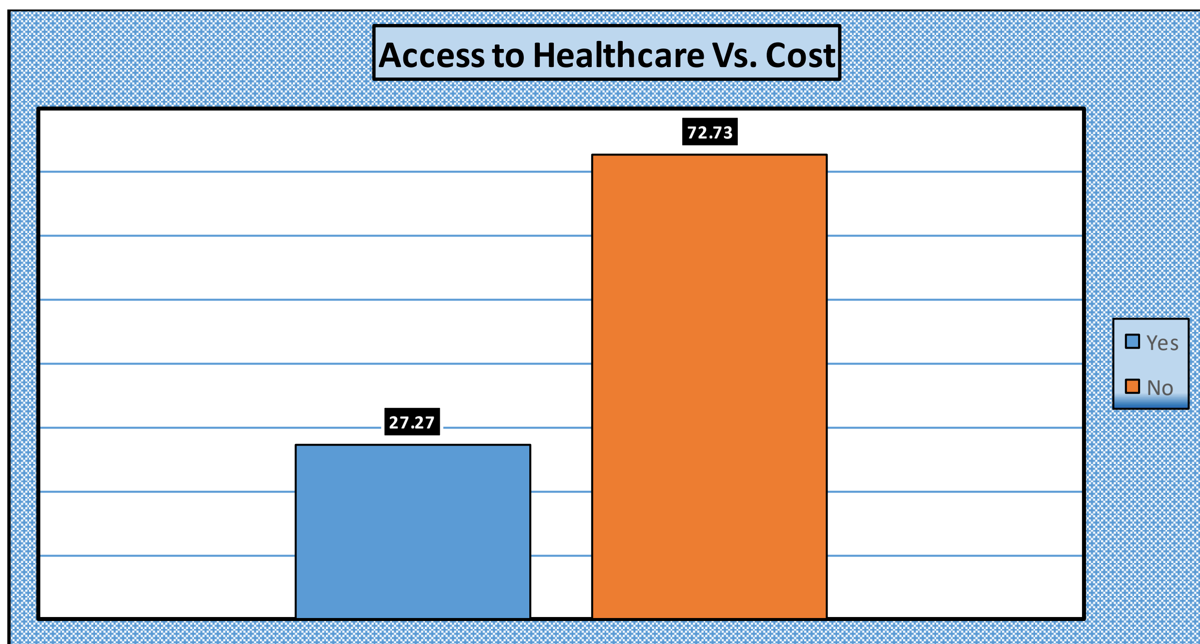
The study found that 53.72% of the respondents from urban area found challenges in accessing healthcare. Among the total respondents 16.53 said that the quality of healthcare in their area is not good; 12.40% found the healthcare as expensive; 8.26% each had expressed that they had to travel significant distance to access healthcare and the hospitals in their area lacks good infrastructure; 4.13% experiences gender-based discrimination and were not taken to hospital by the family and finally 1.65% opined that the hospitals in their area of residence lack human resources.





(Figure 69-Source: Data collected by the researcher) **(Figure 70-Source: Data collected by the researcher)**

5.4.7 Figure 71: Have you ever had to forgo health care because of costs?

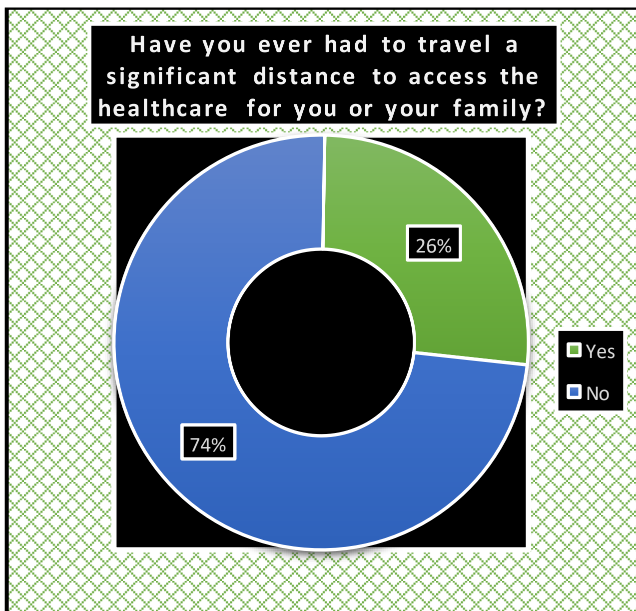


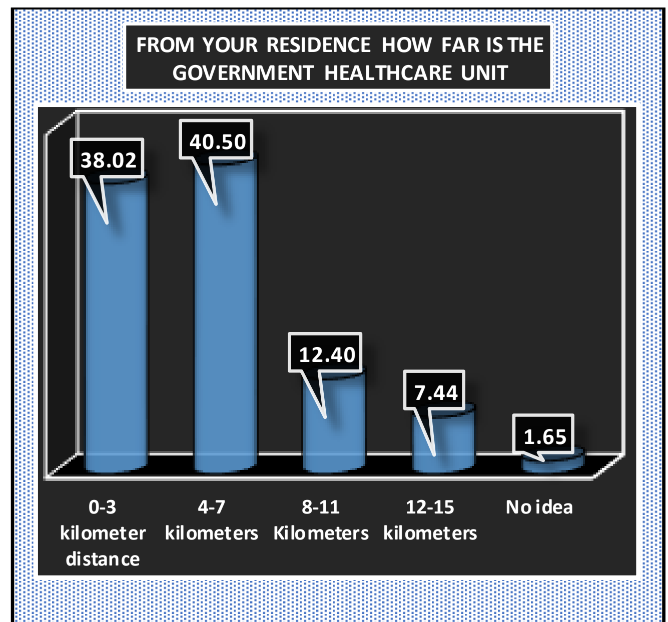
(Figure 71-Source: Data collected by the researcher)

The study found that minority (27.27%) answered as they had to forgo healthcare because of cost whereas majority 72,73% expressed that they never had to compromise on availing healthcare due to cost.

5.4.8 Figure 72 & 73: Access to healthcare VS. Distance

For the question to understand challenges in access to healthcare due to distance 74% answered as they didn't face any such issue whereas 26% did face issues in accessing healthcare due to distance. More specifically 40.50% of the population has access to healthcare within 4-7 KM distance of their residence. 38.02% were living in 0-3KM distance of the healthcare unit followed by 12.40% residing 8-11 KM radios and 7.44% in 12-15 KM distance. 1.65% said they don't have any idea about where the public healthcare unit is situated as they don't go to public hospitals.

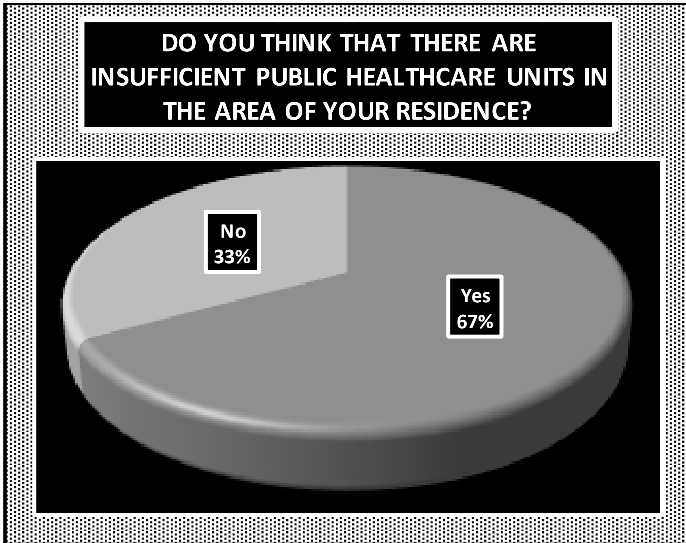


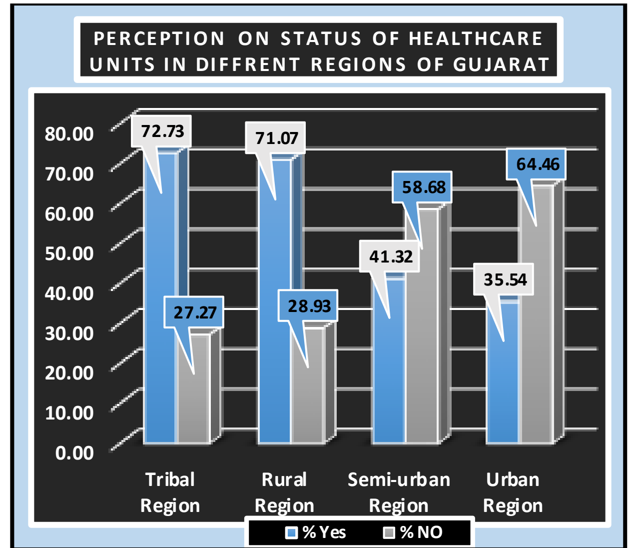


(Figure 72-Source: Data collected by the researcher) **(Figure 73-Source: Data collected by the researcher)**

5.4.9 Figure 74 & 75: Perception on adequacy of Public Healthcare units

As mentioned in the introduction of healthcare in urban area in table 4 healthcare units in urban area are inadequate, it is not proportionate to the standard policy guideline and the population. As per the reports there is shortfall of all urban PHC's, Urban CHC's and District hospitals. In the current study this question was included to understand the perception of the respondents on the same and the study found that 67% had expressed that there is a smaller number of public healthcare units in their area of residence whereas 33% said that there is adequate number of healthcare units in their area.

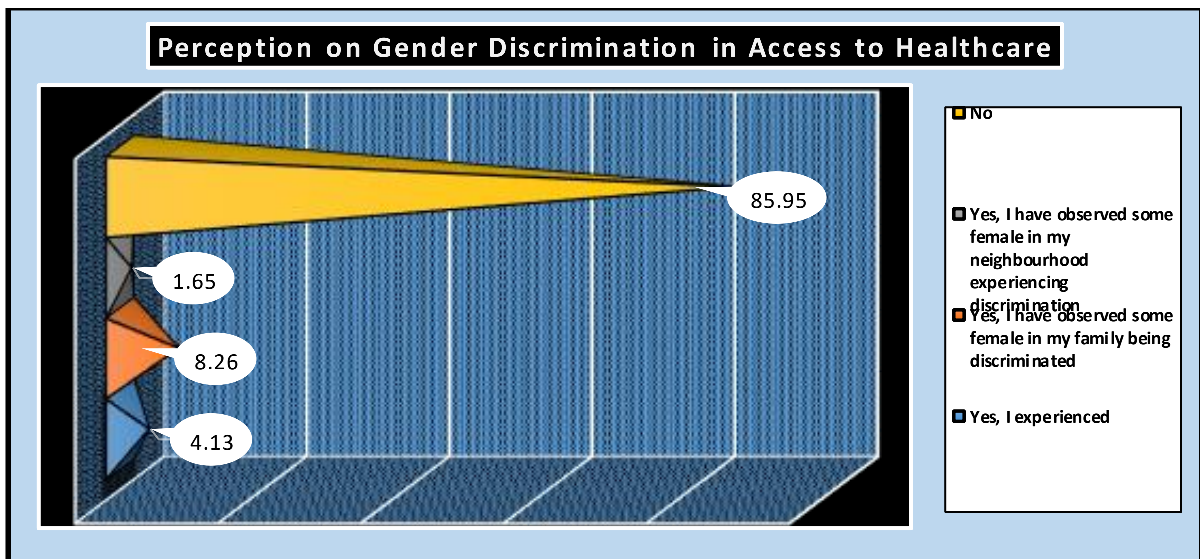




(Figure 74-Source: Data collected by the researcher) (Figure 75-Source: Data collected by the researcher)

The figure 74 above depicts that 72.73% expressed that there is insufficient number of healthcare units in tribal areas; 71.07 thinks that rural areas has inadequate number of healthcare units; 41.32% voted for semi-urban region followed by 35.54% saying urban areas too did not have enough number of public healthcare units.

5.4.10 Figure 76: Perception on Gender Based Discrimination in Access to Healthcare

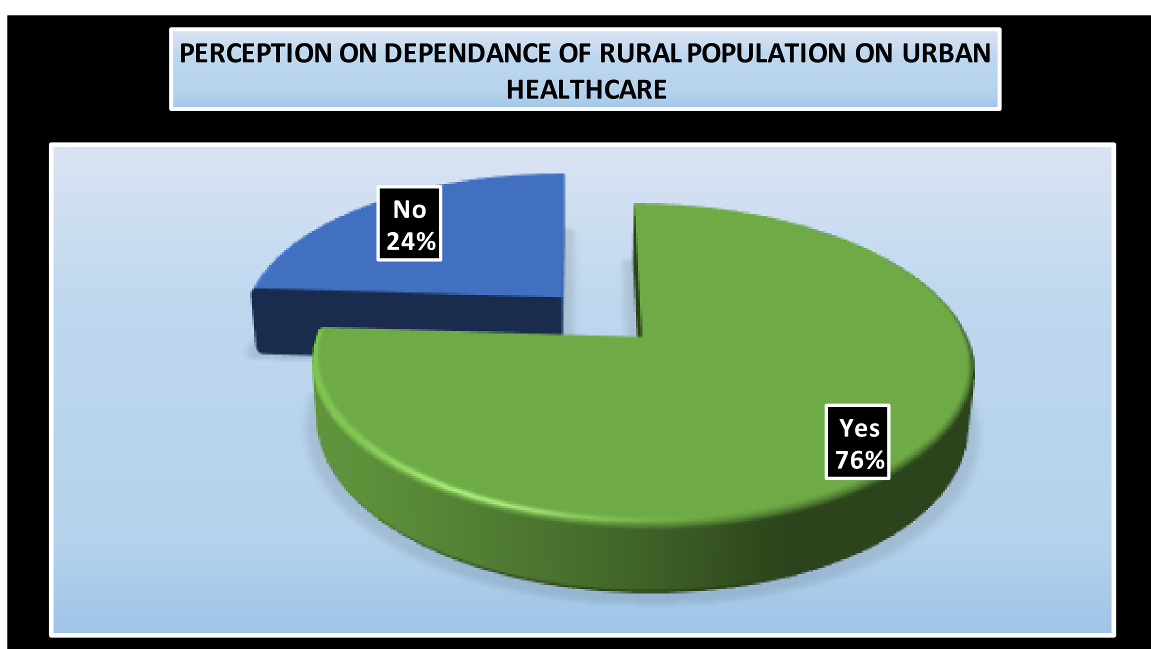


(Figure 76-Source: Data collected by the researcher)

Like the other two regions the respondents from urban region also has shared some instances of discrimination based on gender. However, the ratio is less as compared to the other two regions. The figure 76 above illustrates that majority (85.95%) of the respondents expressed that they haven't experienced or observed any such instances whereas 8.26% said they saw some females in their family faced challenges from family while trying to access healthcare; 4.13% had confirmed that they experienced the same and 1.65% shared their experience of observing the females in their neighborhood being discriminated in matters of healthcare by the family. In other words, the illness of females are not given any importance as that of male. In case of immunization also this attitude of many families are visible.

5.4.11 Figure 77: Perception on Dependence of Rural/Tribal Population on Urban Health care

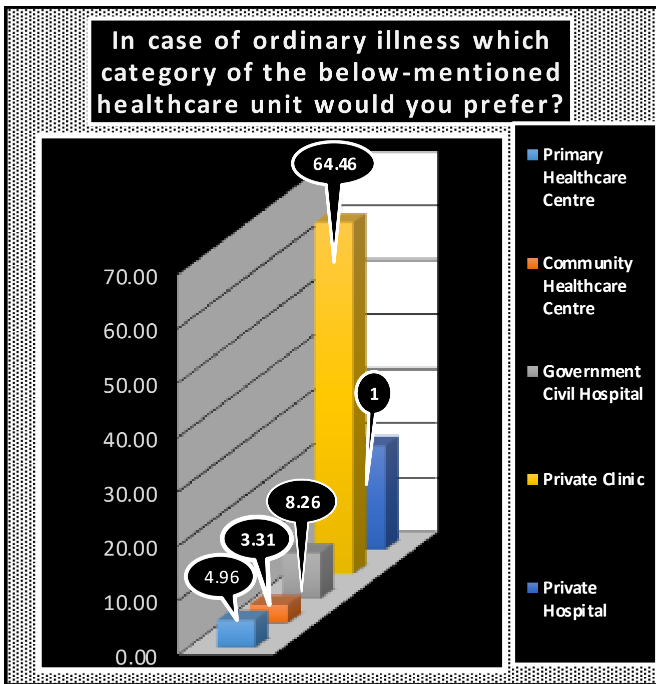
As per the findings 76% of the respondents are of the opinion that the rural population are dependent on the urban healthcare. It has been found in the study though there are adequate number of healthcare units developed by government in rural areas, due to low quality, low hygiene, lack of doctors and bed, people prefer to go to the urban private clinics.

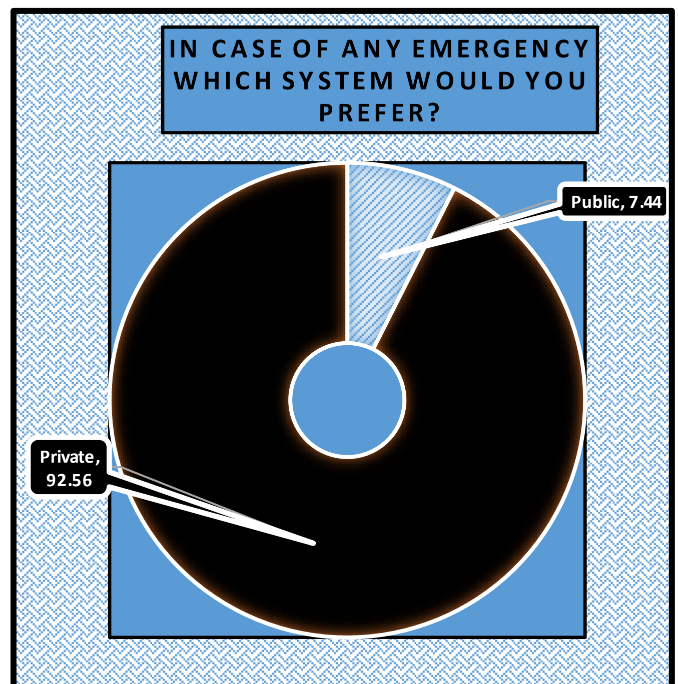


(Figure 77-Source: Data collected by the researcher)

5.4.12 Figure 78 & 79: Preference of hospitals by the Respondents in case of Ordinary Illness and Emergency

The figure below illustrates that majority (64.46%) has expressed that they would prefer private clinic in case of ordinary illness followed by 19.01% choosing private hospital; 8.26% chose Government Civil Hospital; 4.96% Primary Healthcare Centre and 3.31% CHC.



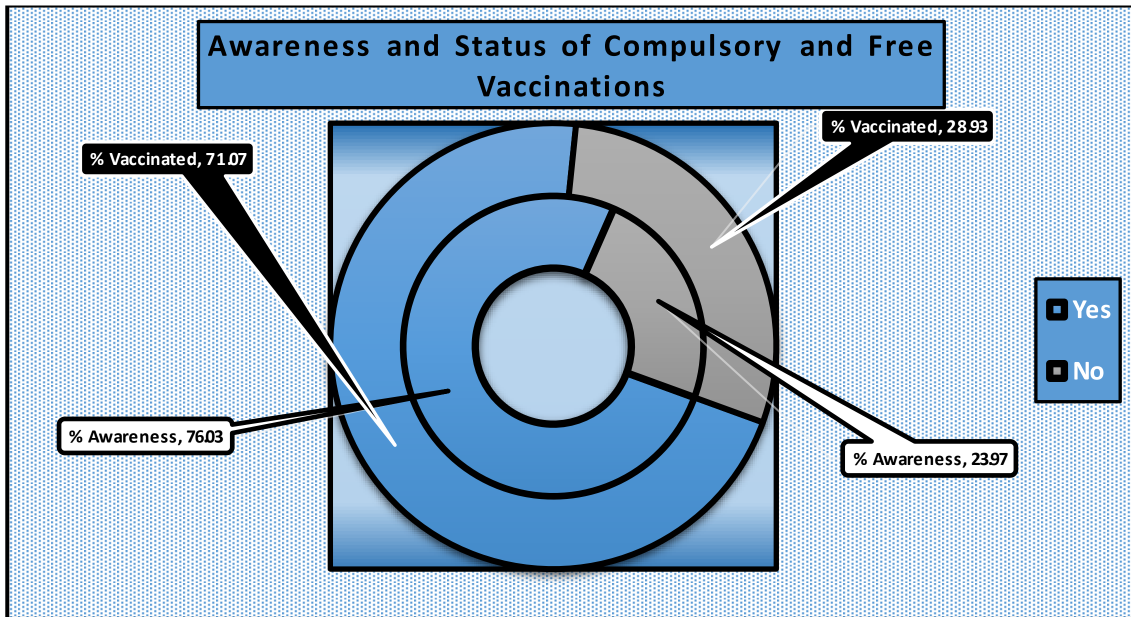


(Figure 78-Source: Data collected by the researcher) **(Figure 79-Source: Data collected by the researcher)**

It is clear from the above figure 62 that 95.56% of the respondents would prefer private hospital in case of emergency and only 7.44% voted in favor of public healthcare system.

5.4.13 Figure 80: Awareness and Status of Compulsory and Free Vaccinations

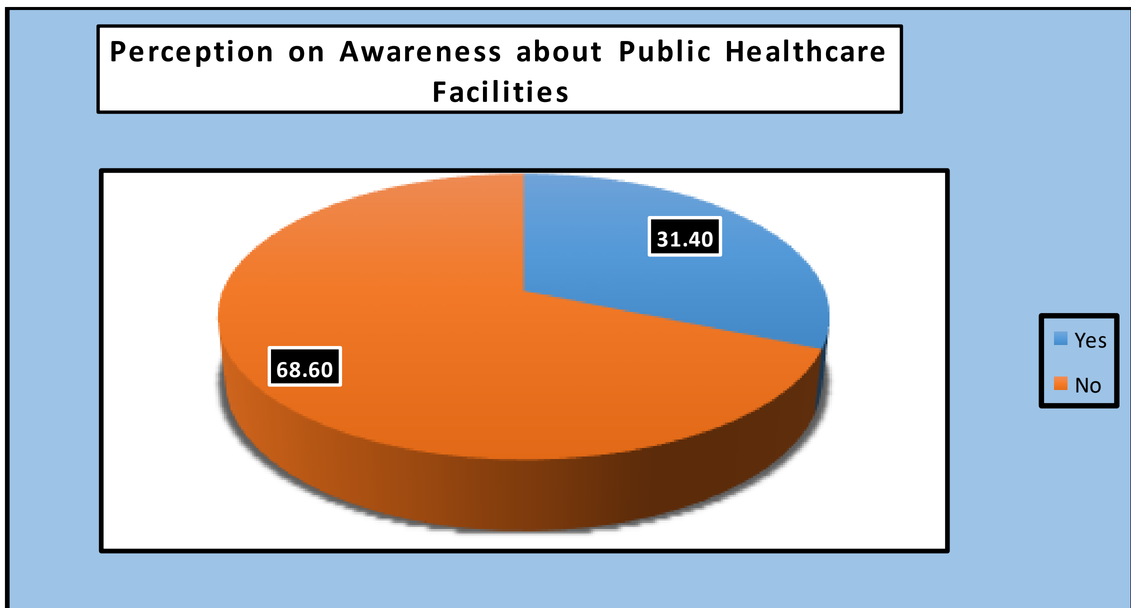
The study found that of the total respondents 76.03% are having awareness on the compulsory and free vaccination provided under the Universal Immunization Scheme and 71.07% acknowledged that the children in their family are fully vaccinated. Only 23.97% are unaware of this Immunization Programme and 28.93% households have not availed the immunization under the scheme.



(Figure 80-Source: Data collected by the researcher)

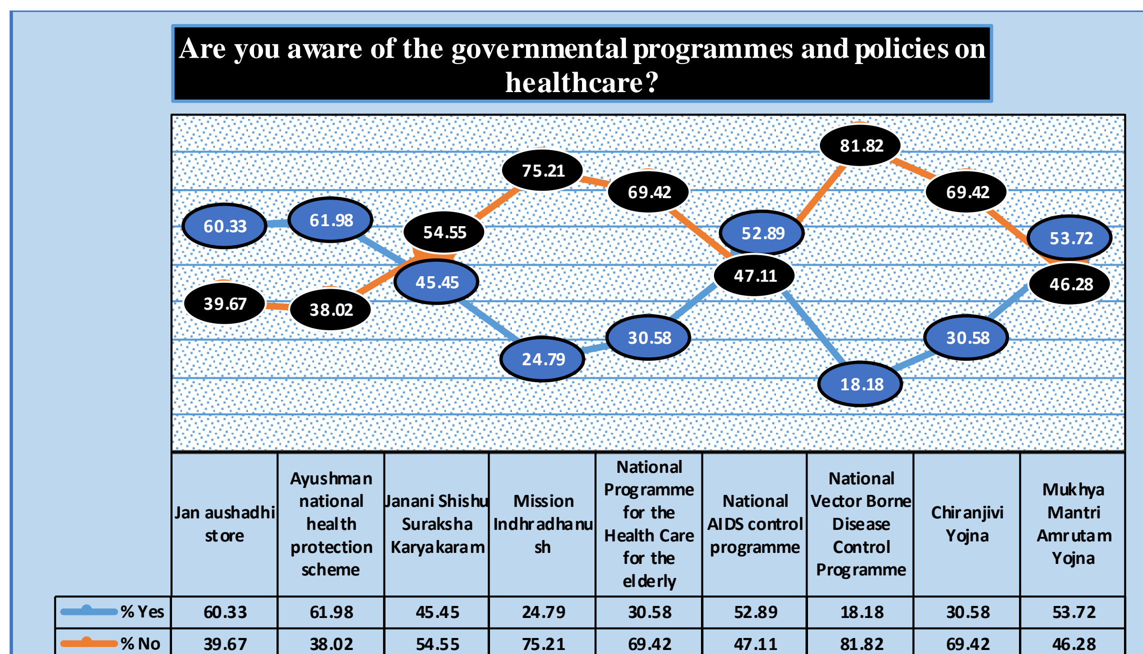
5.4.14 Figure 81, 82 & 83: Do you think you have enough information about the healthcare facilities provided by the Gujarat government?

As per the findings 68.60% of the population believes that they don't have complete awareness about the healthcare facilities provided by the Government of Gujarat.



(Figure 81-Source: Data collected by the researcher)

On the other hand, 31.40% said they have full awareness on the government initiatives on public healthcare.

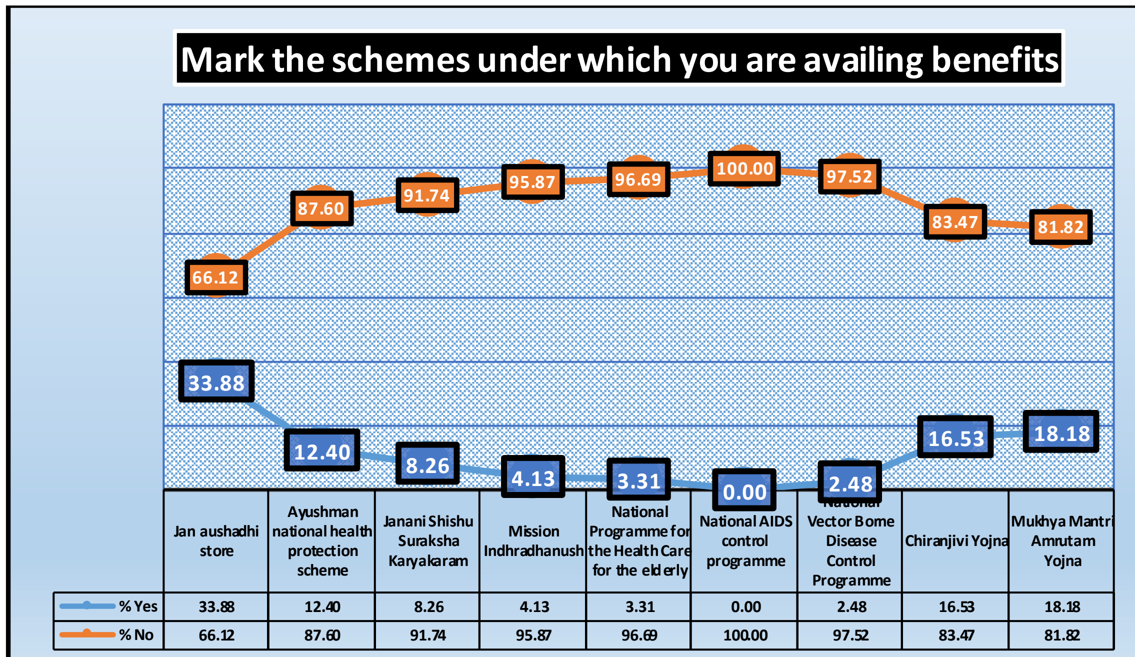


	Jan aushadhi store	Ayushman national health protection scheme	Janani Shishu Suraksha Karyakaram	Mission Indhradhanush	National Programme for the Health Care for the elderly	National AIDS control programme	National Vector Borne Disease Control Programme	Chiranjivi Yojna	Mukhya Mantri Amrutam Yojna
% Yes	60.33	61.98	45.45	24.79	30.58	52.89	18.18	30.58	53.72
% No	39.67	38.02	54.55	75.21	69.42	47.11	81.82	69.42	46.28

(Figure 82-Source: Data collected by the researcher)

It is clear from the figure 82 that majority (61.98%) of the respondents were aware of Ayushman National Health Protection Scheme and as per the figure 67 below 12.40% of the respondents were availing benefits under this scheme; 60.33% were aware of the Jan Aushadhi Store 33.88% were availing benefits under the same; 53.72% expressed that they are aware of Mukhya Mantri Amrutam Yojna and 18.18 % of them are availing benefits under the same.

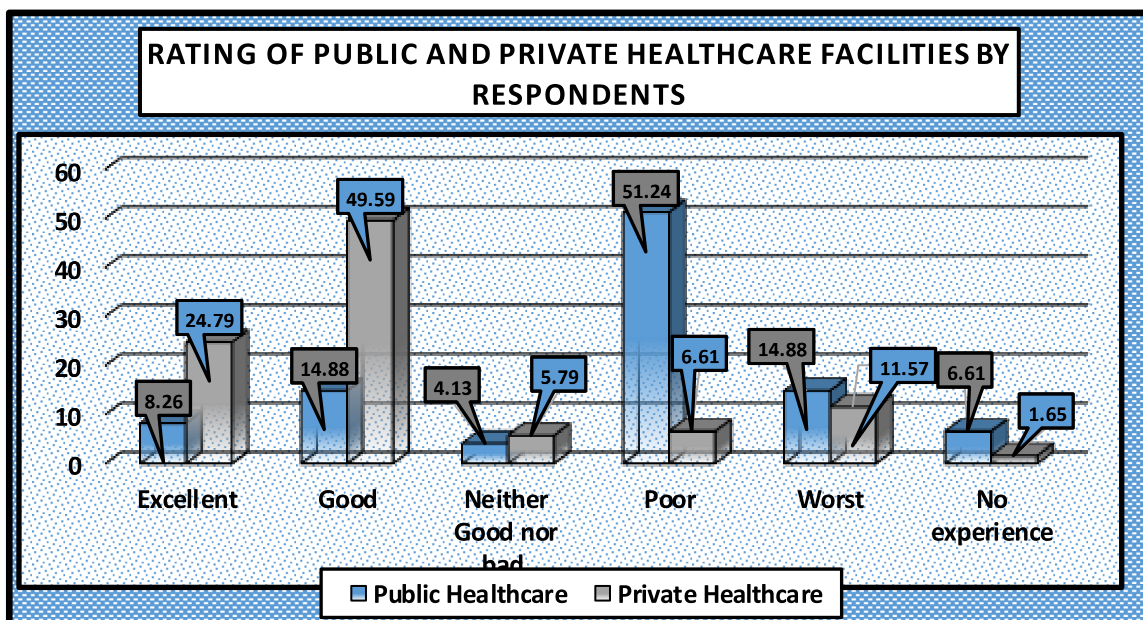
52.89% are aware about National AIDS Control programme; 45.45% has awareness on Janani Shushu Suraksh Yojna. It has been found in the study that awareness about the programmes are more in the urban area but very less people are availing the benefit. Eligibility and income may be the two main reasons for the same.



	Jan aushadhi store	Ayushman national health protection scheme	Janani Shishu Suraksha Karyakaram	Mission Indhradhanush	National Programme for the Health Care for the elderly	National AIDS control programme	National Vector Borne Disease Control Programme	Chiranjivi Yojna	Mukhya Mantri Amrutam Yojna
% Yes	33.88	12.40	8.26	4.13	3.31	0.00	2.48	16.53	18.18
% No	66.12	87.60	91.74	95.87	96.69	100.00	97.52	83.47	81.82

(Figure 83-Source: Data collected by the researcher)

5.4.15 Figure 84: Perception of Respondents on Public and Private Healthcare Units in Gujarat



(Figure 84-Source: Data collected by the researcher)

It is evident from the above figure that the surveyed population in the urban area has a positive approach towards private healthcare system. The 5-point Likert scale question

received a mixed opinion. As per the findings from the field 24.79% rated private healthcare as excellent whereas only 8.26% thought that public healthcare is good. 49.59% rated private healthcare as good and 14.88 thought public healthcare is good. 51.24 said public healthcare is poor followed by 14.88% rating it as worst whereas only 6.61% thought private healthcare is poor and 11.57% rated it as worst.

5.5 Discussion and Findings from Comparative Analysis

In the present study the field survey is carried out by the researcher in two phases. The first phase was during September- November 2019. Later on the outbreak of pandemic and the subsequent lockdown has hampered the data collection as there were restrictions on travelling. Later on in June 2021 the researcher started the field survey and was able to complete the same by September 2021. As mentioned in Chapter 3, the field research was carried out with an aim to examine the magnitudes of inequalities in the healthcare sector on the grounds of Gender, Geography, and economic status with respect to access, quality, affordability, availability of health care in the state of Gujarat (with special reference to Tribal, Rural and Urban Regions) and to explore the initiatives taken by the government of India and the Gujarat government in ensuring proper healthcare to the citizens of India and making quality and affordable healthcare system accessible and available to the people without any neglect and discrimination. The study was carried out in to tribal, rural and urban region of state of Gujarat. For each region the researcher had selected one district each namely Panchmahal dictrict for tribal population, Gandhinagar for rural population and Ahmedabad for urban population.

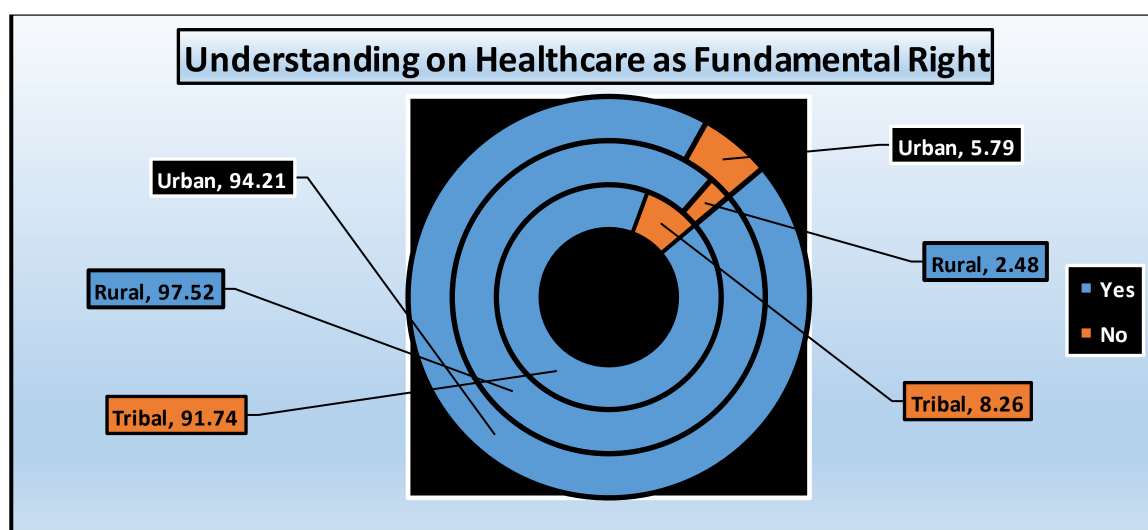
The study analyzed the gender, income and number of members in the family of the respondent to have basic idea about the personal profile of the respondent. The study witnessed 60.33% male respondents, 38.29% female respondents and 1.38% were not willing to disclose their gender. Though the researcher wanted to bring equal representation of both the genders, due to the prevailing pandemic situation it was difficult for the researcher to find more females for the purpose of collection of data.

In case of annual income, it has been found that of the total respondents more than 50% of the urban population were earning more than Rs. 5,00,000/- per annum and the same was

35.54 for the rural population. Majority of the tribal respondents were earning less than RS. 50,000-1,00,000/- per annum. The study found that more than 30% of the tribal population were falling in BPL category and the same was only 2% in case of rural areas. Hence, we can say that the income status of tribal population is poor as compared to the rural and urban region.

Whereas in case of healthcare spending the urban population found to be incurring the major Out of Pocket expenditure. It has been found that 15.7% of the surveyed population is spending 4lakh and above annually on healthcare. In case of tribal and rural population, the majority expressed that they spent up to RS. 5,000/- in healthcare annually. One inference which can be drawn from this data after comparing with the data on choice of hospital is that the OOP is less in case of tribal and rural population because a greater number of respondents chose public healthcare units in case of ordinary illness but the urban population showed a tendency to approach private healthcare clinics and hospitals in case of ordinary illness too. As the private healthcare system is expensive, they end up paying more. Another reason can be the applicability of government health protection schemes are limited to BPL and middle-income category. Hence the urban population is out of coverage.

5.5.1 Figure 85: Understanding on Healthcare as Fundamental Right

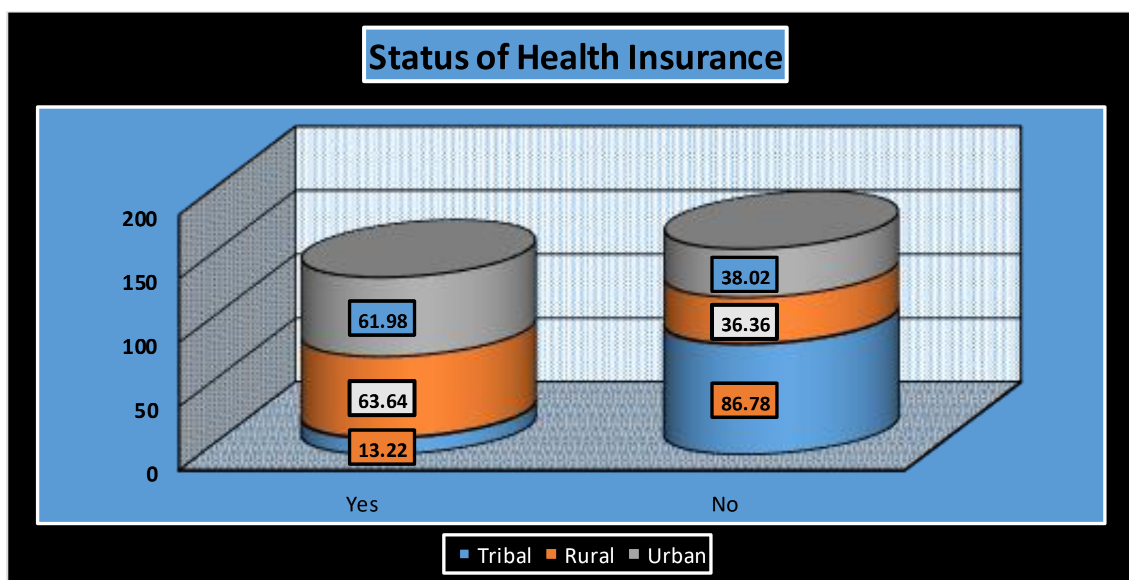


(Figure 85-Source: Data collected by the researcher)

The survey found that majority (94.49%) of the surveyed population is aware that healthcare is fundamental right. The awareness is high in rural areas as compared to the other two whereas it is low in tribal region. Even though awareness is high they don't know how to get it enforced in case of infringement and how far they can enjoy it as a right, what are the responsibilities of the government towards public healthcare etc.

5.5.2 Figure 86: Status of Health Insurance

The Universal Health Coverage envisioned by Government of India aims "*Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services*"[540]. Financial protection is one among the ten principles of UHC adopted by India. Without giving proper health insurance coverage to public achieving UHC is impossible.



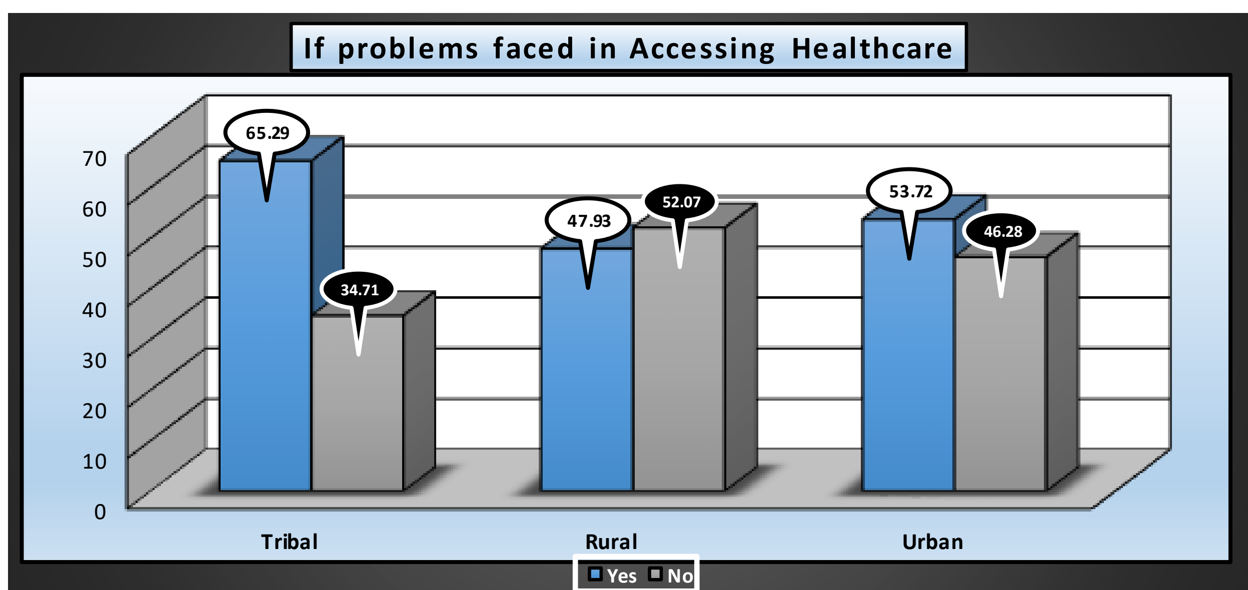
(Figure 86-Source: Data collected by the researcher)

[540] National Health Portal Of India, "Universal Health Coverage" <https://www.nhp.gov.in/universal-health-coverage_pg> accessed November 16, 2021.

The figure above depicts that the improvement in relation to health insurance coverage is not appreciable as only 54.27% of the total respondents were having insurance coverage and 45.73% are still out of health insurance coverage. It has been found that the percentage of possession of health Insurance is more in rural population (61.98%) followed by urban population (61.98%).

5.5.3 Figure 87: Access to Healthcare Vs. Challenges

The figure 87 below makes it clear that 65.29% of the tribal population faced more issues while accessing healthcare followed by urban population (53.72%). It was reported to be less in rural area as compared to the other two regions.



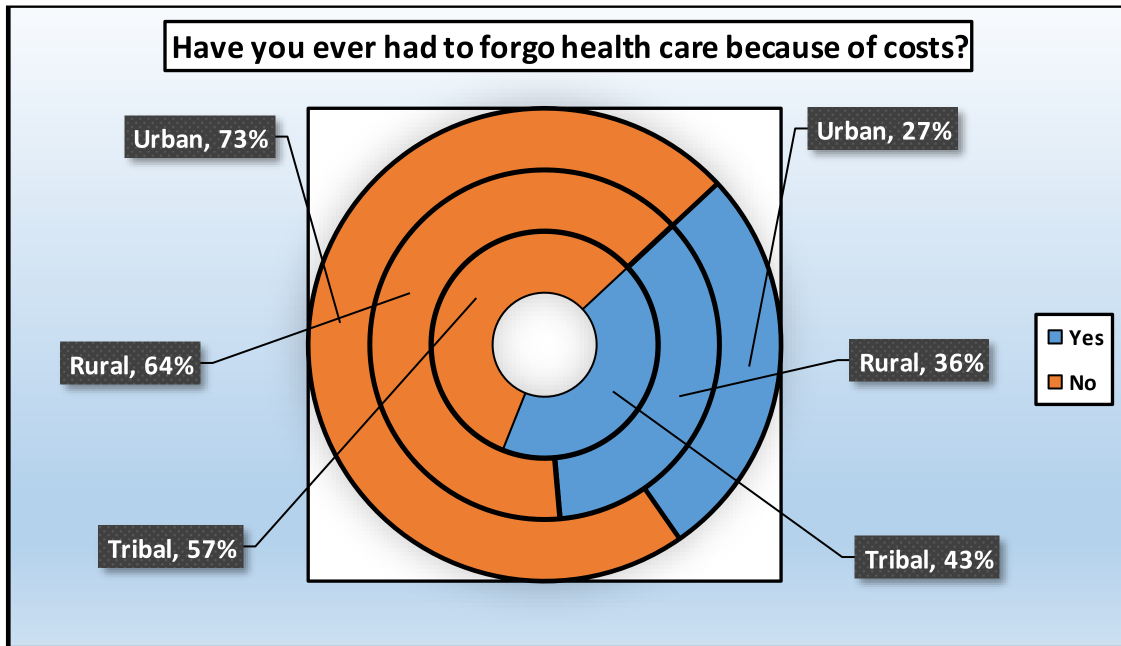
(Figure 87-Source: Data collected by the researcher)

The below table demonstrates the various problems faced by respondents in accessing healthcare. Majority of tribal population had to travel a significant distance to access healthcare and for them inadequacy of quality healthcare unit in their area of residence seems to be the root cause whereas the rural and urban population found the poor quality of healthcare in their area as the issue. The table above shows that 38.29% of the total respondents didn't face any issue in accessing healthcare; major quoted reason was poor quality of healthcare and distance of healthcare units from their residence.

Challenges in Accessing Healthcare				
Description	**Tribal**	**Rural**	**Urban**	**Percentage**
Not applicable as I have given 'No' as my answer to the previous question	17.36	51.24	63.64	38.29
I had to travel long distance to access healthcare	36.36	16.53	3.31	20.39
The quality of healthcare in my area is very poor	28.1	22.31	16.53	22.31
Healthcare is not affordable for me as it was highly expensive in my area	7.44	7.44	4.13	9.09
Hospitals in my area lacks Hygiene	3.31	2.48	2.48	2.75
The hospital in my area lacks good infrastructure	4.13	0	8.26	4.13
My family was not interested in taking me to hospital because I am a girl	0.83	0	0	
Hospitals in my area lacks Human Resources	2.48	0	1.65	

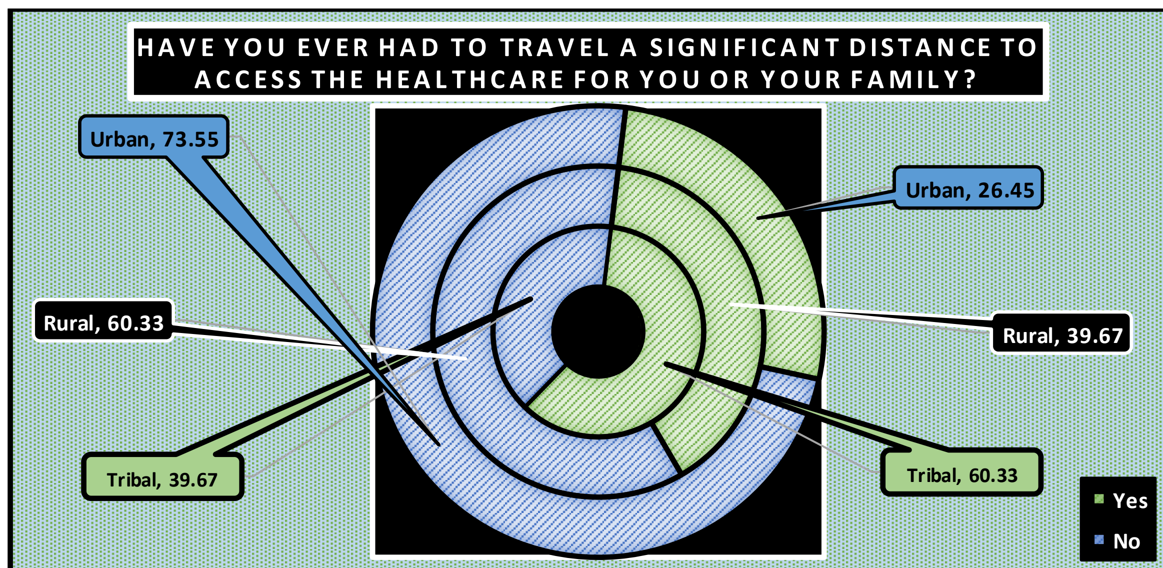
(Table 27 –Source: Data collected by the researcher)

Majority of the total respondents (64.74%) didn't face ant issue in accessing healthcare due to the cost whereas 36.26% had to forgo healthcare as they found it to be expensive. From the regions (below figure 88) 43% of the tribal population; 36% of the rural population and 27% of the urban population had to forgo healthcare due to cost.



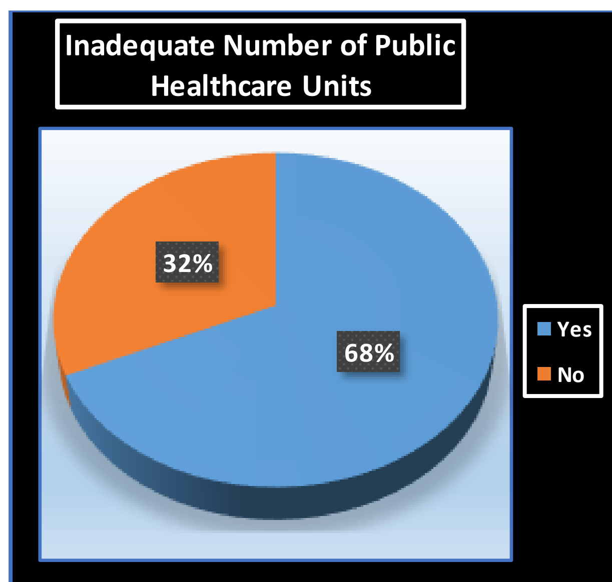
(Figure 88-Source: Data collected by the researcher)

It has been found from the ground that of the total respondent's majority 57.85 didn't had to travel long distance to access healthcare where as 42.15% had to travel significant distance to access the same. Majority of the tribal population (60.33) followed by rural and urban respectively have had faced challenge in accessing healthcare due to distance.



(Figure 89-Source: Data collected by the researcher)

Another challenge faced by the population is the inadequacy in number of Public Healthcare Units in their area of residence.



(Figure 90-Source: Data collected by the researcher)

Do you think that there are insufficient public healthcare units (Government) in the area of your residence?			
Answer	Tribal	Rural	Urban
Yes	65.29	72.73	66.94
No	34.71	27.27	33.06

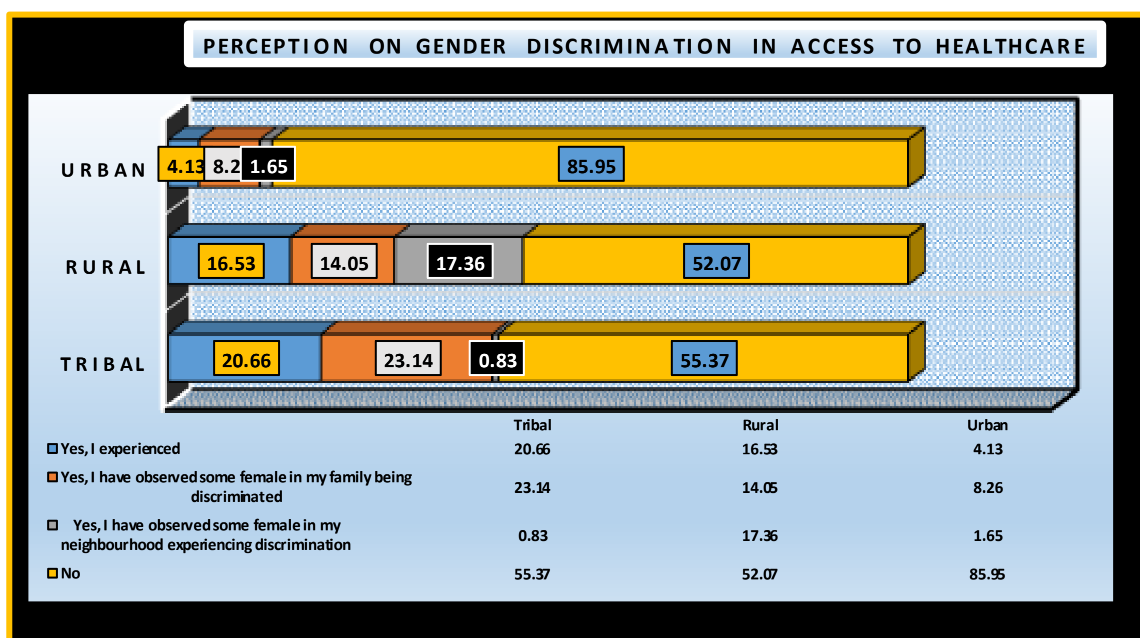
(Table:28-Source: Data collected by the researcher)

Figure 90 depicts that majority (68%) of the total respondents expressed that there is inadequate number of public healthcare units in their area of residence. More specific explanation is that 72.23% of the rural population, 66.94% of the urban population and 65.29% of the tribal population has agreed to the fact that there are lack of healthcare units in their area of residence.

Please tick the option of your choice. Do you think that there are insufficient public healthcare units in the below-mentioned areas of the state of Gujarat?						
	Tribal		Rural		Urban	
Category	% Yes	% NO	% Yes	% NO	% Yes	% NO
Tribal Region	85.95	14.05	88.43	11.57	72.73	27.27
Rural Region	85.95	14.05	76.03	23.97	71.07	28.93
Semi-urban Region	32.23	67.77	55.55	45.45	41.32	58.68
Urban Region	23.97	76.03	23.14	76.86	32.54	64.46

(Table 29-Source: Data collected by the researcher)

In the opinion of the respondents there is insufficient public healthcare units in both tribal and rural regions. But the government of Gujarat in recent past has implemented more efforts to improve the healthcare infrastructure of rural and tribal areas. As per the reports Gujarat has attained the standard guideline set by the government of India in case of Rural and tribal areas but the government is slammed by media and the Hon'ble High Court for not matching the GoI standard norm in case of healthcare facilities of urban areas.



(Figure 91-Source: Data collected by the researcher)

Gender discrimination is another comes as a barrier in the development of the nation. This practice finds its roots in patriarchal system followed in our country and it has left its imprints in the society. In the present study it has been found that the majority (64.46%) of the respondents did not experience or observe such instances of gender discrimination in relation to accessing healthcare. 15.15% agreed that they have observed some of their family members being discriminated in matters of access to healthcare; 13.77% of the respondents expressed that they have experienced discrimination and it is almost 35.97% of the total females participated in the survey. 6.61% observed such discrimination happening in their neighborhood.

5.5.4 Table 30: Status of Awareness and Usage of Free and Compulsory Vaccination under Universal Vaccination Scheme

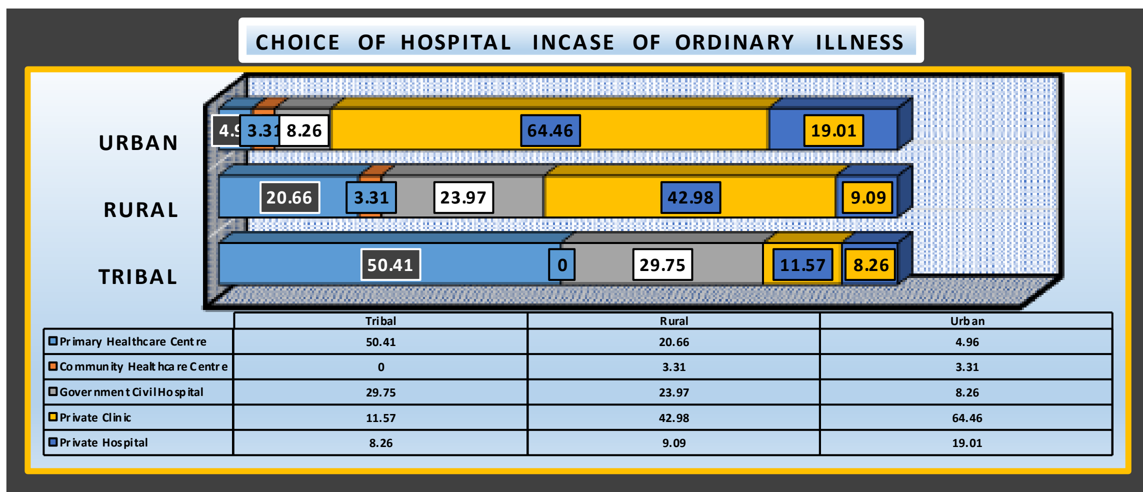
	Tribal		Rural		Urban	
Answer	**% Awareness**	**% Vaccinated**	**% Awareness**	**% Vaccinated**	**% Awareness**	**% Vaccinated**
Yes	90.91	67.77	85.95	76.03	76.03	71.07
No	9.09	32.23	14.05	23.97	23.97	28.93

(Table 30-Source: Data collected by the researcher)

The study found Universal Immunization Programme as one of the successfully implemented one as 84.3% of the total respondents were aware of the same. The above table illustrates that tribal area had maximum awareness on governments free and compulsory vaccination scheme however the utilization of the scheme seems to be little low as compared to the other two regions.

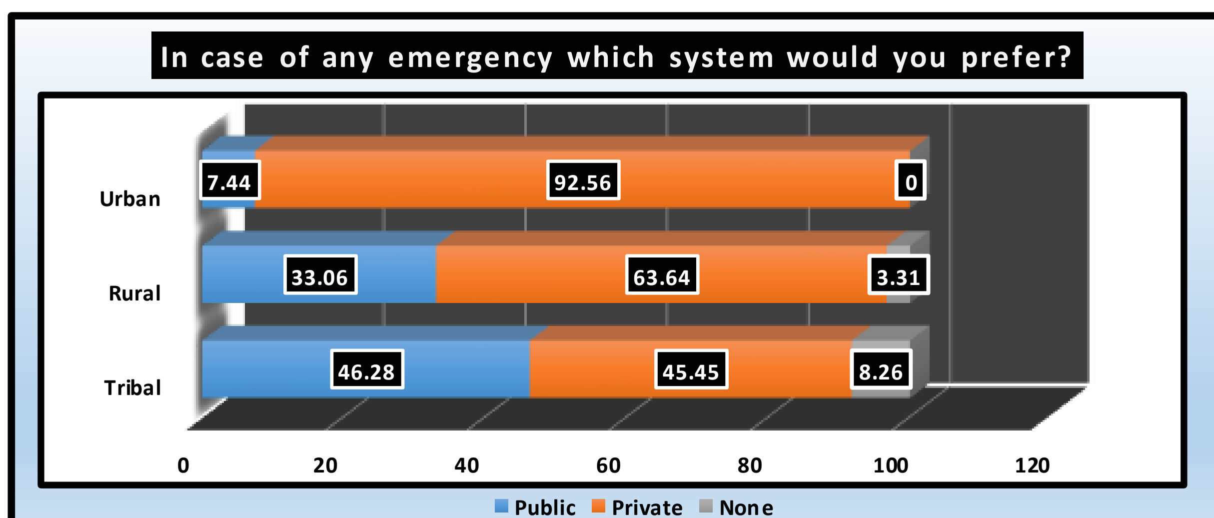
5.5.5 Figures 81-82: Preference of Healthcare system for ordinary illness and Emergency

The figure below shows the preference of respondents in case of ordinary illness like flu, fever etc. It has been found that majority (39.94%) of the respondents chose private clinic as their option in case of ordinary illness followed by 25.34% choosing Primary Healthcare Centre, it was due to the majority of tribal population opted PHC's as their option in case or ordinary illness. 20.66% chose Government District Hospital; 11.85% private hospital and 2.20% Community Healthcare Centres.



(Figure 92-Source: Data collected by the researcher)

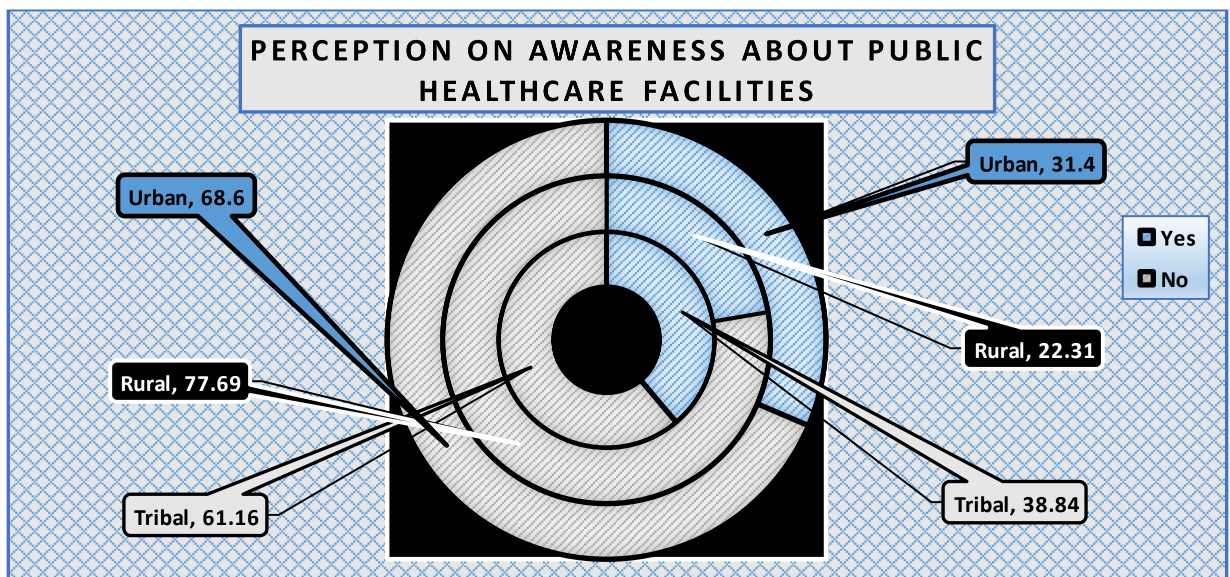
Similarly, in case of emergency also it has been found that majority opted private healthcare system over public healthcare system. It is an alarming situation for the government that even after putting in place many efforts and schemes to improve the public healthcare system, still public lack faith in it. This question yield majority 68.32% opting private healthcare system followed by 28.93% opting public healthcare and 2.75% opting none but traditional method. From the figure above it is clear that from each region also very less percentage of public is ready to choose public healthcare in case of emergency.



(Figure 93-Source: Data collected by the researcher)

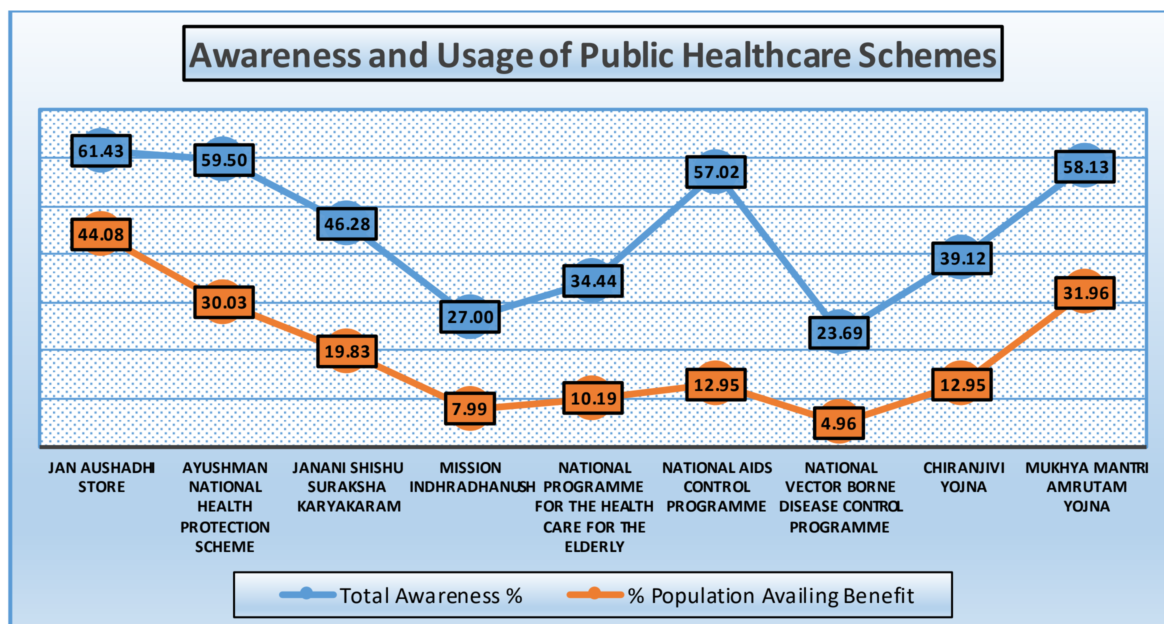
5.5.6 Awareness on Government Initiatives on Healthcare and percentage of population utilizing the same

From the ground it has been found that of the total 363 respondents 69.15% expressed that they lack awareness on the public healthcare facilities provided by the government. From the figure above it is clear that 77.69% of the respondents from rural areas, 68.6% of the respondents from urban region and 61.16% of the respondents from the tribal region thought they lack information on the government healthcare facilities and there is need for more awareness programmes.(Refer below figure 83)



(Figure 94-Source: Data collected by the researcher)

The below figure 83 depicts that 61.43% of the total respondents are having awareness on Jan Aushadhi Store and 44.08% of them are availing it; 59.50% are aware and 30.03% are availing benefit under Ayushman National Health Protection Scheme; 58.13% are aware of Mukhya Mantri Amrutam Yojna and 31.96% of the population are availing the benefit under the scheme; 57.02% are aware about the National AIDS control programme; 46.28% are aware and 19.83% are availing benefit under Janani Shishu Suraksha Yojna.



(Figure 95-Source: Data collected by the researcher)

The below table depicts the responses given by the respondents on their awareness on specific programmes implemented by the government and what are the programmes under which they avail benefits.

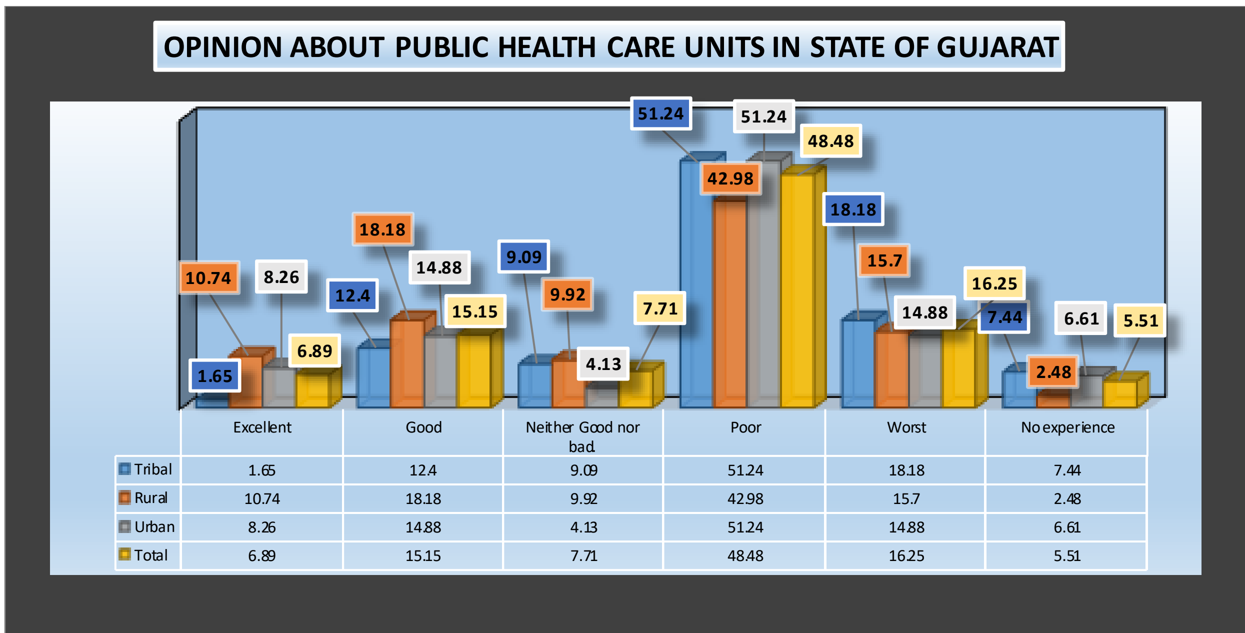
Are you aware of the governmental programmes and policies on healthcare?						
	Tribal		**Rural**		**Urban**	
Categories	**% Yes**	**% No**	**% Yes**	**% No**	**% Yes**	**% No**
Jan Aushadhi store	49.59	50.41	74.38	25.62	60.33	39.67
Ayushman National Health Protection Scheme	61.16	38.84	54.55	45.45	61.98	38.02
Janani Shishu Suraksha Karyakaram	53.72	46.28	39.67	60.33	45.45	54.55
Mission Indhradhanush	33.06	66.94	23.14	76.86	24.79	75.21
National Programme For The Health Care For The Elderly	42.15	57.85	30.58	69.42	30.58	69.42
National AIDS Control Programme	57.85	42.15	60.33	39.67	52.89	47.11

National Vector Borne Disease Control Programme	29.75	70.25	23.14	76.86	18.18	81.82
Chiranjivi Yojna	53.72	46.28	33.06	66.94	30.58	69.42
Mukhya Mantri Amrutam Yojna	73.55	26.45	47.11	52.89	53.72	46.28
Mark the schemes under which you are availing benefits						
	Tribal		**Rural**		**Urban**	
Categories	**% Yes**	**% No**	**% Yes**	**% No**	**% Yes**	**% No**
Jan Aushadhi Store	24.79	75.21	73.55	26.45	33.88	66.12
Ayushman National Health Protection Scheme	29.75	70.25	47.11	52.89	12.4	87.6
Janani Shishu Suraksha Karyakaram	21.49	78.51	29.75	70.25	8.26	91.74
Mission Indhradhanush	11.57	88.43	8.26	91.74	4.13	95.87
National Programme For The Health Care For The Elderly	15.7	84.3	11.57	88.43	3.31	96.69
National AIDS Control Programme	14.05	85.95	9.09	90.91	0	100
National Vector Borne Disease Control Programme	8.26	91.74	6.61	93.39	2.48	97.52
Chiranjivi Yojna	19.83	80.17	16.53	83.47	16.53	83.47
Mukhya Mantri Amrutam Yojna	38.02	61.98	39.67	60.33	18.18	81.82

(Table 31-Source: Data collected by the researcher)

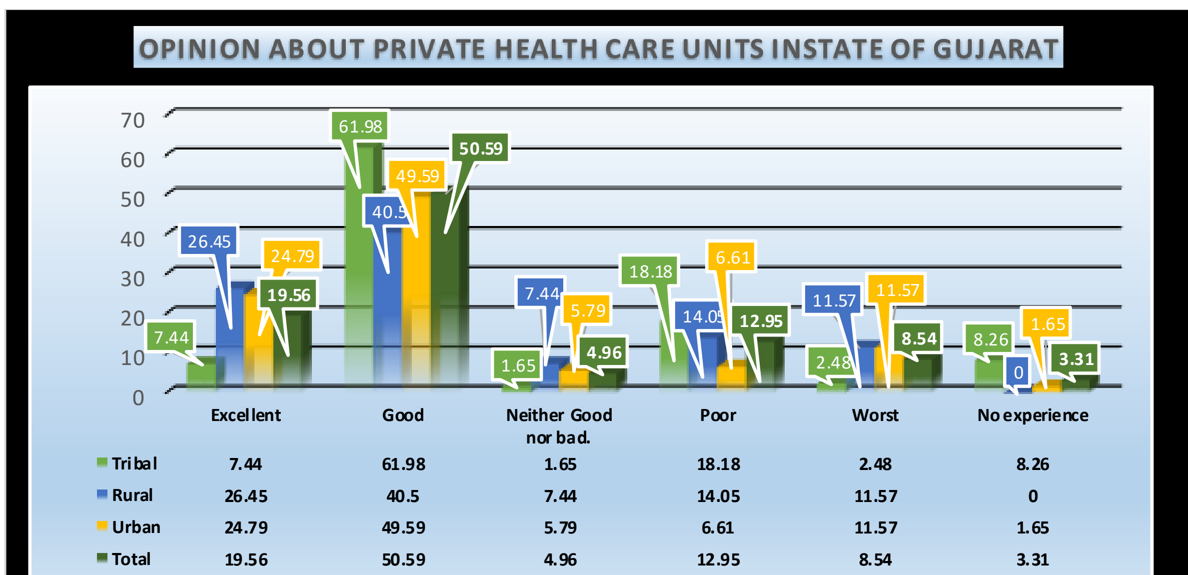
It has been found that majority of the rural population has more awareness on government schemes than population from tribal and urban region.

5.5.7 Figure 96: Rating of public and Private Healthcare Units



(**Figure 96**-Source: Data collected by the researcher)

Of the total respondents 48.48% of the total respondents rated public healthcare system as poor followed by 16.25% rating it as worst. 5.51% doesn't have any experience with public healthcare system; 15.15% thinks that it is good; for 6.89% it is excellent and 7.71 has a neutral opinion. One of the noteworthy findings is that majority of all three regions rated it as poor.



(**Figure 97**-Source: Data collected by the researcher)

The figure above shows the region wise rating of private healthcare system along with the total. It has been found that 50.59% of the population rated it as good followed by 19.56% rating it as excellent. For 12.95% of the respondents, it is poor and 8.54 rated it as worst. 4.96% has got a neutral opinion and 3.31% doesn't have any experience with private healthcare system.

5.6 Analysis of Data Collected from Second Category of Respondents

The second category of respondents include the healthcare providers. To understand the current status of three tier system of healthcare in Gujarat and also the facilities provided by private hospitals in Gujarat, the researcher had conducted a field survey covering the PHC's, CHC's, District Hospitals and one Multispecialty Private Hospital from each region. The data was collected using observation method and through open ended questionnaire. The analysis of the data is discussed in detail below;

Primary Healthcare Centres and sub-Centres are the first contact point for healthcare of the rural and tribal community, for urban region there are Urban PHC's. As mentioned through figure 6, Gujarat has 7274 Sub-Centres, 1178 Primary Health Centres, 300 Community Health Centres, 24 District hospitals and 12 Medical Colleges as per the Government data. The government has developed the rural healthcare infrastructure as per the norms of the central government however the data are depicting that there is shortage of public healthcare units in urban areas.

5.6.1 Basic Facilities Provided by Public Healthcare System

With respect to the Primary Healthcare, the PHC's were developed with an aim to provide Comprehensive primary healthcare to public, to maintain acceptable quality care and services and to make the services available as per the requirement of the community. During the survey it has been observed by the researcher that though the government has developed enough public healthcare units, still there exist shortage of healthcare professionals. None of the surveyed PHC's are working 24X7. The surveyed PHC's were having single nurse/midwife as in charge of the same. It has been found that they are not

visiting the unit regularly or there is no regular timing. Though the guideline provides for 24 hours' emergency services, outpatient services and inpatient services with 6 beds, the surveyed PHC's were not providing all these services other than maternal-child health including family planning and implementation of some of the healthcare programmes.

The Community healthcare Centres (CHC's) aims to provide expert care with acceptable standard of quality as per the needs of the community. Regarding the Community Healthcare Centres the researcher has a mixed opinion. As per the government data the state has developed more than 300 Community Healthcare Centres. Majority of them are functioning in government owned buildings. During the survey, it has been found that some of them are functioning well with good facilities, specialists and other required staff whereas some of them were unhygienic and without basic requirements. They had less Doctors, overcrowded, untidy, inadequate washrooms etc. Even the surroundings found to be filthy. During the interaction with patients, it has been found that some of the doctors are not regular and not visiting the CHC on time. After 5-6 visits to one CHC, the researcher couldn't meet the superintendent as the person was not present in the hospital. The report by statistical division of Ministry of Health and family Welfare itself is highlighting that there is shortfall of 1330 specialists, 170 radiographers, 163 Pharmacists, 109 Lab technicians in rural CHC's. It has been noted that the surveyed CHC's are providing both OPD and IPD services, new born care, eye care services, maternal healthcare and Family Planning services. In addition to the same some of the National Health programmes like Communicable Disease Control Programmes, Non-Communicable Disease Control programme, Programme for Elderly care etc. are also carried out by the CHC's.

Gujarat has 24 District hospitals, 36 sub-divisional hospitals 30 mobile medical units and 12 medical colleges. All 24 building where the district hospitals are functioning are owned by the government. The data from the statistical department of Ministry of Health and Family Welfare shows that there is shortfall of doctors in position of the district hospitals in Gujarat; the sanctioned number is 413 unfortunately only 251 of them are in position. Similarly, there is shortage for other hospital staff too, the sanctioned number of para medical staff is 1592 but there are only 1281 in position. This was observed by the researcher too during the survey.

The district hospitals provide curative care via diagnosis and treatment free of cost to the public. They are majorly situated in urban areas of the state. The District Civil Hospitals are offering both inpatient care and outpatient care. The Janani Shishu Suraksha Karyakram, Rastriya Swasthya Bima Yojana, Mukhyamantri Amrutam Yojana, Rogi Kalyan Samiti, Pradhan Mantri Jan Arogya Yojna are some of the schemes implemented through the District Civil Hospitals. The below given is the organisation Chart of the District Hospital of Ahmedabad. As per the data provided by hospital, they had 2000 beds for inpatient care in 2018. With an objective to enhance preventive health of the children, decrease Neonatal Mortality Rate and to provide for immunity to fight against fatal diseases the civil hospital also runs a vaccination centre.

The experience of the researcher with the district hospitals were not so great. The District hospital of Ahmedabad found to be better as compared to Gandhinagar Civil Hospital. At the time of the survey the superintendent of one of the District hospital has not granted permission to the researcher to conduct the survey within the hospital premises and the person found to be admitting the fact that there are some inherent issues with the administration.

The Civil hospitals provides facilities like general examination, general medicine, Obstetrics and Gynaecology, General Speciality, General surgery, Pediatrics, Orthopedics, ENT Surgery, Opthalmology, Dermetology, Dental Services, Neurosurgery, Nephrology. They also have pathology laboratory, Pharmacy and Radiology Department. They also provide Auxiliary Services like Mortuary and Post mortem room, ambulance services, medical record and hospital management information etc.

The below given is the organisational structure of the District Civil Hospital of Ahmedabad.

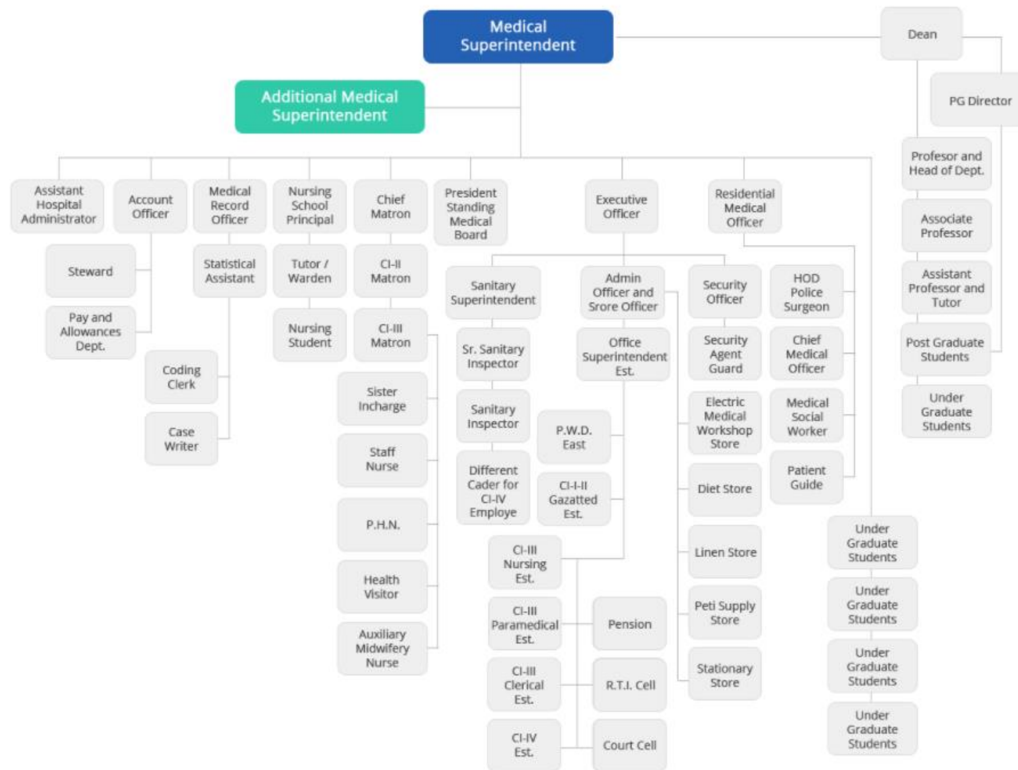
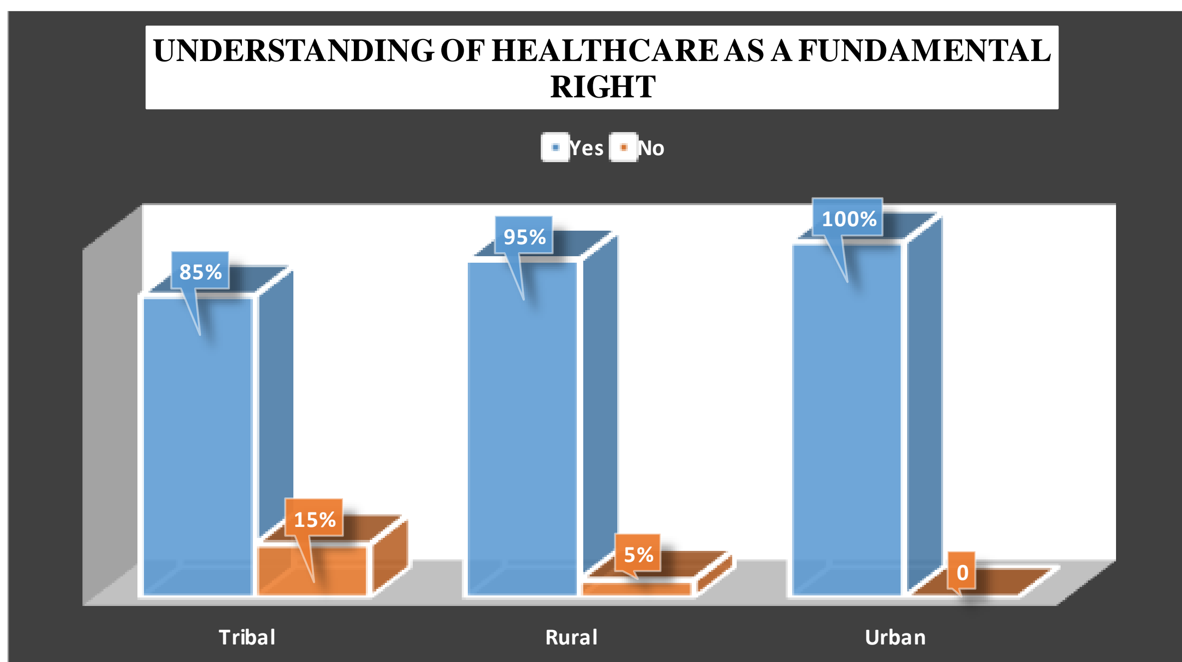


Figure 98: Source-Official website, Civil Hospital Ahmedabad[541]

The Private hospitals chosen for the study were multi-speciality hospitals. It has been found in the survey that the hospitals were having good human resources. The premises and the hospital building including the washrooms were maintained very clean. They had all facilities within the hospital premises including diagnostic facilities, pharmacy and all specialist's cares. The patients found in the hospital seems to be very happy with the services except for the expenses. It has been found that the private hospitals are providing services under Mukhya Mantri Amrutam Yojana, to monitor the same there is an office of MAA yojana created within the private hospital premises. One of the private hospital during the time of data collection in 2019 said that more than 1400 patients have availed benefit under Mukhya Mantri Amrutam Yojana within two years of its implementation. At the time of survey, the coordinator informed that 20 patients per day is approaching the hospital for availing the benefit under the scheme.

[541] "Organization Chart | About Us | Civil Hospital, Ahmedabad" <https://civilhospitalahd.gujarat.gov.in/organization-chart.htm> accessed November 29, 2021.

5.6.2 Figure 99: Understanding on Healthcare as a Fundamental Right



(**Figure 99**-**Source: Data collected by the researcher**)

The above figure depicts that of the total respondents 93.33% of the respondents considers healthcare as a fundamental right, which includes 85% from the tribal region, 95% from the rural region and 100% from the urban region. Only 6.67% still thinks that it is not a fundamental right. The people who answered in 'NO' are ASHA workers.

5.6.3 Do you know about the governmental programmes and policies aiming at developing the healthcare system in India? If yes, how your hospital is implementing them.

100% of the healthcare providers from public healthcare units are aware of the schemes implemented by the government through their organisation however the only 17% of the private healthcare providers were aware of those schemes and majority were not knowing many of the government schemes. Regarding the second question in case of Sub-Centres, PHC's and CHC's. the ASHA workers visit the households and spread awareness on determinants of health, health services provided by the healthcare units and the need for

timely utilization of health & family welfare services to the public. The public avail the benefits from the nearest healthcare units as per their requirement. In some cases, ASHA workers also provide them supplements and vaccines at their household too. The study found that the working of ASHA workers is more effective in the rural regions than the tribal and urban areas.

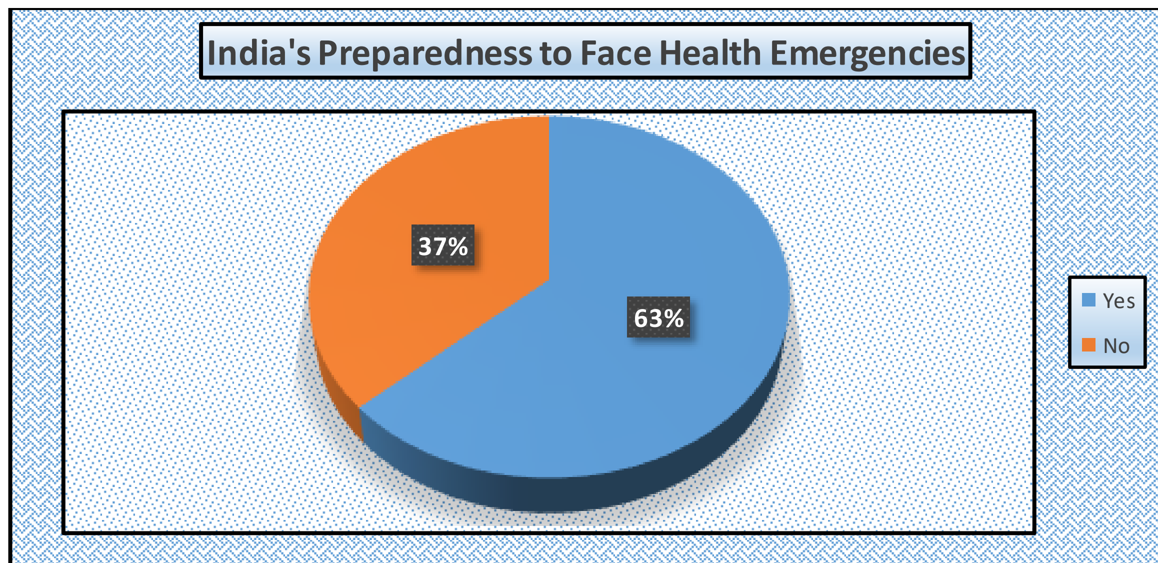
5.6.4 Opinion on the existence of inequalities in access to healthcare based on Gender, Geography and economic status

Majority i.e., 76% of the rural healthcare providers think that there exists gender-based discrimination in the rural areas. According to them the parents are least cared about the health status of girl child as compared to the boy. This is reflected in the pattern of availing vaccination too. Whereas only 56% of the tribal healthcare providers acknowledged the gender-based discrimination observed in their areas. In case of urban areas, it was only 7%.

When we talk about unequal distribution of healthcare units between urban and rural region. 81.65% of the total respondents agree that there are more healthcare facilities in urban region but more public healthcare units are found in rural regions of Gujarat. For them the major challenge is that people are preferring private clinics over government healthcare units. They observed a stigma/lack of trust in public on the government public healthcare systems. A solution as mentioned by them is that of the government servants and the politicians and their family choose the public healthcare units for their treatments, they can set an example for the public.

With respect to the economic capacity in accessing healthcare, 97% of the total respondents opined that there is no financial burden in accessing public healthcare. However, in the government sector other than hospitalisation and consultation, the patient has to pay expenses incurring on account of medicine, diagnosis etc. Similarly, the rich people have access to good healthcare provided by private multi-speciality hospitals they are not accessible to the poor.

5.6.5 Figure 100: Perception on India's Preparedness to face health emergencies



(Figure 100-Source: Data collected by the researcher)

The above figure illustrates the perception of respondents on India's preparedness to face health emergencies. The interesting observation here is 63% of the respondents opined that India is ready to deal with health emergencies whereas 37% thinks that it is difficult for the country to deal with emergencies. The 63% data here were collected before the pandemic outbreak in 2019. Rest data ie., the 37% were collected during the pandemic and none of the participant were of the opinion that the country is capable of facing health emergencies. May be this opinion is developed after the hitting of Covid Pandemic and after watching the country struggling to deal with the same.

5.6.6 Perception on Public and Private Healthcare Systems

Every healthcare provider surveyed for the research believes that the private healthcare system in terms of service and quality are better as compared to the public healthcare system in our country. There is availability of more private hospitals with more advanced facilities than what is provided by the public healthcare units. But we cannot say that all private healthcare units are good in quality service and accessible to public. Due to the high expenses, they are not accessible to the marginal groups of the society.

40% of the total respondents opined that the condition of public healthcare is improving day by day. India's private health expenditure is 3 times more than the public health

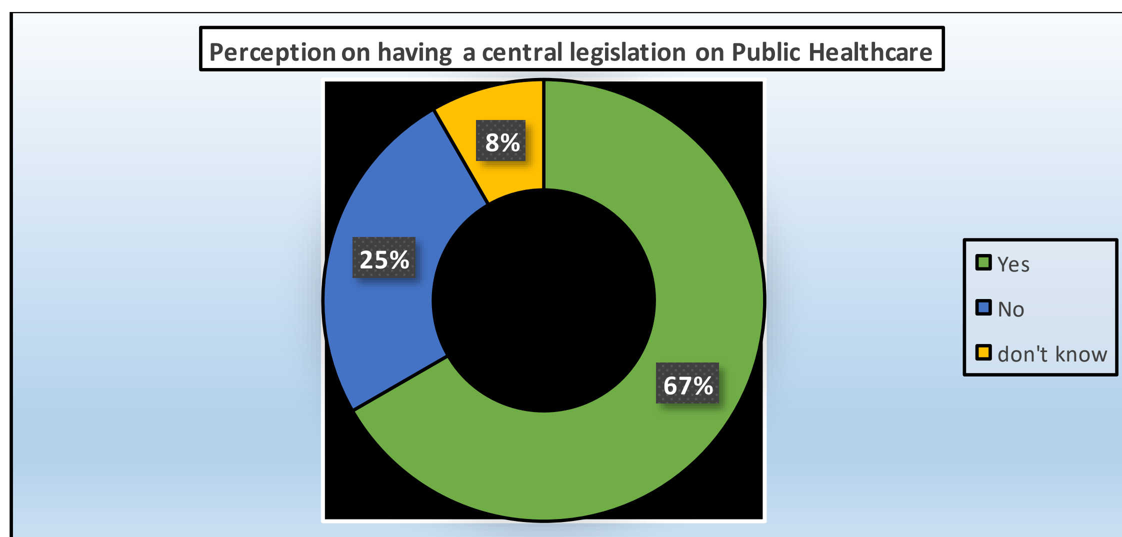
expenditure. Hence the services provided by the private sector are better as they have developed good infrastructure. However, we have got good experienced doctors in public healthcare. AIIMS is one of the public hospitals with worlds best doctors working in It.

A 23% of the total respondents had also suggested public-private partnership as a solution for the current challenges the country is undergoing and, in their words, regulation of private health sector especially in matters of fee and other charges are very essential in India.

A 15% of the total respondents mentioned good training and access to latest technology and world class machines as one of the reasons for success of the private sector. They are more professional in their approach and private sector is having a greater number of beds, ICU, operation theatres, emergency care etc.

5.6.7 Perception on having a central legislation on Public Healthcare

From the figure 101 below, it is clear that majority (67%) of the total respondents were of the opinion that there should be a uniform legislation aiming to regulate the public healthcare system. 25% of the population were in in favour of having a central legislation and 8% of them respondents didn't have any opinion on the same.



(Figure 101-Source: Data collected by the researcher)

5.7 Analysis of Data Collected from Third Category of Respondents

The third category of respondents included ten Public Healthcare experts representing Academia, Public health, Health Economics, Healthcare Management, Advocates, Bureaucrats and representatives of Civil Society. The researcher found it necessary to understand the point of view of different stakeholders of public healthcare and management to understand their perception on the challenges the Indian healthcare system is currently undergoing, the reasons for such challenges and the possible solutions. The technique used to collect data was FGD and Interview Method. The analysis of the data along with the question are discussed in detail below;

5.7.1 What is your opinion on the current status of public Healthcare system in India? What are the major challenges and lacunas found in our healthcare system?

One of the experts from public healthcare in the Focus Group Discussion (FGD) had narrated a small story to explain the approach of different countries towards administration. He took the example of death of Mumtaz Mahal in 1631 due to postpartum haemorrhage after giving birth to her 14th child. As a result, the disturbed king Shah Jahan-built Taj Mahal as a token of love to his beloved wife spending the public fund. There has been a similar scenario in Sweden where the Swedish queen who was pregnant had some complications in her pregnancy and the king had to call doctors from France to help his queen with the delivery. Annoyed by this situation the king had spent more money in the public healthcare system to strengthen the same instead of building a monument. He sent his healthcare professionals to train them in maternal and child care. Therefore, Sweden has the lowest MMR today.

The next expert described the healthcare system as super, good, and bad. Super because with many issues in the healthcare system, the country was able to vaccinate one billion plus people. Another achievement is the eradication of polio, small pox etc., some of our Institutes like AIIMS are having the world's best specialists. Our vaccination programme and the general care provided by the public health units are ranked by him as good. Similarly, the country has shown an upward trend in many indicators like IMR, MMR,

Leprosy, TB, malnutrition etc. The public health expenditure is poor, our government hospitals doesn't have stock of all medicine they prescribe, lack of technology and machines in government hospitals are highlighted by him some of the challenges. He compared the doctor to population ratio of public healthcare system in rural India with UK and Germany and pointed that it is one doctor to 15,000 people in India whereas one doctor for 2,000 people in UK and Germany.

One of the legal experts had highlighted the privacy related issues with the hospitals as there is no confidentiality of data. There were instances were human right commission had to interfere. Examples are the Gorakhpur incident were many children were died due to lack of oxygen and also the death of many women in Madhya Pradesh after delivery. They also highlighted the judicial intervention during Covid 19. The judiciary intervened and directed the state governments and the centre to ensure proper treatment, testing and also to make healthcare accessible to public. Healthcare system in Gujarat is compared with cattle shed by the higher judiciary in the state. Judiciary has intervened in administration of government when pregnant women were kept outside the vaccination drive. The expert also highlighted some of the judgements like Paschim Benga Khet Mazdoor Samiti VS. UoI and CERC VS. UoI , in which the Hon'ble Supreme Court explicitly held healthcare as an integral part of Article 21. The expert advocated the need for shifting subject healthcare from state list to concurrent list and having a uniform legislation on public healthcare. He also emphasised that there is a need for regulating the private healthcare system in India.

5.7.2 In your opinion whether the National policies, programmes and Schemes on Healthcare are yielding outcomes?

In opinion of one of the public healthcare experts some of the schemes were well implemented and yielded the benefit which was intended at the time of implementation. Examples are the Smallpox and Leprosy eradication programmes. Whereas the programmes aiming to eradicate Polio and the Universal Immunisation Programme are showing an upward trend. The programmes on maternal and child healthcare; family planning and fertility reduction are also yielding some benefits. Programme on Malaria

eradication is a failure though there were some improvements. Though the National Health Policy 2002 aimed at 'Healthcare for All' was not a success story. Anaemia and malnutrition even after many programmes to ensure access to nutrition is a catastrophe. In matters of cardiovascular diseases our national programmes seem to be weak and the same is the cause for major deaths in India. Schemes on non-communicable diseases are not yielding the desired benefits. The RSBY intending to achieve Universal Health Coverage is marching towards success. He concluded by saying that we have a mixed bag of programmes in which some are yielding benefits and some are not.

As per the UN Projection Geriatric population are the fastest growing population segment in India, and with more than a hundred million people aged above 60 years, India is already facing some of the challenges of population ageing. It is reported that the number of older persons will rise to 354 million in 2050 accounting for almost 20% of the population. Do you believe it is high time for India to think about Long Term care?

Demographic transition from high fertility to low fertility level and epidemiological transition high mortality low mortality rate, leads to population expansion and more geriatric population in the country, hence it is high time that India should start thinking on lines of long-term care. This is going to be the last generation which takes care of their parents as well as their children, coming generations might not adopt the same practice.

In opinion of the expert from civil society, government should plan and inculcate good lifestyle, eating and living habits in people so that they stay healthy even after crossing the age of 60 and there will be less disease/ health related burden. Taking the example of Germany, she pointed that Germany is spending 20% of their health expenditure on aged care, if we don't pay attention in developing healthy population, we will end up spending more amount in aged and long-term care.

Share your thoughts on the public healthcare expenditure by Government of India. What should be India's approach to make quality public healthcare accessible, affordable and acceptable to public? What is your analysis about Ayushman Bharat Yojana?

The expert on health economics called India as one of the most privatised healthcare markets in the world. The major part of the healthcare expenditure in India comes from private sector. 70% of the outpatient care and 60% of the inpatient care comes from the

private sector. In India the Constitution envisages duty under List II to the states to formulate healthcare policies and execute them, but over the years the roles and responsibilities of the state and central government got mixed up and in reality, now Central government is formulating them. Examples are the National Health Mission, the Ayushman Bharat Yojna. Last three to four decades India spent about 1% of the GDP in public healthcare. In case of public healthcare spending specially in NHM and Ayushman Bharat, the 2/3rd of the funding comes from the state government and rest from central government.

The fact is that among the three-tier administrative system the third tier that is the local bodies are inactive in case of majority states except in Kerala, Karnataka etc.

Tax funding, mobilizing of fund from other sectors, shifting of subject health from state list to concurrent list; Strong regulation to govern the whole healthcare sector, improving the governance are the keys to achieve quality healthcare system more accessible to public.

In your opinion how the Patent Amendment act 2005 and the practice of issuing the product patent is impacting the access to medicine?

This shift of process patent to product patent has huge implications on the accessibility and affordability of healthcare market. This leads to high market concentrations and monopoly leading to high price of medicines. Compulsory licensing is one of the policy option available to the country which was once invoked in case of cancer medicine. The TRIPS don't stop government from regulating the price. Public procurement and distribution is another solution to make patented medicine much more affordable.

In words of healthcare management professional, the way we manage the healthcare system is critical. To ensure effective healthcare delivery, the healthcare professional should have proper training and should be made accountable for their work.

5.7.3 In your opinion how far "Right of everyone to the enjoyment of the highest attainable standard of physical and mental health" is practiced in India? Do you think there exist inequalities in access to healthcare based on gender, region and financial status?

As per the opinion of the health management and gender studies expert, health is an intersectoral topic. Current situation is that the understanding of health has reduced only to healthcare. It is a multifaceted concept; the concentration should be on good physical and mental health. Unless we see rights in to entitlements which can be converted in to translatable actions, they are not rights just mercy. She highlighted the inequalities prevalent in the system between states and also between urban, rural and tribal region.

Next speaker from civil society has stressed on the importance of mental health which is majorly neglected by the country. She said the three categories of people are getting missed from the policy coverage. The first category being 'missing middle', though they are not having the good financial background, since not getting covered by the government schemes as they don't fall in BPL category. Secondly the invisible category like sex workers, prisoners, refugees etc., due to the special condition that they are in they might not have an Aadhaar card or the related documents necessary to avail the benefits. Thirdly the tokenised group, the vulnerable sections like women, children etc., there are instances where after marriage the women changed the house and she is automatically out of ration and coverage of some schemes.

The complicated formalities while accessing benefits under the schemes, duplication of work etc. leads to people not opting the same.

One of the experts concluded by saying "poor people's wealth is their health", it is the duty of the state to protect the same.

5.7.4 What are your thoughts on Social Justice in Healthcare?

In healthcare equity is more relevant than equality. In simple words the difference between equity and equality is that "equality simply means everyone is treated the same exact way, regardless of need or any other individual difference. Equity, on the other hand, means

everyone is provided with what they need to succeed". Equity should be both vertical and horizontal. One observation shared by the expert is that an uneducated Dalit woman from rural area has less access to healthcare as that of an educated general category woman from urban area. This shouldn't happen in the country; this will fail the whole concept of social justice.

There is a gap in data creation and protection in the healthcare system. Private hospitals data are not available. This needs to be taken care of.

After analysing the discussion, it is relevant to quote the words of Dr. Amberdkar during his final speech in Constituent Assembly in 25th November 1949. He said *".....I feel, however good a Constitution may be, it is sure to turn out bad because those who are called to work it, happen to be a bad lot. However, bad a Constitution may be, it may turn out to be good if those who are called to work it, happen to be a good lot. The working of a Constitution does not depend wholly upon the nature of the Constitution. The Constitution can provide only the organs of State such as the Legislature, the Executive and the Judiciary. The factors on which the working of those organs of the State depend are the people and the political parties they will set up as their instruments to carry out their wishes and their politics*".

5.8 Conclusion

The study found that there is improvement in the public healthcare sector of Gujarat but the same is happening in a slow pace. The development of healthcare sector is not in pitch with the economic development of the state. When we analyse the trend of healthcare spending in Gujarat the state invested 0.41% of its GDP (2.84% of the total budgetary allocation and RS. 1151.3 crore) in healthcare in 2006-07[542]. The budgetary allocation witnessed a upward trend in the subsequent years. The same was RS. 5086.65 crore in 2013-14, RS. 6369.88 Crore in 2014-15, RS. 7410.68 Crore in 2015-16 and RS. 8153.83 Crore in 2016-17. The percentage of total budget 4.24% in 2013-14 increased to 5.59% in 2016-17 and then there was a decline and reached 5.37% of the total budgetary allocation

[542] Mahender Jethmalani, "Public Investment for Health Care in Gujarat" <www.pathey.in> accessed November 17, 2021.

in 2016-17. When compared with GDP, there were only marginal change in the allotment. It was 0.41% in 2006-07 and increased to 0.77% in 2013-14, 0.71% in 2014-15, 0.79% in 2015-16 and 0.75% in 2016-17[543]. In 2017-18 Gujarat allocated 5.86% of its total expenditure, RS. 7432 Crore in healthcare and the same was found 0.72% of its GDP[544]. In 2018-19, Gujarat has allocated 4.5% of the total budgetary allocation i.e., RS. 8172 Crore and the same was lower to the healthcare spending of 18 other states[545]. The subsequent year 2019-20 the state allocated 5.8% of its total budgetary allocation for healthcare[546]. It was RS. 11,225 Crore in 2020-21 and RS. 11,304 Crore in 2021-22 which is 5.7% of the total budgetary allocation. However, this amount is not in consonance with the standard set under National Health Policy, 2017. Under NHP 2017 the states are expected to increase their healthcare spending to 2.5% of the GDP. The state has even overlooked government of India's instruction to spent 8% of total budgetary allocation on healthcare too. The distribution of fund on National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) also was unequal, as per the reports 93% of the fund was allotted to NRHM and only 7% was given to NUHM. This can be one of the reason for shortfall in healthcare units in urban area.

Even after governments efforts to make healthcare accessible for all, it has been found that there exists a huge gap based on region of residence, gender, income, awareness etc. The study found that maximum population has the information that healthcare is their fundamental right though they are not aware of how to claim the same. The status of health insurance as discussed above is still in a despairing position. Majority of the surveyed population doesn't even know the importance of health insurance. It has been found that there is a huge gap in the system due to unavailability of human resources.

The tribal area alone is having shortfall of 666 Auxiliary Mid Wife (ANM-Female), 963 Male Health Worker, 26 Female Health Worker, 83 surgeons, 310 specialists and so on. It is 535 ANM Female, 1226 HW Male, 939 HW female and so on in rural region and 97 lab technician, 61 doctors, 21v specialists, 14 Radiographer and so on in urban areas. Urban

[543] Jethmalani (n 543).
[544] PRS India, "Gujarat Budget Analysis 2018-19" <https://prsindia.org/budgets/states/gujarat-budget-analysis-2018-19> accessed November 17, 2021.
[545] India, "Gujarat Budget Analysis 2018-19" (n 545).
[546] PRS India, "Gujarat Budget Analysis 2019-2020" <https://prsindia.org/budgets/states/gujarat-budget-analysis-2019-2020> accessed November 17, 2021.

area also has inadequate number of healthcare units, there is requirement of 24 urban PHC's, 16 urban CHC's and 13 District hospitals.

Even though the government has created enough number of healthcare units under the NRHM in rural and tribal regions this will not serve the purpose without enough human resources. Similarly, there are issues with the quality of healthcare provided, hygiene of the healthcare units, other facilities like clean water, sanitation, bed etc, available in those units and evidently the working hours of those healthcare units. Lack of resources, Geographical isolation, poor implementation of policies and programmes and poor socio-economic and human development are the main reasons for poor healthcare in tribal region. Challenges due to geographical area and poor connectivity are adding to the problem as the healthcare workers are hesitant to take up a job in the tribal areas. OOP spending on healthcare is another obstacle which come in the way of development of these vulnerable sections. In addition to this there exist the issues of gender inequality too. The study also found that there is a huge dependency of rural and tribal population on urban healthcare units and large amount of the public lacks faith in public healthcare units. Majority of the respondents rated public healthcare system as poor and private as good though they are expensive.

Hence the researcher would like to conclude by emphasizing on the point that this is an alarming situation for the government that even after having a good economic development, the government has failed to strengthen the public healthcare system. The government need to work more on ensuring quality in the system and also to attain the trust of the public. More time and money should be spent on spreading awareness; strengthening the infrastructure; ensuring access to healthcare to all. Uninterrupted monitoring of the working of the system is required. Expanding the coverage of public health insurance should also be the target of the government.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

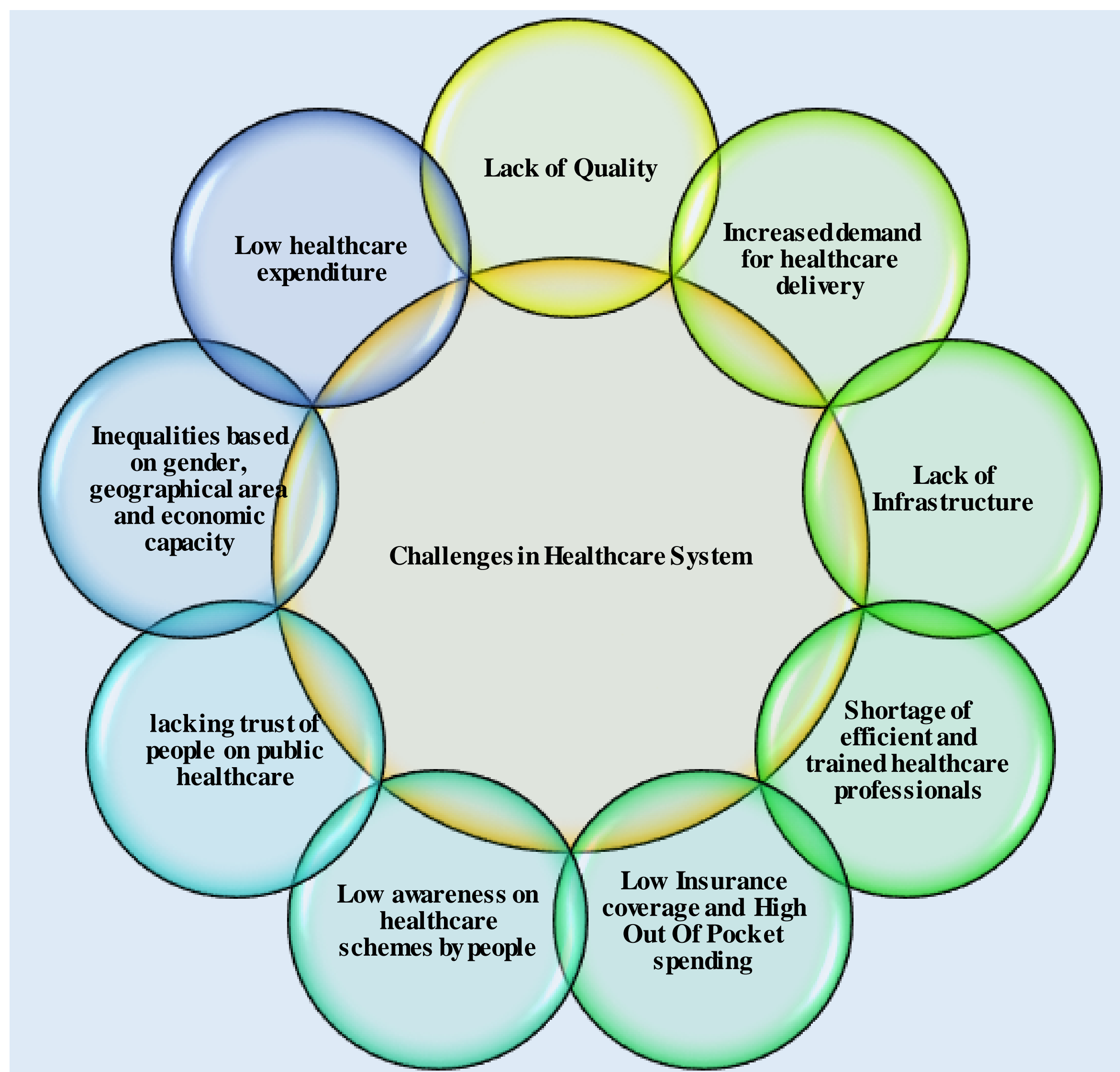
6.1 Conclusion

Achieving "Healthcare for All" and "Highest attainable standard of health for all" are the two obligations shouldered on government of India by the international Law. The Constitution of India also under part III and Part IV obliges the government to ensure access to healthcare for all without any discrimination. The International Law suggests a 'human right based approach to healthcare' to be adopted by the country to give it colors of right and make it enforceable. India's journey to achieve Universal Health Coverage/Healthcare for All/Highest Attainable Standard of health mark decades of hard work with stories of success and failure. As discussed under Chapter 4A The role played by Indian Judiciary and Government of India in strengthen the healthcare system, improving the quality and accessibility are noteworthy. The government had initiated its work on healthcare in1943, even before independence, by appointing Bhore committee to review the health status and requirements of the country and to give recommendations. Following the same many committees were appointed by the government to evaluate the functioning of the healthcare system and suggest ways to improve the same. Based on the recommendations given by various committees, the government had created various healthcare units tribal, rural and urban areas. In addition to that the government has been putting in place a number of schemes to address many issues and challenges the healthcare sector was experiencing. Some of such programmes yielded benefits, best example is elimination of small pox some didn't. The 7 decades' journey of the country towards making quality healthcare accessible to all witnessed many ups and downs.

The government is successful in creating many healthcare units throughout the nation and also in training and appointing considerable number of healthcare professionals in its healthcare units. In rural areas government introduced a three tier system of healthcare by making primary, secondary and tertiary healthcare available to people through various healthcare units with varied facilities. Some of the states like Kerala, Andhra Pradesh are performing well in key indicators of health, but this is not the case with majority of the states. The government has also created many institutes for training and research in health

related matters and councils to monitor and fix the standards of healthcare profession. Even after all these efforts the government is unable to accomplish the goal of Universal Health Coverage.

The current study found that the public healthcare system of India is still under the curb of many issues and challenges. Some of the issues are demonstrated through the below figure.



(Figure 102: Challenges of Healthcare System)

The current study found that there are 8 major challenges that the healthcare system is undergoing even in the 21st century. Lack of quality is a serious issue which is deliberated under chapter 4A. The healthcare system is slammed for lack of quality leading to death. It

has been found that the death due to poor quality of care accounts for 122 Indians per 1,00,000 populations in a year.

Next point to be discussed is the increased demand for healthcare. The major reason for such increased demand is the increasing population. The communicable diseases like Covid 19, TB, HIV are adding to this burden of the country. When all the developed nations are fighting Covid 19 third wave so far situation is under control in India. The country was successful in reaching the doorsteps of the people with vaccination. The country was successful in eliminating Polio, the last case is reported in 2011 from west Bengal. WHO has declared India a polio free nation. The country is steadily improving in the TB cases too as the report says there was a 25% decline of TB cases in India between January to December 2020. However, with a 24 lakh reported cases of TB it seems to be difficult for India to eliminate TB by 2025. With Vector Borne Disease Control Programme India is still struggling to find answers for Malaria, Visceral Leishmaniasis, Bancrftian Filariasis, Japanese Encephalitis and Dengue. In addition to this majority of the impoverished in the country is undergoing threats of diarrhea and cholera due to the poor living conditions in which they reside. Non- Communicable Diseases (NCD's) contribute around 60% of the deaths happening in India. India is the major contributor of total deaths due to NCD's in South-East Asia region. The major NCD's found in India include Cancer, Cardiovascular diseases, Diabetes, chronic respiratory diseases, Hypertension, Obesity and Overweight. The studies are depicting that many factors are contributing to this increased disease burden of India, they include pollution, lifestyle, poor living conditions etc.

It has been found that the healthcare infrastructure development is not in consonance with the with the increasing population and the demand. In addition to that a considerable number of Primary Healthcare Units are functioning in rented buildings, some of them lacks beds, continuous water supply, electric supply, Labour room, approach roads etc. Majority of them are not providing 24X7 services. Many healthcare units in rural areas doesn't have specialists, emergency care, anaesthetists. Majority of them are untidy and hygiene is not maintained. This is one of the reasons because of which people opt out public healthcare units.

Shortage of human resources in healthcare is a known challenge India is facing. As per the records of National Health Workforce Accounts data 2018, India has 5.76 million health

workers in total which include 1.16 million allopathic doctors; 2.34 million nurses/midwives, 1.20 million pharmacists, 0.27 million dentists and .79 million AYUSH (traditional) medical practitioners. However, the active workforce estimated by NSSO 2017-18 found only 3.12 million. The current healthcare force in India is well below the threshold of 44.5 doctor, nurses and midvices per 10,000 popoulation fixed by WHO.

In India the bottom 50% are covered with comprehensive hospitalization benefits under Ayshman Bharat-Pradhan Mantri Jan Arogya Yojana along with the state government extension schemes, which constitutes around 70 crore individuals, nearly 20% (25 crore) are covered through social health insurance schemes and private voluntary insurance scheme. Almost 30% of the total population are devoid of health insurance protection. As a path to achieve Universal Health Coverage, Government of India devised Ayushman Bharat in 2018. As discussed above at the time of implementation the scheme aimed at creating 150000 Health and Wellness Centres by 2022 to deliver comprehensive Primary Health Cere along with preventive, promotive, curative, rehabilitative and palliative care. Under the second component of the scheme namely Pradhan Mantri Jan Arogya Yojana (PMJAY), the government aims to achieve financial protection to 500 million people in matters of healthcare at point of healthcare. However, the publically sponsored health insurance schemes are covering only hospitalization charges, a very few covers transportation and medicine too. Hence the beneficiaries are left with no option other than spending Out of Pocket for medication, diagnosis etc. This will force the BPL population to embrace poverty. The Out-of-Pocket Healthcare Spending is high in India, as per the reports 62.7% of the total healthcare spending’s were OOP in 2018.

Figure 103: Status of achievement by states in meeting the goal set under the Ayushman Bharat Scheme- Source [547]

The study found that India has marked a milestone in universalizing primary healthcare as on March 2021 as the plan of nation to operationalize 70,000 Health and Wellness centres (AB-HWC's) under the scheme has achieved by the country. Even in the phase of pandemic the work done by these AB-HWC's are commendable. The above figure depicts the status of achievement by states in meeting the goal set under the Ayushman Bharat Scheme.As per the figure above the states highlighted in green color (11 states) have almost met the target of creating Health and Wellness Centres for their respective states whereas the other states are almost between 0-50% stage of its target.

Low awareness on healthcare schemes has direct nexus with low healthcare utilization. It has been found in the study that majority of the population doesn't have a proper understanding on the healthcare schemes provided by Government of India and the concerned states. The awareness is less in urban areas followed by tribal areas. Whereas the rural population seems to be more aware than the other two categories but the usage is

[547] Government of India, "Health and Wellness Centres" (*Official Website Ayushman Bharat*) <https://ab-hwc.nhp.gov.in/> accessed November 21, 2021.

low in rural areas too. Another major issue is the lack of trust on public healthcare by the people. This discussion draws our attention to the reported cases of death due to poor quality of healthcare and negligence by the healthcare professionals. Public doesn't have the faith in public healthcare system to approach them in case of emergencies. The is attributable to the poor infrastructure, non-availability of doctors and healthcare professionals, poor quality of care, poor hygiene etc.

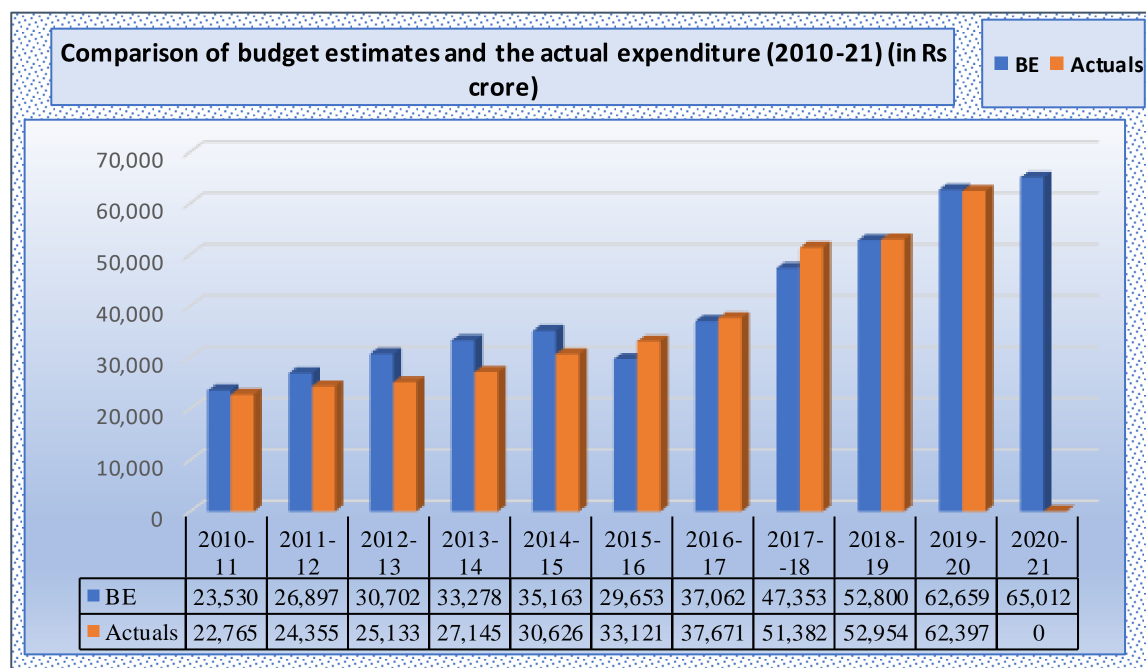
The last point to be discussed is the inequalities in access to healthcare. As shown in the above figure the disparities are based on gender, geographical area of residence and economic status. The sad reality is that even after 70 years of independence the country is still under the clutches of social evils like discrimination based on gender. This has already been discussed under chapter 4B (figure 20, 42, 64 & 79) where the field study from Gujarat found incidents of gender based discrimination in matters of healthcare too. Many families neglect the girl children and doesn't take them to hospital in case of ordinary illness. There are reports showing girl children are discriminated in case of providing vaccination too. They are not provided with nutritious food. In short the girl children are not getting the same attention that a male child of the same family gets. This has led to more health issues like malnutrition, anemia etc in girl children.

India has unequal healthcare facilities between the states and within the states too. When we talk about disparity between the states, it is due to the strategies adopted by the states are different. Healthcare being a state subject, each state is looking after the healthcare in a different way. Only 6 states in India is having a legislation on public healthcare. Kerala is a top performer in healthcare indicators with a score of 74.01, it is 62.61 in case of Gujarat and only 34.44 in case of Uttar Pradesh. This difference is bound to happen. The inequality between tribal, rural and urban areas within a state is also a common issue in India. This has already been discussed of chapter 4A. The table has already explained the difference in bed distribution among urban-rural healthcare units. It has been found that rural area where 60% of the total population of the country lives has access only to 279588 beds whereas in case of urban area it is 431173. Similarly, rural area doesn't have any specialist/emergency care units. The Multi-specialty hospitals are also concentrated in urban India. When comparing the private and public sectors, India has 43,486 private hospitals, 1.18 million

beds, 59,264 intensive care units, and 29,631 ventilators. Nearly 62 percent of India's total health infrastructure is made up of private infrastructure.

Next is inequality based on income. 6.7% of the total population of India lives below poverty line. Only people with good economic capacity can afford treatments in multi-specialty private hospitals. Inadequacy of public healthcare system doesn't provide good care to them whereas highly expensive private healthcare system doesn't open their doors to them.

India's public health spending (which includes both the national and state governments) remained constant at roughly 1.3 percent of GDP between 2008 and 2015, growing slightly to 1.4 percent in 2016-17. Between 2018 and 2020, it stood at 1.2-1.6 percent of GDP. This is much less than the worldwide average of 6%. It's worth noting that the National Health Policy of 2017 envisions increasing this to 2.5 percent of GDP by 2025. In fiscal year 2018 it was 1.58 trillion India Rupees.



	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017--18	2018-19	2019-20	2020-21
BE	23,530	26,897	30,702	33,278	35,163	29,653	37,062	47,353	52,800	62,659	65,012
Actuals	22,765	24,355	25,133	27,145	30,626	33,121	37,671	51,382	52,954	62,397	0

(Figure 104: Source -PRS)[548]

548 "Demand for Grants 2021-22 Analysis: Health and Family Welfare" <https://prsindia.org/budgets/Parliament/demand-for-grants-2021-22-analysis-health-and-family-welfare> accessed May 30, 2022.

The above figure shows that there is development in the budgetary allocation to healthcare sector, it was 23,530 crores in 2010-11 and 65,012 crores in 2020-21. However, this upgradation is not able to meet the healthcare needs of the growing population. The country is spending only 2.1% of its GDP in to healthcare sector whereas it is 15.5% in case of defence.

The budget allocation of the country itself shows that very less importance has been given to the healthcare sector. The below table represents the budget allocation of India from 2019-20 to 2021-22 for various sectors.

Budget heads	**2019-20**	**2020-21**	**2020-21**	**2021-22**	**(Actuals 2019-20 to BE 2021-22)**
Defence	4,52,996	4,71,378	4,84,736	4,78,196	3%
Consumer Affairs, Food and Public Distribution	1,17,096	1,24,535	4,50,687	2,56,948	48%
Home Affairs	1,34,978	1,67,250	1,49,388	1,66,547	11%
Rural Development	1,23,622	1,22,398	1,98,629	1,33,690	4%
Agriculture and Farmers' Welfare	1,01,775	1,42,762	1,24,520	1,31,531	14%
Road Transport and Highways	78,249	91,823	1,01,823	1,18,101	23%
Railways	69,972	72,216	1,11,234	1,10,055	25%
Education	89,437	99,312	85,089	93,224	2%
Chemicals and Fertilisers	82,063	71,897	1,35,559	80,715	-1%
Communications	43,939	81,957	61,060	75,265	31%

Health and Family Welfare	64,258	67,112	82,928	73,932	7%
Jal Shakti	25,683	30,478	24,286	69,053	64%
Housing and Urban Affairs	42,054	50,040	46,791	54,581	14%
Other Ministries	12,60,209	14,49,071	13,93,577	16,41,398	14%

(Table 32: Budget allocation of Government of India for various sectors from 2019-22 Amount mentioned is in crores)[549]

The table above depicts that the country is neglecting the much important healthcare sector. The country id spending six times more amount in Defence. More importance is given to the infrastructure development too. Even during the health emergency, the country has not allocated more budget to strengthen the healthcare sector. Whereas USA spends 17.9% of its GDP on healthcare it was 3.5trillion US dollars in 2017, which is 10,739 US Dollars per person. Australia spent 195.7 billion Dollars on healthcare during 2018-19 it amounts to $7772 per person, the country spends 10% of its GDP on healthcare. India is one among the 40 countries which spends the lowest in public healthcare.

The field study of Gujarat found that the healthcare system of Gujarat is developing in aslo pace. The development of healthcare sector is not in pitch with the economic development of the state. Gujart's healthcare spending is low as compared to many other states in India. It was 0.41% of the GDP in 2006-07 and increased to 0.77% in 2013-14, 0.71% in 2014-15, 0.79% in 2015-16 and 0.75% in 2016-17. Gujarat's budget allotment towards public healthcare is not meeting the standard set by National Health Policy, 2017, under which the states are expected to increase their healthcare spending to 2.5% of the GDP. The state has even overlooked government of India's instruction to spent 8% of total budgetary allocation on healthcare too. The distribution of fund on National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) also was unequal, as per the reports 93% of the fund was allotted to NRHM and only 7% was given to NUHM.

Even after governments efforts to make healthcare accessible for all, it has been found that there exists a huge gap based on region of residence, gender, income, awareness etc. The

[549] "Union Budget 2021-22 Analysis" <https://prsindia.org/budgets/Parliament/union-budget-2021-22-analysis> accessed May 30, 2022.

study found that maximum population has the information that healthcare is their fundamental right though they are not aware of how to claim the same. The status of health insurance as discussed above is still in a despairing position. Majority of the surveyed population doesn't even know the importance of health insurance. It has been found that there is a huge gap in the system due to unavailability of human resources.

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6.2 Recommendations

- The analysis found that Human Right Based Approach if implemented in true sense can yield some good benefit. It suggests the key practices to be adopted by the healthcare system to make it Universal. Lack of these principles in the planning and execution of healthcare delivery is the major reason for its failure in India. To achieve this the government needs to work on the below key areas.

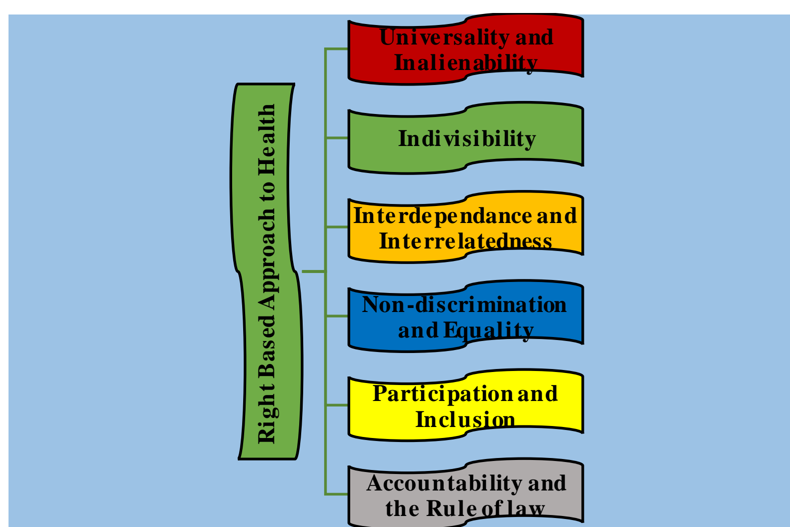

Figure 105: Key principles of HRBA

- Along with the above mentioned the country should work on eliminating disease and also promoting wellness.

- In India, the right to health must be formally recognized. Furthermore, it should be implemented in accordance with the basic principles of solidarity, proportionality, and transparency in international human rights and health law. To achieve this, the subject of public healthcare must be moved from the state list to the concurrent list.

- India must invest in human resources for health in order to increase the number of active health professionals and improve the skill mix, which would necessitate investments in professional colleges and technical education. India also requires incentives to attract skilled health professionals to the labour market, as well as extra training and skill development for those who are already employed but underqualified. In addition to that the Medical Council should make compulsory practice of healthcare professionals in rural and tribal area minimum for two years in within 10 years of completing the course.

- Despite the ability to pay nominal premiums, the above discussed 30% population remains uninsured in the absence of a low-cost health insurance product. A comprehensive policy tailored to this market, which builds on the existing Arogya Sanjeevani plan and adds out-patient coverage, could help to extend health insurance coverage.

- The scope and coverage under Employee's state Insurance scheme should be increased to cover all organized and unorganized sector workers/employees.

- The healthcare expenditure of the country should be raised to meet the healthcare needs of the public. The utilization of such fund should aim at removing inequalities

based on region. More budget should be utilized to make quality healthcare accessible to tribal and rural population.

- The healthcare units in Tribal and Rural region should have emergency facilities and should work 24X7.

- The programmes are schemes should be revised to include migrants and refugees.

- The tribal community's health is inextricably related to their culture and traditions. Because of their unique way of life, an integrated approach to healthcare id appreciable. Healthcare schemes should be planned after considering the geographical and social conditions.

- Decentralized approach with funding and responsibility in relation to execution and power to local bodies. The healthcare units functioning in Local bodies must be made accountable to the local self-governments.

- The government should both Central and State level invest time and money towards Human Development, this is one of the reason due to which Kerala is performing well in health Index.

- More awareness programmes to be devised to reach the majority. Unless until there is awareness, people will not be able to access the benefits under the government initiatives.

- The government should work on confidence building of public on public healthcare systems and encourage them to use public hospitals. This can be with the help of NGO's/Civil Societies/ASHA workers etc.

- Collaborative work with Civil societies and academic institutions for matters of research and awareness.

- Guaranteeing good health for all is an essential prerequisite to ensure healthcare for all. Increased demand for healthcare is one of the challenge the country is facing. For the same the country should work to achieve good health. To achieve good health, the people should have access to nutritious food, potable water, standard living conditions, education, employment and pollution free environment.

- Collaborative work between the departments of governments like department of health and family welfare, social justice department, department of women and child welfare, labor department etc. can yield more positive outcome.

- With the help of women and child welfare department the government can work towards removing gender based discrimination.

- Regulating private hospitals through a legislation and fixing the fee will make the private system also accessible to the poor. Private-public partnership is also a suggestable measure.

- Regular monitoring of implemented programmes and schemes. Action plan based on findings of evaluation. Effective utilization of technology in implementation and evaluation of schemes.

- Replication of practices of best performing states and countries will help in improving the system.

- The country should concentrate on population control by introducing policies with incentives. The programme on family planning should be implemented more effectively.

- 93% of the preventable mortality happens in developing countries, India is a major contributor, hence more funding should be utilized for technology development and scientific research.

- Collaborative work based on mutual trust has to be developed with other nations for conducting research and also for sustainable transfer of technologies in relation to healthcare.

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ANNEXURE I

ટાર્ગેટ ગ્રુપ 1 માટે પ્રશ્નાવલી

આ સર્વેક્ષણ શૈક્ષણિક હેતુ માટે કરવામાં આવ્યો છે. આ સંશોધનનો સરકાર અથવા કોઈ અન્ય સંગઠન સાથે કોઈ લેવા-દેવા નથી અને તે સંપૂર્ણ રીતે શૈક્ષણિક ઉદ્દેશ માટે કરવામાં આવી રહ્યો છે.

આ અભ્યાસનો મુખ્ય ઉદ્દેશ એ છે કે ગુજરાતમાં આરોગ્ય સંભાળ પ્રણાલીની વર્તમાન સ્થિતિની તપાસ કરવી અને સમજવું. વિશિષ્ટ ઉદ્દેશ ગુણવત્તાયુક્ત આરોગ્યસંભાળની આપવામાં પડતા પડકારોનો અભ્યાસ કરવાનો છે; અને લિંગ, ભૂગોળ અને નાણાકીય માપદંડ, વગેરે પર આધારિત અસમાનતાઓ; અને સરકારી કાર્યક્રમો અને નીતિઓની અસરનું મૂલ્યાંકન કરવા માટે.

હું વચન આપું છું કે હું ઉત્તરદાતાઓ વિશેની વિગતો ગુપ્ત રાખીશ. હું તમને ખાતરી આપું છું કે આ માહિતીનો ઉપયોગ શૈક્ષણિક હેતુ સિવાય અન્ય કોઈ હેતુ માટે કરવામાં આવશે નહીં જેના માટે આ માહિતી એકત્રિત કરવામાં આવી રહી છે.

મારા સંશોધનનો ભાગ બનવા બદલ તમારો આભાર.
ધન્યા

* Required

વ્યક્તિગત માહિતી

1. જવાબ આપનારનું નામ

2. લિંગ *

Mark only one oval.

- ( ) સ્ત્રી
- ( ) પુરુષ
- ( ) ટ્રાંસ જાતિ
- ( ) કહેવાનું પસંદ નથી

3. ઉત્તરદાતાનું વર્તમાન નિવાસસ્થાન

4. સાચો વિકલ્પ પસંદ કરીને વિસ્તારનો ઉલ્લેખ કરો *

Mark only one oval.

- શહેરી
- ગ્રામીણ
- અર્ધ-અર્બન
- આદિજાતિ

5. તમારા પરિવારના સભ્યોની કુલ સંખ્યા *

Mark only one oval.

- 1
- 2
- 3
- 4
- 5
- 6
- 7 અને ઉપર

6. તમારા પરિવારની વાર્ષિક આવક કેટલી છે? *

Mark only one oval.

- 10,000 / - સુધી
- 10, 000-50,000/-
- 50,000-1,00,000/-
- 1,00,000-2,00,0000
- 2,00,000 -4,00,000/-
- 5,00,000 અને તેથી વધુ

7. સરનામું (વૈકલ્પિક)

8. ઇમેઇલ (વૈકલ્પિક)

9. ફોન નંબર (વૈકલ્પિક)

આરોગ્ય સંભાળ ના હક પરના પ્રશ્નો: મુદ્દાઓ અને પડકારો

10. શું તમને લાગે છે કે આરોગ્ય સંભાળ એ મૂળભૂત અધિકાર છે? *

Mark only one oval.

- હા
- ના

11. શું તમારી પાસે હાલમાં આરોગ્ય વીમો છે? *

Mark only one oval.

- હા
- ના

12. તમે વાર્ષિક સ્વાસ્થ્યસંભાળ માટે કેટલા પૈસા ખર્ચ કરો છો? *

Mark only one oval.

- 5000 / - સુધી
- 5,000-10,000/-
- 10,000-20,000/-
- 20,000-40,000/-
- 40,000-50,000/-
- 50,000 અને તેથી વધુ

13. શું તમને ક્યારેય આરોગ્ય સંભાળની માટે સંસાધનોની ઉપલબ્ધતામાં સમસ્યા નો સામનો કરવો પડ્યો છે ? *

Mark only one oval.

- હા
- ના

14. જો હા તો, સંસાધનોની ઉપલબ્ધતામાં સમસ્યા નાં કારણો શું છે? *

Check all that apply.

- [ ] આરોગ્ય સંભાળ મેળવવા માટે મારે લાંબા અંતરનો પ્રવાસ કરવો પડ્યો
- [ ] મારા ક્ષેત્રમાં આરોગ્યની ગુણવત્તા ખૂબ જ નબળી છે
- [ ] આરોગ્ય સંભાળ મારા માટે પોસાય તેમ નથી કારણ કે તે મારા વિસ્તારમાં બહુ મોંઘી છે
- [ ] મારા વિસ્તારની હોસ્પિટલમાં આધારરૂપ વ્યવસ્થાનો અભાવ છે
- [ ] મારા પરિવારને મને હોસ્પિટલમાં લઈ જવામાં રસ નહોતો કારણ કે હું એક છોકરી છું
- [ ] મારા ક્ષેત્રની હોસ્પિટલોમાં માનવ સંસાધનોનો અભાવ છે
- [ ] મારા વિસ્તારની હોસ્પિટલોમાં સ્વચ્છતાનો અભાવ છે

15. ખર્ચાને લીધે તમારે ક્યારેય આરોગ્ય સંભાળ લેવાની જતી કરવી પડી છે? *

Mark only one oval.

- હા
- ના

16. તમારા અથવા તમારા પરિવાર માટે આરોગ્ય સંભાળ મેળવવા માટે તમારે ક્યારેય કોઈ નોંધપાત્ર અંતરનો પ્રવાસ કરવો પડ્યો છે? *

Mark only one oval.

- હા
- ના

17. તમારા નિવાસસ્થાનથી સરકારી આરોગ્ય સંભાળ કેન્દ્ર (આશરે અંતર) કેટલું છે? *

Mark only one oval.

- 0-3 કિલોમીટરનું અંતર
- 4-7 કિલોમીટરનું અંતર
- 8-11 કિલોમીટરનું અંતર
- 12-15 કિલોમીટરનું અંતર

18. શું તમને લાગે છે કે તમારા નિવાસસ્થાન આસપાસના વિસ્તારમાં અપૂરતા જાહેર આરોગ્યસંભાળ કેન્દ્ર (સરકારી) છે? *

Mark only one oval.

- હા
- ના

19. કૃપા કરીને તમારી પસંદના વિકલ્પને ટિક કરો. શું તમને લાગે છે કે ગુજરાત રાજ્યના નીચે જણાવેલ વિસ્તારોમાં અપૂરતા જાહેર આરોગ્યસંભાળ કેન્દ્ર છે? *

Check all that apply.

	હા	ના
આદિજાતિ ગુજરાત	☐	☐
ગ્રામીણ ગુજરાત	☐	☐
શહેરી ગુજરાત	☐	☐
અર્ધ શહેરી ગુજરાત	☐	☐

20. શું તમે અથવા તમારા પરિવારમાં આરોગ્ય સંભાળ સંસાધનોની ઉપલબ્ધતા કરવાનો પ્રયાસ કરતી વખતે કોઇએ ક્યારેય જાતિના આધારે ભેદભાવનો અનુભવ કર્યો છે ? *

Mark only one oval.

- હા, મેં અનુભવ કર્યો
- હા, મેં મારા કુટુંબની કેટલીક સ્ત્રીઓને ભેદભાવ રાખતા જોયા છે
- હા મેં મારા પાડોશમાં કેટલીક સ્ત્રીઓને ભેદભાવ અનુભવતા જોયા છે
- ના

21. શું તમે ભારતમાં સાર્વત્રિક રસીકરણ પ્રોગ્રામ અંતર્ગત સરકાર દ્વારા અપાયેલી ફરજિયાત અને મફત રસીકરણ વિશે જાણો છો? *

Mark only one oval.

- હા
- ના

22. શું તમારા કુટુંબનાં બાળકોને રાષ્ટ્રીય રસીકરણ પ્રોગ્રામ હેઠળ સૂચિબદ્ધ તમામ 15 રસીઓ માટે રસી અપાય છે? *

Mark only one oval.

- હા
- ના

23. નીચે આપેલા નિવેદન વિશે તમારો અભિપ્રાય શું છે: ગ્રામીણ લોકોની મોટાભાગની વસ્તી શહેરી આરોગ્ય સંભાળ પદ્ધતિ અથવા ખાનગી આરોગ્ય પ્રદાતાઓ પર આધારિત છે. *

Mark only one oval.

- હા
- ના

24. સામાન્ય બીમારીના કિસ્સામાં તમે નીચે જણાવેલ આરોગ્ય સંભાળ કેન્દ્રની કઇ શ્રેણીને પસંદ કરશો? *

Mark only one oval.

- પ્રાથમિક આરોગ્ય કેન્દ્ર
- કમ્યુનિટિ હેલ્થકેર સેન્ટર
- સરકારી સિવિલ હોસ્પિટલ
- ખાનગી ક્લિનિક
- ખાનગી હોસ્પિટલ

25. કોઈ પણ કટોકટીના કિસ્સામાં તમે કઈ સિસ્ટમ પસંદ કરશો? *

Mark only one oval.

- ખાનગી હોસ્પિટલ
- જાહેર હોસ્પિટલ
- કંઈ નહીં

26. શું તમને લાગે છે કે ગુજરાત સરકાર દ્વારા આપવામાં આવતી આરોગ્ય સંભાળ સુવિધાઓ વિશે તમારી પાસે પૂરતી માહિતી છે? *

Mark only one oval.

- હા
- ના

27. શું તમે આરોગ્ય સંભાળ અંગેનાં સરકારી કાર્યક્રમો અને નીતિઓ વિશે જાગૃત છો? *

Check all that apply.

	હા	ના
જન ઔષધિ સ્ટોર	☐	☐
આયુષ્માન રાષ્ટ્રીય આરોગ્ય સુરક્ષા યોજના	☐	☐
જનની શિશુ સુરક્ષા કાર્યકર્મ	☐	☐
મિશન ઇન્દ્રધનુષ	☐	☐
વૃધ્ધો માટે આરોગ્ય સંભાળ માટે રાષ્ટ્રીય કાર્યક્રમ	☐	☐
રાષ્ટ્રીય એડ્સ નિયંત્રણ કાર્યક્રમ	☐	☐
રાષ્ટ્રીય વેક્ટર બોર્ન ડિસીઝ કંટ્રોલ પ્રોગ્રામ	☐	☐
ચિરંજીવી યોજના	☐	☐
મુખ્યમંત્રી અમૃતમ યોજના	☐	☐

28. જે યોજનાઓ હેઠળ તમે લાભ મેળવી રહ્યા છો તે યોજનાઓ માર્ક કરો. *

Check all that apply.

	હા	ના
જન ઔષધિ સ્ટોર	☐	☐
આયુષ્માન રાષ્ટ્રીય આરોગ્ય સુરક્ષા યોજના	☐	☐
જનની શિશુ સુરક્ષા કાર્યકર્મ	☐	☐
મિશન ઇન્દ્રધનુષ	☐	☐
વૃધ્ધો માટે આરોગ્ય સંભાળ માટે રાષ્ટ્રીય કાર્યક્રમ	☐	☐
રાષ્ટ્રીય એડ્સ નિયંત્રણ કાર્યક્રમ	☐	☐
રાષ્ટ્રીય વેક્ટર બોર્ન ડિસીઝ કંટ્રોલ પ્રોગ્રામ	☐	☐
ચિરંજીવી યોજના	☐	☐
મુખ્યમંત્રી અમૃતમ યોજના	☐	☐

29. ગુજરાત રાજ્યમાં જાહેર આરોગ્ય સંભાળ કેન્દ્રો વિશે તમારો શું મત છે? *

30. ગુજરાત રાજ્યમાં ખાનગી આરોગ્ય સંભાળ કેન્દ્રો વિશે તમારો શું મત છે? *

31. ભારતની આરોગ્ય સંભાળ તંત્ર રચના વ્યવસ્થા વિશે તમારો શું મત છે? *

32. હાલની આરોગ્ય સંભાળ તંત્ર રચના વ્યવસ્થામાં તમે કયા ફેરફારો જોવા માંગો છો? સૂચનો. *

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Google Forms

Questionnaire for Target Group 1: Healthcare Consumers

This is a survey conducted for academic purpose. This research has nothing to do with the government or any other organization and is purely academic in nature.

The main objective of the study is to examine and understand the current status of access to healthcare system in Gujarat. The specific objectives are to study the challenges in terms of access to quality healthcare; inequalities based on gender, geography and financial criteria, etc.; and also to assess the impact of government programmes and policies.

I hereby promise that I shall keep the details about the respondents confidential. I assure you that this data will not be used for any other purpose other than the academic purpose for which this is being collected.

Thanking you for being a part of my research
Dhanya

* Required

Personal Profile

1. Name

____

2. Gender *

Mark only one oval.

- ( ) Female
- ( ) Male
- ( ) Third Gender
- ( ) Prefer not to say

3. Place of current residence of the respondent

____

4. Specify the area by choosing the correct option *

Mark only one oval.

- Urban
- Rural
- Semi-Urban
- Tribal
- Other: ________________

5. Total number of members in your family *

Mark only one oval.

- 1
- 2
- 3
- 4
- 5
- 6
- 7 and above

6. What is the annual income of your family? *

Check all that apply.

- Up to 10,000/-
- 10, 000-50,000/-
- 50,000-1,00,000/-
- 1,00,000-2,00,0000
- 2,00,000 -4,00,000/-
- 5,00,000 and above

Other: ________________

7. Address (optional)

8. Email (optional)

9. Phone number(optional)

Questions on Access to Healthcare: Issues and Challenges

10. Do you think that healthcare is a fundamental right? *

Mark only one oval.

- Yes
- No

11. Do you currently have health insurance? *

Mark only one oval.

- Yes
- No

12. How much money you spend on healthcare per annum? *

Check all that apply.

- [ ] up to 5000/-
- [ ] 5,000-10,000/-
- [ ] 10,000-20,000/-
- [ ] 20,000-40,000/-
- [ ] 40,000-50,000/-
- [ ] 50,000 and above

Other: [ ] ____________________

13. Have you ever had problems accessing healthcare? *

Mark only one oval.

- ( ) Yes
- ( ) No

14. If yes, what are the reasons for the non accessibility that you have experienced?

Check all that apply.

- [ ] Not applicable as I have given 'No' as my answer to the previous question
- [ ] I had to travel long distance to access healthcare
- [ ] The quality of healthcare in my area is very poor
- [ ] Healthcare is not affordable for me as it was highly expensive in my area
- [ ] The hospital in my area lacks good infrastructure
- [ ] My family was not interested in taking me to hospital because I am a girl
- [ ] Hospitals in my area lacks Human Resources
- [ ] Hospitals in my area lacks Hygiene

Other: [ ] ____________________

15. Have you ever had to forgo health care because of costs? *

Mark only one oval.

- Yes
- No

16. Have you ever had to travel a significant distance to access the healthcare for you or your family? *

Mark only one oval.

- Yes
- No

17. From your residence how far is the government healthcare unit(approximate distance)? *

Mark only one oval.

- 0-3 kilometer distance
- 4-7 kilometers
- 8-11 Kilometers
- 12-15 kilometers
- Other: ____________________

18. Do you think that there are insufficient public healthcare units (Government) in the area of your residence? *

Mark only one oval.

- Yes
- No

19. Please tick the option of your choice. Do you think that there are insufficient public healthcare units in the below-mentioned areas of the state of Gujarat? *

Check all that apply.

	Yes	No
Tribal Gujarat	☐	☐
Rural Gujarat	☐	☐
Urban Gujarat	☐	☐
Semi-urban Gujarat	☐	☐

20. Have you/someone in your family/nighbeourhood ever experienced discrimination based on gender while trying to access healthcare? *

Check all that apply.

- ☐ Yes, I experienced
- ☐ Yes I have observed some female in my family being discriminated
- ☐ Yes I have observed some female in my neighbourhood experiencing discrimination
- ☐ No

21. Do you know about the Compulsory and free vaccinations given by government under Universal Immunisation Programmes in India? *

Mark only one oval.

- ◯ Yes
- ◯ No

22. Whether the children of your family are vaccinated for all 15 vaccinations listed under the National Immunisation Priogramme? *

Mark only one oval.

- Yes
- No

23. What is your opinion about the below statement: Most of the rural population are dependent on urban healthcare system or private health providers? *

Mark only one oval.

- Yes
- No

24. In case of ordinary illness which category of the below-mentioned healthcare unit would you prefer? *

Mark only one oval.

- Primary Healthcare Centre
- Community Healthcare Centre
- Government Civil Hospital
- Private Clinic
- Private Hospital

25. In case of any emergency which system would you prefer? *

Check all that apply.

- Private
- Public
- None

Other: ______________________

26. Do you think you have enough information about the healthcare facilities provided by the government of Gujarat? *

Mark only one oval.

- ( ) Yes
- ( ) No

27. Are you aware of the governmental programmes and policies on healthcare? *

Check all that apply.

	Yes	No
Jan aushadhi store	☐	☐
Ayushman national health protection scheme	☐	☐
Janani Shishu Suraksha Karyakaram	☐	☐
Mission Indhradhanush	☐	☐
National Programme for the Health Care for the elderly	☐	☐
National AIDS control programme	☐	☐
National Vector Borne Disease Control Programme	☐	☐
Chiranjivi Yojna	☐	☐
Mukhya Mantri Amrutam Yojna	☐	☐

28. Mark the schemes under which you are availing benefits *

Check all that apply.

	Yes	No
Jan aushadhi store	☐	☐
Ayushman national health protection scheme	☐	☐
Janani Shishu Suraksha Karyakaram	☐	☐
Mission Indhradhanush	☐	☐
National Programme for the Health Care for the Elderly	☐	☐
National AIDS control programme	☐	☐
National Vector Borne Disease Control Programme	☐	☐
Chiranjivi Yojna	☐	☐
Mukhya Mantri Amrutam Yojna	☐	☐

29. What is your opinion about public health care units in State of Gujarat? *

30. What is your opinion about private health care units inState of Gujarat? *

31. What is your opinion about the healthcare system of India? *

32. What all changes you want to see in the present healthcare system? Suggestions. *

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Google Forms

ANNEXURE II

Questionnaire for Respondent Category 2

1. How many employees are working with your healthcare Unit? Kindly mention the number in the below columns.

a. Doctors [ ]

b. Nurses [ ]

c. Other staff [ ]

d. Management [ ]

2. Can you explain me the basic facilities your hospital is providing?

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3. Do you consider health as a fundamental right? Are you aware of the judgements of Hon'ble SC on right to healthcare?

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4. Do you know about the governmental programmes and policies aiming at developing the healthcare system in India? If yes how your hospital is implementing them.

5. Which is the most availed Governmental programme on healthcare by the patients from this healthcare unit?

6. Do you think that the public healthcare system of India is not as efficient as the private?

7. What is your opinion on the inequalities in access to healthcare based on Gender, Geography and economic status? What are your suggestions to overcome such inequalities?

8. In your opinion what are the issues the present healthcare system is undergoing?

9. What are your suggestions to improve the healthcare system of India and make quality healthcare available, accessible and affordable to public without any discrimination?

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10. In your opinion how important is health insurance? Do you think that OOP is one of the reason forcing vulnerable sections to embrace poverty? In your opinion is it possible for India to achieve Universal health coverage?

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11. Do you think our country is prepared to face threat of new contagious disease like Nipah virus? What are your suggestions?

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12. Do you think that there should be a central legislation regulating both public and private healthcare system? Why?

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Do you want to get involved?

It is not necessary to give your personal information to do the survey. You can choose to remain anonymous. However, if you would like to get involved in my research on right to healthcare, you can share your personal details below.

I hereby promise that I would keep the anonymity of you during and after the course of my research, if you don't wish to get involved.

Name: ____

Phone: ____

Address: ____

Email: ____

ANNEXURE III

Questionnaire for Experts

1. What is your opinion on the current status of public Healthcare system in India? What are the major challenges and lacunas found in our healthcare system? Throw some light on the viability of Universal and free healthcare in India.

2. In your opinion whether the National policies, programmes and Schemes on Healthcare are yielding outcomes?

3. As per the UN Projection Geriatric population are the fastest growing population segment in India, and with more than a hundred million people aged above 60 years, India is already facing some of the challenges of population ageing. It is reported that the number of older persons will rise to 354 million in 2050 accounting for almost 20% of the population. Do you believe it is high time for India to think about Long Term care?

4. Share your thoughts on the public healthcare expenditure by Government of India. What should be India's approach to make quality public healthcare accessible, affordable and acceptable to public? What is your analysis about Ayushman Bharat Yojana?

5. As per the data in 2018, Indians spent around 62.7% of their total health spending as out-of-pocket expenditure, which is only 10.81% in USA, 16.71% in UK, 17.72 in Australia and 35.75% in China. In your opinion how can we deal with this issue.

6. In your opinion how the Patent Amendment act 2005 and the practice of issuing the product patent is impacting the access to medicine?

7. In your opinion how far "Right of everyone to the enjoyment of the highest attainable standard of physical and mental health" is practiced in India? Do you think there exist inequalities in access to healthcare based on gender, region and financial status?

8. What are your thoughts on Social Justice in Healthcare? To carry out social justice in health care settings what are the various leadership skills to be demonstrated by the administrators?

9. Since you have analysed the publicly funded health insurance scheme of Tamilnadu in detail and published many articles on it can u please share some of the realities on the ground faced by low income groups to understand the role of such policies in right to universal healthcare?
10. As an academician and an advocate of Human Rights, what is your analysis of Right to Health as a fundamental right and what role the judiciary and the legislature has played in acknowledging the same.

11. How do you see the debate of shifting healthcare as a state subject to a concurrent subject? Though the judiciary has affirmed right to healthcare as a fundamental right, is it a high time that we strengthen it by creating a new provision under part III. What will be the consequences of the same?

12. What is your opinion about the step taken by Karnataka Government to regulate Private Healthcare System Through 'Karnataka Private Medical Establishments (Amendments) Bill 2017'?

ANNEXURE IV

AS INTRODUCED IN THE RAJYA SABHA
ON THE 22ND NOVEMBER, 2019

Bill No. XLI of 2019

THE RIGHT TO UNIVERSAL AND FREE HEALTH CARE BILL, 2019

A

BILL

to provide for the right to free and compulsory healthcare services and universal health to people and for matters connected therewith and incidental thereto.

BE it enacted by Parliament in the Seventieth year of the Republic of India as follows:—

CHAPTER I

PRELIMINARY

Short title, extent and commencement.

1. (*1*) This Act may be called the Right to Universal and Free Health Care Act, 2019.

5 (*2*) It shall extend to whole of India.

(*3*) It shall come into force on such date as the Central Government may, by notification in the Official Gazette appoint.

Definitions.

2. In this act, unless the context otherwise requires,—

(*a*) "appropriate Government" means—

(*i*) in relation to a hospital established, owned or controlled by the Central Government, or the administrator of the Union Territory, having no Legislature, the Central Government; 5

(*ii*) in relation to a hospital, other than the hospital referred to in sub clause (*i*), established within the territory of—

(*a*) a State, the State Government;

(*b*) a Union territory having Legislature, the Government of that Union territory. 10

(*b*) "hospital" means any recognised hospital providing healthcare facilities and services and includes—

(*i*) a hospital established, owned or controlled by the appropriate Government or a local authority;

(*ii*) an aided hospital receiving aid or grants to meet whole or part of its expenses from the appropriate Government or the local authority; 15

(*iii*) a hospital belonging to a specified category; and

(*iv*) an unaided hospital not receiving any kind of aid or grants to meet its expenses from the appropriate Government or the local authority.

(*c*) "hospital Management Committee" means any Committee or Authority having power to direct or Control any or all of the operations of the hospital; 20

(*d*) "individual" means any person with Indian citizenship according to the Citizenship Act, 1955. 57 of 1955.

(*e*) "local authority" means a Municipal Corporation or Municipal Council or *Zila Parishad* or *Nagar Panchayat* or *Panchayat*, by whatever name called, and includes such other authority or body having administrative control over the hospital or empowered by or under any law for the time being in force to function as a local authority in any city, town, or village. 25

(*f*) "person belonging to disadvantaged group" means a person belonging to the Scheduled Caste, the Scheduled Tribe, the socially and educationally backward class or such other group having disadvantage owing to social, cultural, economical, geographical, linguistic, gender or such other factor; 30

(*g*) "person belonging to weaker section" means a person belonging to such a family whose annual income is lower than the minimum limit specified by the appropriate Government; 35

(*h*) "specified category" means category of hospitals specified in the Clinical Establishments (Registration and Regulation) Act, 2010. 3 of 2010.

(*i*) "underlying determinants of health" means factors affecting health other than direct diseases and includes facilities of safe drinking water and adequate sanitation, clean air, safe food, adequate nutrition, healthy working and environmental conditions, and health-related education. 40

3. (*1*) Every individual shall have a right to free and compulsory health care facilities and services in any hospital in geographical proximity.

Right to Free and Compulsory Health Care facilities and services.

(*2*) For the purpose of sub-section (*1*), no individual shall be liable to pay any kind of charges or expenses which may prevent him or her from availing healthcare services.

5 **4.** (*1*) Where in a hospital, there is a lack of healthcare and medical facilities, an individual shall have a right to seek transfer or refer to any other hospital.

Right to seek to transfer or referred to other hospital.

(*2*) Where an individual is required to move from one hospital to another, either within a State or outside, for any reason whatsoever, such individual shall have a right seek transfer to any other hospital, for getting medical treatment.

10 (*3*) For seeking transfer/referral in such other hospital, the Head or In-charge of the hospital where such individual was last admitted, shall immediately issue the transfer/referral certificate:

Provided that delay in producing transfer/ referral certificate shall not be a ground for either delaying or denying admission in such other hospital:

15 Provided further that the head or In-charge of the hospital delaying issuance of transfer/ referral certificate shall be liable for disciplinary action under the service rules applicable to him or her.

5. (*1)* Every individual shall have the right to basic necessities of life affecting the health conditions.

Right to Universal Heath.

20 (*2*) Every individual shall have the right to opportunity to enjoy the highest attainable level of health.

(*3*) Every individual shall have a right to universal health in and around his or her surroundings, which may include "underlying determinants of health".

6. Failing to provide the "underlying determinants of health" to an individual without 25 sufficient and reasonable cause, the appropriate Government shall provide compensation to the individual as per provisions of this Act.

compensation or failure to provide underlying determinants of heath.

7. The appropriate Government shall establish, within such areas of limits of neighbourhood, as may be prescribed, a hospital, where it is not so established, within three years from the Commencement of this Act.

Establishment of new hospitals.

30 **8.** (*1)* The Central Government and the State Government shall have concurrent responsibility for providing funds for carrying out the provisions of this Act.

Central and State Government to provide funds.

(*2)* The Central Government shall prepare the estimates of capital and recurring expenditure for the implementation of the provisions of the Act.

(*3)* The Central Government shall provide to the State Governments, as grants-in-aid 35 of revenues, such percentage of expenditure as it may determine, from time to time, in consultation with the State Governments for the purposes of this Act.

(*4)* The Central Government may make a request to the President to make a reference to the Finance Commission to examine the need for additional resources to be provided to any State Government so that the said State Government may provide its share of funds for 40 carrying out the provisions of the Act.

(*5)* The State Government shall, after taking into consideration of the sums provided by the Central Government and its other resources, be responsible to provide funds for implementation of the provisions of the Act.

(*6)* The Central Government shall,—

45 (*a)* develop and enforce standards for training of doctors;

(*b)* provide technical support and resources to the State Government for promoting innovations, researches, planning and capacity building.

Duties of appropriate Governments.

9. The appropriate Government shall,—

(*a*) provide free and compulsory healthcare facilities and services to every individual;

Explanation.—The term "free and compulsory healthcare" means obligation of the appropriate Government to provide free and compulsory healthcare facilities to every individual;

(*b*) entitle every individual with universal health facilities.

Explanation.—The term "universal health" means, the underlying determinants of health affecting the health of an individual.

(*c*) ensure availability of a hospital;

(*d*) ensure that the individual belonging to weaker section and the individual belonging to disadvantaged group are not discriminated against and prevented from availing healthcare facilities and underlying determinants of health facilities on any grounds;

(*e*) provide infrastructure including hospital, medical staff and learning equipments;

(*f*) ensure and monitor admission of individuals in hospitals;

(*g*) ensure good quality healthcare facilities and underlying determinants of health facilities conforming to the standards and norms as may be specified; and

(*h*) ensure timely entitlement of healthcare facilities and underlying determinants of health facilities.

Responsibilities of Hospitals and Doctors.

10. (*1*) For the purposes of this Act, a hospital shall provide free and compulsory healthcare facilities and services to all individuals admitted therein;

(*2*) The privately owned hospitals providing free and compulsory healthcare facilities and services shall be reimbursed expenditure so incurred by it to the extend to per-individual expenditure incurred by the State, or the actual amount charged from the individual, whichever is less, in such manner as may be precribed:

Provided that such reimbursement shall not exceed per-individual expenditure incurred by a hospital specified in clause (*b*) of section 2:

Provided further that where such hospital is already under obligation to provide free healthcare facilities and services to a specified number of individuals on account of it having received any land, building, equipment or other facilities, either free of cost or at a concessional rate, such hospital shall not be entitled for reimbursement to the extent of such obligation.

(*3*) Every hospital shall provide such information as may be required by the appropriate Government or the local authority, as the case may be.

Protection against physical or mental harassment.

11. (*1*) No individual shall be subjected to physical punishment or mental harassment in providing free healthcare facilities and services;

(*2*) Whoever contravenes the provisions of sub-section (1) shall be liable to disciplinary action under the service rules applicable to such person.

12. No hospital shall be established or recognised under section 18, unless it fulfils the norms and standards specified in the Act.

Formations of Hospital Management Committee.

13. (*1*) There shall be constituted a Management Committee, in the manner prescribed, consisting of not more than ten members including the Chairperson for every hospital under this Act.

(*2*) The Hospital Management Committee shall perform the following functions, namely:—

Functions of the Hospital Management Committee.

(*a*) monitor the working of the hospital;

(*b*) prepare and recommend hospital development plan;

5 (*c*) monitor the utilisation of the grants received from the appropriate Government or local authority or any other source; and

(*d*) perform such other functions as may be prescribed.

Duties of doctors.

14. (*1*) A doctor appointed in a hospital described under clause (b) of section 2, shall perform the following duties, namely:—

10 (*a*) maintain regularity and punctuality in attending hospital;

(*b*) conduct and complete the treatment of the individual in accordance with the provisions;

(*c*) admit and treat the individual timely;

(*d*) assess the learning ability of each individual and accordingly supplement 15 additional instructions, if any, as required;

(*e*) regularly inform family members of the individual undergoing treatment and apprise them about the recovery, progress and relevant updates about the health of the individual; and

(*f*) perform such other duties as may be prescribed.

Disciplinary action against defaulting doctors.

20 (*2*) A doctor committing default in performance of duties specified in sub-section (1), shall be liable to disciplinary action under the service rules applicable to him or her:

Provided that before taking such disciplinary action, reasonable opportunity of being heard shall be afforded to such doctor.

(*3*) The grievances, if any, of the doctor shall be redressed in such manner as may be 25 prescribed.

Maintaining doctor-patient ratio.

15. Within six months from the date of commencement of this Act, the appropriate Government and the local authority shall ensure that the Doctor-Patient Ratio, as may be specified is maintained in each hospital.

Additional Functions of the National Medical Commission.

16. (*1*) The National Medical Commission constituted under The National Medical 38 of 2019. 30 Commission Act, 2019 shall, in addition to the functions assigned to them under that Act, also perform the following functions, namely:—

(*a*) examine and review the safeguards for rights provided by or under this Act and recommend measures for their effective implemention;

(*b*) inquire into complaints relating to individual's right to free and compulsory 35 health care and universal health; and

(*2*) The Commission shall, while inquiring into any matters relating to individual's right to free and compulsory health care and universal health, have the same powers as 39 of 2019. assigned to them respectively under the said National Medical Commission Act, 2019.

(*3*) Where the State Medical Council has not been constituted in a State, the appropriate 40 Government may, constitute such authority to exercise the powers conferred on, and to perform the functions assigned to it under this Act, in such manner and subject to such terms and conditions, as may be prescribed.

Protection of Right of Individuals.

17. (*1*) Any person having any grievance relating to the right to an individual under this Act may make a written complaint to the local authority having jurisdiction.

(*2*) After receiving the complaint under sub-section (1), the local authority shall decide the matter as early as possible after affording a reasonable opportunity of being heard to the parties concerned.

(*3*) Any persons aggrieved by the decision of the local authority may prefer an appeal to the State Medical Council or the authority prescribed under sub-section (3) of section 16, as the case may be. 5

(*4*) The appeal preferred under sub-sectioin (3) shall be decided by State Medical Council or the authority prescribed under sub-section (3) of section 16, as the case may be, as provided under clause (b) of sub-section (1) of section 16.

Power to issue guideline and directions.

18. (*1*) The Central Government may issue guidelines and give such directions to the State Government or the local authority as the case may be as it deems fit for the purposes of implementation of the provisions of this Act. 10

(*2*) The appropriate Government may issue guidelines and give such directions, as it deems fit, to the local authority or the Hospital Management Committee regarding implementation of the provisions of this Act. 15

(*3*) The local authority may issue guidelines and give such directions, as it deems fit, to the Hospital Management Committee regarding implementation of the provisions of this Act.

Protection from prosecution or legal proceeding.

19. No prosecution for offences punishable shall be instituted except with the previous sanction of an officer authorised in this behalf, by the appropriate Government, by notification. 20

20. No suit or other legal proceeding shall lie against the Central Government , the State Government, the National Medical Commission, the State Medical Commission, the local authority, the Hospital Management Committee or any person, in respect of anything which is done in good faith or intended to be done, in pursuance of this Act, or any rules or order made thereunder. 25

Act to supplement other laws.

21. The provisions of this Act shall be in addition to and not in derogation of any other law for the time being in face.

Power to make rules.

22. (*1*) The appropriate Government may, by notification, make rules, for carrying out the provisions of this Act. 30

(*2*) In particular, and without prejudice to the generality of the foregoing powers, such rules may provide for all or any the following matters, namely:—

(*a*) the manner of giving special training and the time-limit thereof to doctor and medical staff;

(*b*) the area of limits for establishment of a neighbourhood hospital; 35

(*c*) the manner of maintenance of records of individual admitted in the hospital;

(*d*) the manner and extent of reimbursement of expenditure;

(*e*) the manner of redressing grievances of individual.

STATEMENT OF OBJECTS AND REASONS

Right to health and education are the founding pillars of any welfare state. India, after entitling the Right to Education, looks forward towards a legislation entitling Right to Health. Every nation-state is obliged to support the right to health through the allocation of meximum available resources. A rights-based approach to health requires that health programmes and schemes must prioritize the needs of those furthest behind first towards greater equity, a principle that has been echoed in the recently adopted 2030 Agenda for Sustainable Development and Universal Health Coverage, Even the WHO Constitution (1946) envisages "......the highest attainable standard of health as a fundamental right of every human being."

The health statistics of India are intensely worrying. According to the National Health Profile 2018, an average Indian spends a meager amount of Rs. 3 per day on his healthcare facilities. Infant Mortality Rate is still at a high figure i.e. 34 per 1000 in India. One allopathic government doctor in India, on an average, attends to a population of 11,082, which is 10 times more than the WHO recommended doctor-population ratio of 1:1,000. India is still facing a large number of casualties during break out of epidemics like Japanese Encephalitis and Swine Flu. Hence, India needs to entitle healthcare facilities to the people as a basic human right.

The Bill would also ensure free and universal healthcare facilities to every individual of India. The binding right to health would enable the last man standing to get healthcare facilities at no cost. The binding right to health would also enable the Centre and the State to allocate greater funds towards the healthcare, strengthening the healthcare system of India.

Hence, this Bill.

ABHISHEK MANU SINGHVI

FINANCIAL MEMORANDUM

Clause 3 of the Bill provides for Right to Free and Compulsory Healthcare facilities and services. Clause 7 provides for the establishment of hospitals, within such areas or limits of neighbourhood, where it is not so established, within three years from the commencement of this Act. Clause 13 provides for the establishment of hospital management committees. The Bill, if enacted, will involve expenditure from the Consolidated Fund of India. It is not possible at present to quantify the funds that may be involved.

MEMORANDUM REGARDING DELEGATED LEGISLATION

Clause 22 of the Bill empowers the appropriate Government to frame rules by notification in the Official Gazette, to carry out the provision of the Bill. The rules to be framed by the Government pertain to matters of administrative detail only. The delegation is, therefore, normal in character.

RAJYA SABHA

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BILL

to provide for the right to free and compulsory healthcare services and universal health to people and for matters connected therewith and incidental thereto.

(*Dr. Abhishek Manu Singhvi, M.P.*)

MGIPMRND—3612RS(S3)—22-11-2019.

THE GUJARAT PUBLIC HEALTH ACT, 2009

STATEMENTS OF OBJECTS AND REASONS

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THE GUJARAT PUBLIC HEALTH ACT, 2009

STATEMENTS OF OBJECTS AND REASONS

To comply with the obligations imposed by the Constitution of India as well as relevant laws adopted by the national, state and local government, to ensure guaranteed public health conditions and rational and quality health services for all.

PREAMBLE

Recognizing:

1. The socio economic imbalances and inequities of health services especially affecting the vulnerable groups (those residing in rural and difficult-to-access areas, areas under environmental stress, tribals, urban poor, migrant population, unorganized labour, internally displaced people, people living with HIV/AIDS backward and scheduled castes and tribes, women, children and people living with disability);

2. The role of a clean living and work environment in maintaining and as a pre-requisite to public health;

3. The immediate and long-term health implications posed by industrial accidents and disasters;

4. The need to establish a society based on democratic values, social justice and fundamental human rights;

5. The need to improve the quality of life of all citizens and to free the potential of each person.

Bearing in mind that:

1. Article 47 of the Constitution of India's Directive Principles, recognizes the duty of the state to raise levels of nutrition and the standard of living and to improve public health as among its primary duties;

2. The Supreme Court of India has explicitly recognized the right to life under Article 21 of the Constitution, as including within its ambit the right to health and health care;

3. Public health and sanitation is a state subject according to the VII schedule of the Constitution, and it is the duty of the State Legislature to make laws with respect to it;

4. India has ratified various International Covenants (like the International Covenant for Economic, Social and Cultural Rights 1966) that recognize the right to health and health care as basic rights that all persons are entitled to, and that the State is thereby obliged to ensure these rights;

5. General Comment 14 (2000) on Article 12 of the International Covenant on Economic, Social and Cultural Rights lays specific obligations on the State Parties to take steps towards the full realization of

the right to health. The Indian government is obliged to comply with the General Comments of the respective monitoring bodies under International Covenants on the right to health and related matters;

6. India is a signatory to the International Health Regulations (2006) of WHO and is obliged to operationalise these regulations;

7. India has ratified various International Covenants (Convention for the Elimination of all Forms of Discrimination against Women, Convention for Child Rights and others mentioned above), that recognize the rights of certain groups, including women and girls, children, persons affected by HIV/AIDS, persons with mental health problems and persons with disability, to be provided with specific services that address their special health needs. There is thus an obligation on India, as a state party to ensure these rights;

8. India has been a signatory to the Programme for Action of the International Conference on Population and Development (1994) and the Platform of Action for the Fourth World Women's Conference (1995) that codify and legitimize reproductive and sexual rights of citizens of India

and is thus obliged to respect, fulfill and protect these rights;

9. India is a signatory to numerous treaties and international conventions, such as the Basel Convention on Transboundary Movement of Hazardous Wastes, the Stockholm Convention on Persistent Organic Pollutants, and the Rotterdam Convention on Prior Informed Consent aimed at protecting public health and environment;

10. Rapidly changing socio-economic cultural and political contexts in the era of Liberalization, Privatization and globalization is demanding the re-definition of public health to also include mental health needs;

11. Private Health Care Establishments have been providing services to people and have a potential of collaboration with the Public Health system, to ensure universal coverage with quality health care, and to establish a process of standardization and participatory regulation, in order to harness this resource.

In order to:

1. Operationalise the right to Health Care as recommended by the National Human Rights Commission through the enactment of a State

Public Health Act that recognizes and delineates the health rights of citizens, duties of the public health system and specifies broad legal and organizational mechanisms to operationalise these rights;

2. Identify and strengthen the public health infrastructure to improve and sustain the public's health through statutory reforms in a manner that ensures its accountability;

3. To set a broad mission for providing essential public health services and functions principally through the efforts of state and local public health agencies in collaboration with others in the public health system, including through the co-operation and formal collaborations between the Centre and State regarding public health planning, priority setting, information and data sharing, reporting, resource allocation, funding, service delivery in accordance with various National Health Policies and Programmes;

4. Identify scientifically and legally sound and effective powers and responsibilities of state or local public health agencies to provide essential and equitable public health services and functions, including powers to respond to public health emergencies, and to ensure that such agency while exercising its power to accomplish public health

services and functions, shall employ policies and practices that least infringes on the rights or interests of individuals. Employing the least restrictive alternative does not require the agency to adopt policies or programs that are less effective in protecting the public's health or safety;

5. Ensure respect for the dignity of each individual under the jurisdiction of the State or the Local Public Health Agency regardless of his/her residency status, especially of groups that may be in a vulnerable position;

6. Ensure that State and local public health agencies do not discriminate in an unlawful manner against individuals on the basis of their race, ethnicity, religious beliefs, sex, sexual orientation, or disability status;

7. Protect and promote ongoing public health education and outreach to ensure community participation in accomplishing public health goals. Ensure active involvement of Non-governmental Organizations, Community based organizations, Disabled Peoples Organizations, Organizations working on disability issues, Co-operatives, women's organizations, environment protection bodies, and traditional socio-cultural-religious organizations in promotion of public health;

8. Unite the various elements of the health system as well as elements of the health sector with other sectors affecting health, in a common goal to actively promote and improve the health system in the state (various elements of the health system like: private and public, rural and urban, promotive- preventive- curative and rehabilitative, Health and Family Welfare, national health programmes and HIV/AIDS);

9. Strive for the best/ optimal quality of health services while at the same time ensuring specified minimum standards in the short term;

10. Facilitate the implementation of the National Rural Health Mission (NRHM) that was launched by the Government of India. The NRHM aims to improve health care services by making provision for certain essential services to be provided as guaranteed services at various levels of the healthcare institution (PHCs, CHCs or SHCs) in accordance with the Indian Public Health Standards;

11. Establish a health system based on the comprehensive primary health care approach, decentralized management, principles of equity and efficiency and sound governance with active participation of civil society representatives;

12. Promote a spirit of shared responsibility and cooperation for public health among various stakeholders;

13. Involve the private medical sector in health service delivery, for promoting public health goals without weakening the public health system or diluting its responsibility;

14. Regulate the public and private health sectors, and their mutual relationships within a rights framework, for achieving the greatest public health good;

15. Provide opportunities for the exercise of community rights to determinants of health and health services by promoting awareness of health and human rights.

***

THE GUJARAT PUBLIC HEALTH ACT, 2009

(……..of 2009)

[………………., 2009]

An Act to make provision for different determinants of Public Health and for matters connected therewith or incidental thereto.

WHEREAS, it is expedient to make provision for promoting, advancing, improving health and also to ensure guaranteed public health services to all the people of State of Gujarat and other purposes connected thereof.

Be it enacted by Legislature, State of Gujarat in the ……………………year as follows:

PART - I

PRELIMINARY

1. Short title, extent, commencement and application

(1) This Act may be called the Gujarat Public Health Act, 2009.

(2) It extends to the whole of the State of Gujarat

(3) It shall come into force on such date as the State Government may, by notification, in the Official Gazette, appoint.

2. **Definitions**

(1) *"Aggrieved person"* means any person who can make an application for grievance under the Act or rules, and includes

(a) User of the service; or

(b) Person designated by the user; or

(c) An adult member of the family; or

(d) Guardian of the user, in case of user being a minor; or

(e) In event of the death of the user or his/her being incapacitated due to existing physical/mental/emotional state rendering him/her incapable to designate, a person willing to take up the responsibility for the user.

(f) Any person/persons whose collective community rights are violated.

(2) *"Community based services"* means preventive and promotive outreach services delivered at community level to specific individuals (such as immunization) or to the entire community at large (such as chlorination of wells, pollution prevention, epidemic control activities etc.)

(3) *"Communicable disease"* means a disease resulting from an infection due to pathogenic agents or toxins generated by the infection, following the direct or indirect transmission of the agents from the source to the host.

(4) *"Condition of public health importance"* means a disease, syndrome, symptom, injury, or other threat to health that is identifiable on an individual or community level and that can reasonably be expected to lead to adverse health effects in the community.

(5) *"Contagious disease"* means an infectious disease that can be transmitted from individual to individual.

(6) *"Contaminated material"* means wastes or other materials exposed to or tainted by chemical, radiological, or biological substances or agents.

(7) *"Council"* means a council or any such body recognized by the government for the registration of the various practitioners of any systems of medicine or providers of any health services;

(8) "Determinants of Health" means and includes, social and economic factors which have a direct bearing on health of the people. For instance,

the following may be construed as determinants of health:

(a) Nutrition

(b) Water Supply

(c) Environment

(d) Sanitation

(e) Education

and the like;

(9) *"Disaster"* means an actual or imminent event, whether natural or otherwise occurring in any part of the State which causes, or threatens to cause all or any of the following:

(a) widespread loss or damage to property, both immovable and movable; or

(b) widespread loss of human life or injury or illness to human beings; or

(c) damage or degradation of environment; and any of the effects specified in sub-clauses (i) to (iii) is such as to be beyond the capacity of the affected community to cope up with using its own resources and which disrupts the normal functioning of the community;

(10) *"Disaster Management"* means a continuous and integrated process of planning and implementation of measures with a view to:

(a) mitigating or reducing the risk of disasters;

(b) mitigating the severity or consequence of disasters;

(c) capacity-building;

(d) emergency preparedness;

(e) assessing the effects of disasters;

(f) providing emergency relief and rescue; and

(g) post-disaster rehabilitation and reconstruction;

(11) *"Disaster Management Committee"* shall mean the authority established under the Gujarat State Disaster Management Act, 2003.

(12) *"Essential drugs"* include all drugs, as enumerated by the State Government, on the basis of the National Essential Drug List, that shall be available free of cost to all users at all times in the respective public health care establishments.

(13) *"Essential public health services and functions"* mean those services and functions to:

(a) Monitor health status to identify and solve community health problems;

(b) Investigate and diagnose health problems and health hazards in the community;

(c) Inform, educate, and empower individuals and people about health issues;

(d) Mobilize public and private sector collaboration and action to identify and solve health problems;

(e) Develop policies, and plans, and programs that support individual and community health efforts;

(f) Enforce laws and regulations that protect health and ensure safety;

(g) Promote established linkage between various National Health Programmes;

(h) Ensure convenient and timely access by individuals to needed personal health services;

(i) Develop, maintain and assure a competent and efficient system for delivery of public health services prescribed in this Act , including management of trained cadres of public health personnel;

(j) Evaluate effectiveness, accessibility, and quality of personal and population-based health services;

(k) Promote interaction and joint action between health and other departments, such as environment and labour, the activities of which have a significant bearing on health.

(14) *"Health care establishment"* means the whole or part of a public or private institution, whether for profit or not; where inpatient or outpatient treatment; diagnostic or therapeutic interventions; nursing, rehabilitative, palliative, convalescent, preventive or other health care services or any of them are provided. Healthcare establishment includes clinical establishment meaning any premises used for persons suffering from any sickness, injury or infirmity and shall include hospital and maternity homes.

(15) *"Health Impact Assessment"* means a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential or effects on the health of a population, and the distribution of those effects within the population.

(16) *"Infectious disease"* means a disease caused by a living organism or other pathogen, including a fungus, bacteria, parasite, protozoan, or virus.

Explanation: An infectious disease may be transmissible from individual to individual, animal/bird to individual, or insect to individual.

(17) "Infectious waste" means:

(a) Biological waste, including blood and blood products, excretions, exudates, secretions, suctioning and other body fluids, and waste materials saturated with blood or body fluids;

(b) Cultures and stocks, including etiologic agents and associated biological; specimen cultures and dishes and devices used to transfer, inoculate, and mix cultures; wastes from production of biological and serums; and discarded live and attenuated vaccines;

(c) Pathological waste, including biopsy materials and all human tissues; anatomical parts that emanate from surgery, obstetrical procedures, necropsy or autopsy and laboratory procedures; and animal carcasses exposed to pathogens in research and the bedding and other waste from such animals,

but does not include teeth or formaldehyde (or other preservative agents); and

(d) Sharps, including needles, I.V. tubing with needles attached, scalpel blades, lancets, breakable glass tubes, and syringes that have been removed from their original sterile containers.

(18) "Informed consent" means consent given to a proposed specific intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to the person giving consent adequate information including risks and benefits of, and alternatives to, the proposed intervention in a language and manner understood by such person with no binding to consent after being informed.

(19) "Isolation" means the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals.

(20) "License" means, an authorization that conditionally allows the recipient to conduct, for a specified

period of time, activities that would be unlawful without the authorization.

(21) *"Local authority"* means:

(a) In urban areas, the Municipal Corporation/Mahanagar Palika and the Municipal Commissioner

(b) the Municipal Council/Nagar Palika and the Chief Officer,

(c) In any area in a district as defined in the Gujarat Panchayats Act, 1961, that is comprised within the jurisdiction of a Panchayat concerned, the District Collector/District Development Officer.

(22) *"Local Supervisory Authority"* means-

(a) in the areas falling within the jurisdiction of the Municipal Corporation – the Health Officer of the concerned Municipal Corporation;

(b) in the areas falling within the jurisdiction of the Municipal Council – the Civil Surgeon/ Chief District Medical Officer of the District in which such Council is situated

(c) in the areas not falling in sub-clauses (i), (ii) and (iii) above, the District Health

Officer/Civil Surgeon/ Chief District Medical Officer of the concerned Zilla Panchayat

(23) "*Medical Treatment*" means systematic diagnosis and treatment for prevention or cure of any disease, or to improve the condition of health of any person through allopathic or any other recognized systems of medicine such as Ayurveda, Unani, Homeopathy, Yoga, Naturopathy and Siddha; and includes Acupuncture and Acupressure treatments.

(24) "Municipal Health services" includes:

(a) Water quality monitoring;

(b) Food control and safety;

(c) Waste management;

(d) Health surveillance of premises;

(e) Surveillance & prevention of communicable diseases, including immunization;

(f) Vector control;

(g) Environmental pollution control;

(h) Disposal of dead;

(i) Registration of births & deaths.

(25) "***Notifiable Disease***" means a disease which a Registered Medical Practitioner is required to notify to the Medical and Health Officer of his area under the law for the time being in force, and includes those diseases specified in Schedule I.

(26) *"**Persons with limited paying capacity**"* means

(a) All persons who have received a ration card in the category of Below Poverty Line (BPL)

(b) All persons who have not been included in the above-mentioned sub-clause (i), but have been certified by a designated authority as having limited paying capacity.

Explanation 1: Designated Authority in a rural area for a specific village shall include the Sarpanch or the Government Headmaster; or the Gram Sabha or any other elected representative or the President/Secretary of the Mahila Mandal of the said village; or a Chief Functionary/Secretary of the registered NGO which is a member of the health monitoring committee at the Village Health Centre, Primary Health Centre (PHC) or Block level concerning the said village.

Explanation 2: Designated Authority in an urban area shall include a Government Headmaster; or the Corporator of the concerned area; or the President/ Secretary of the Mahila Mandal or Swasthya Juth; or the

President/ Secretary of the Community Development Society at the Falia Level, or the Neighborhood Group at Ward Level.

Explanation 3: The certificate shall be granted if the person in need of such a certificate falls in one or more of the following criteria:

(a) Member of a woman headed household;

(b) Member of SC/ST, unless he/she or his/her spouse is a government employee in Class I, II or III level, i.e. class III SC/ST employee level' after 'class I or II level';

(c) Member of a family with no landholdings or landholding less than two acres, not employed in the organized sector;

(d) A person who has been granted a Certificate of Disability under the Disabilities Act;

(e) People living with HIV/AIDS.

Explanation 4: All elderly persons shall be eligible for applying as a person with limited paying capacity.

(27) ***"Physiotherapy Clinics/ Physical Therapy Clinics"*** means an establishment where massaging, electrotherapy, hydrotherapy or similar work is usually carried on, for the purpose of treatment of diseases or of infirmity or for any other purpose

whatsoever, whether or not analogous to the purposes herein before mentioned in this clause.

(28) "*Precautionary Principle" means that* in order to protect the environment or public health, a precautionary approach should be widely applied, meaning that where there are threats of serious or irreversible damage to the environment or public health, lack of full scientific certainty should not be used as a reason for postponing cost-effective measures to prevent degradation. The precautionary principle permits a lower level of proof of harm to be used in policy-making whenever the consequences of waiting for higher levels of proof may be very costly and/or irreversible.

(29) *"Prescribed"* means prescribed by rules and regulations made under this Act.

(30) *"Public health"* means assuring the conditions in which the population can be healthy. This includes population-based or individual efforts primarily aimed at the prevention of injury, disease, disability or premature mortality, or the promotion of health in the community, such as assessing the health needs and status of the community through public health surveillance and epidemiological research, developing public health policy, and responding to public health needs and emergencies.

(31) *"Public health agency"* means an organization operated by the Public Health system of the Central, State, or Local government that principally acts to protect or preserve the public's health, with the participation of civil society.

(32) *"Public health agent"* means any official (including a public health official) or employee of a state or local public health agency who is authorized to carry out provisions of this Act.

(33) *"Public health authority"* is the authority envisaged under this Act.

(34) *"Public health emergency"* means an occurrence or imminent threat, including owing to degraded environmental conditions, of an illness or health condition that:

(a) Poses a high probability of any of the following harms:

(i) a large number of deaths or illness in the affected population;

(ii) a large number of serious or long-term disabilities in the affected population, including teratogenic effects, or ;

(iii) widespread exposure to an infectious or toxic agent that poses a significant risk

of substantial future harm to a large number of people in the affected population;

(b) And can be caused by any of the following:

(i) the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin, or;

(ii) any disaster, including major accidents.

Explanation: Public health emergency can be due to communicable infectious diseases, chronic non-infectious, non-communicable conditions affecting large population, notifiable diseases, conditions of public health importance or locally endemic diseases.

(35) "Public sector partner" means central, state or local governments and their public health agencies that provide essential public health services and functions or work to improve public health outcomes with a state or local public health agency.

(36) *"Qualified Medical Practitioner"* means a medical practitioner registered under the relevant medical laws in force. It shall mean a person who possesses any of the recognized medical qualifications and who has been enrolled in the register of the respective medical council, i.e. Allopathy, Dental, Homeopathic and Board of Indian Medicine or any

such council, Board or any other statutory body recognized by the Government.

It shall mean, with respect to Allopathy, persons registered under the Gujarat Medical Council Act, 1967, With respect to Ayurved, Unani and Siddha, persons registered under the Central Council of Indian Medicine Act 1970; with respect to Homeopathy, persons registered under the - Homeopathy Central Council Act 1973.

(37) "*Qualified Nurse*" means any qualified nurse after three years of training and recognized by the Nursing Council.

(38) "**right to food**" means, at least, right of everyone to be free from hunger and malnutrition, and the right of every person to have regular and permanent access to food which is affordable, adequate, safe and nutritious, for a healthy and active life, and culturally acceptable to the population;

(39) "**right to health**" means right of everyone to a standard of physical and mental health conducive to living a life in dignity;

(40) "**right to housing**" means at least, right of everyone to an affordable place where a person can live in safety, privacy, dignity, and peace, under healthy conditions, with access to basic facilities,

and protection from forced eviction, harassment or other threats;

(41) **"right to sanitation"** means at least, right of everyone to access to affordable excreta disposal facilities which can effectively prevent human, animal and insect contact with excreta, and which ensure privacy and protect dignity of all persons, and shall also include provision of sewerage and drainage channels to remove wastewater and excreta and to ensure their safe disposal or treatment;

(42) **"right to water"** means at least, right of everyone to adequate, safe, acceptable, physically accessible and affordable water for personal and domestic uses, which would mean access at least to adequate amount of safe water that is necessary to prevent death from dehydration, to reduce the risk of water-related disease and to provide for consumption, cooking, personal and domestic hygienic requirements;

(43) ***"State Public Health Board"*** means the State Public Health Board established under this Act, to serve as an advisory and, in certain respects, as a decision-making body to the State Health Department and the Health Minister on all matters related to the public health system, including the development of the comprehensive State Public

Health Plan, and perform such other functions as provided for under this Act.

(44) *"underlying determinants of health"* shall mean conditions that are basically necessary for the realization by individuals of the highest attainable standard of health and shall include, without being limited to, adequate levels, in quality and quantity, of food/ nutrition, water, sanitation, and housing;

(45) *"Universal work precautions"* means infection control measures that prevent occupational and nosocomial exposure to or reduce the risk of transmission of pathogenic agents including Hepatitis B, Hepatitis C and HIV and includes the provision for education, training, personal protective equipment such as gloves, gown and masks, hand washing and employing safe work practices.

(46) *"Unsanitary condition"* means a condition or circumstance

(a) that is, or may be, or might become injurious to health; or

(b) that prevents or hinders the suppression of disease; or

(c) that contaminates or pollutes, or may contaminate or pollute food, air, or water; or

(d) that might render food, air, or water injurious to the health of any person;

And includes any hazardous and injurious substances and activities and any circumstance or condition declared to be an unsanitary condition by regulation, but does not include a serious health hazard;

(47) "Wholesome water" means water that is

(a) free from pathogenic agents;

(b) free from harmful chemical substances;

(c) pleasant to the taste, i.e. free from colour and odour and

(d) Usable for domestic purposes.

PART - II

PUBLIC HEALTH SYSTEM

CHAPTER I

DUTIES OF STATE GOVERNMENT

3. Role and Responsibility of State

The State Government shall take all measures to ensure that-

(a) In order to achieve the purposes of this Act, and to provide essential public health services and functions, the State Government shall establish an effective public health infrastructure, with assured necessary and adequate financial allocations and other resources

(b) The public health facilities shall be accessible and staffed with adequate trained human power as specified under the Indian Public Health Standards (IPHS) and other standards adopted by the State Health Department as also have sufficient infrastructure to meet its requirements.

(c) The State Government officers including the health care providers and the members of the

judicial services are given periodic awareness training on the issues addressed by this Act;

(d) Necessary budgetary provisions in terms of adequacy (in terms of how much is enough to offset inflation), priority (in terms of compared to other budget heads), progress (in terms of indicating an improvement in state's response), and equity (in terms of fair allocation of resources), are made for effective implementation of this Act.'

(e) The State government may, by notification, authorize any local authority to incur expenditure on any public health purpose specified in the notification.

(f) Effective co-ordination between the services provided by concerned Ministries and Departments is established and periodical review of the same is conducted;

(g) Protocols for the various Ministries concerned with the delivery of health services are prepared and put in place.

(h) The provisions of this Act are given wide publicity through public media including the television, radio and the print media at regular intervals;

4. **Government Monitoring:** In addition to the Health Information Systems, monitoring by Government agencies and the national and State boards shall include:

   (1) Annual financial audits of the health systems at national, State and district levels by the Comptroller & Auditor General (CAG) as well as by a chartered accountants and any special audit that may be deemed fit by the Governments, by agencies like the Indian Public Auditors, with the help and under the supervision of one or more research and resource institutions in every State, that shall be contracted for this purpose;

   (2) System of mandatory audits of medical records by every health care establishment and institution, public or private;

   (3) System of mandatory audits into maternal and child deaths as well as any other unusual death, by every health establishment and institution, public or private;

   (4) Mandatory requirement for all the health care institutions and establishments to prominently display information regarding the Indian Public Health Standards (IPHS) in various respects; the charter of users' rights; grants received by the institutions; medicines and vaccines in stock; services provided to the users, user charges to be paid (if any), as envisaged in the Right to

Information Act; and the monitoring of performance of the institutions and establishments on such parameters;

(5) Establishment of autonomous institutions with professional expertise and functional and administrative autonomy to conduct independent surveys to periodically assess the progress made on key health parameters; effectiveness of various health initiatives; status in health equity and access to quality health services including costs of health care and impact of health care costs on poverty; track public expenditure on health care; and the Governments, as advised by the respective health boards which shall lay down regulations for their functioning.

5. Authorities under the Act

The State shall establish the following authorities for the purposes of the Act:

(1) State Public Health Authority;

(2) State Public Health Board;

(3) Commissionerate of Health Services;

(4) Health Care Establishment (Registration and Regulation) Authority;

(5) Monitoring Committees, and;

(6) Public Health Redressal Mechanism.

CHAPTER II

PUBLIC HEALTH AUTHORITIES-ROLE AND RESPONSIBILITY

6. State Public Health Authority:

(1) The State government shall establish the State Public Health Authority.

(2) The composition of the Sate Public Health Authority shall be as follows:

(a) The Hon'ble Minister for Health and Family Welfare shall be the Chairperson;

(b) Hon'ble Minister for Education;

(c) Hon'ble Minister for Social Welfare;

(d) Hon'ble Minister for Food and Agriculture;

(e) Hon'ble Minister for Housing;

(f) Hon'ble Minister for Local Self Government;

(g) Hon'ble Minister for Public Works;

(h) Hon'ble Minister for Finance;

(i) Two members of the State Legislature belonging to opposition parties;

(j) Two representatives form recognized NGO's working in public health;

(k) Secretary of Health;

(l) Director of Health Services;

(m) Two Public Health experts and;

(n) One Public Health Law expert;

(3) The State Public Health Authority shall meet once in three months to discuss and implement various decisions taken with respect to the public health and health care services.

7. Powers of the State Public Health Authority:

(1) The authority shall formulate various policies with respect to public health and health care services.

(2) The authority shall allocate a certain portion of the annual budget for public health care services.

(3) The authority shall also direct the public health board to perform its functions, by notification.

(4) To promote the availability of and access to primary, secondary and tertiary health care including acute and episodic care, preventive health services, prenatal and postpartum care, child health, adolescent health, family planning, school

health, chronic disease prevention, child and adult immunization, testing and screening services, geriatric services, dental health nutrition and food safety and health education and other promotion services;

(5) To identify, assess, prevent and ameliorate conditions of public health importance including epidemics and outbreaks through surveillance; epidemiological tracking, programs; treatment; abatement of hazardous and injurious substances and activities; administrative inspections; or other methods;

(6) To create and empower health committees at various levels, so as to expand accessibility and quality of health services.

(7) to provide public health education and information through appropriate programs or messages to the public that promote healthy behaviors or lifestyles, and create awareness among citizens about health issues;

(8) To develop, adopt and implement public health plans through administrative regulations, formal policies, or collaborative recommendations that guide or support individual and community public health efforts.

(9) To establish formal relationships between public and private sector partners within public health system;

8. State Public Health Board

(1) A State Public Health Board shall be established by the State Government to serve as an advisory and, in certain respects, as a decision-making body to the State Health Department and the Health Minister on all matters related to the public health system, including the development of a comprehensive State Public Health Plan.

(2) The appointment of each member of the State Public Health Board shall be for a period of three years.

(3) The Board shall be represented by specific number of persons belonging to the State Health Department; local public health agencies; Public Health Experts; State or local governmental bodies, including those relating to environmental protection, women & child development, rural development, health care facilities, and representatives of Civil Society. Without prejudice to the generality of the composition above-

mentioned, the State Public Health Board shall consist of the following members:

(a) The Chief Secretary, State Government, who shall be the Chairperson;

(b) The Principal Secretary (Health & Family Welfare), who shall be the Co-Chairperson;

(c) The Commissioner of Health and Secretary of Family Welfare, State Government, who shall be the Convener;

(d) The Additional Director of Health Services, who shall be the Secretary;

(e) Secretaries or their nominees, in charge of Departments of Women and Child Development, Public Health Engineering, Water and Sanitation, Panchayat Raj, Rural Development, Social Welfare, Urban Development, Planning, Finance, Social Justice, Tribal Welfare, Information & Broadcasting, Disaster Mitigation/Preparedness;

(f) Nominated elected representatives such as Mayors and Commissioners of the largest Municipal Corporations, MPs, MLAs, Chairmen, Zila Parishad, representatives from the urban

local bodies (women should be adequately represented);

(g) Nominated non-official members (8-10 members) such as public health experts, representatives of medical associations, NGOs, etc.;

Provided that special invitees according to need may be included in the Composition of the Board.

(4) The Board may create sub-committees in order to address specific areas or needs concerning the public health system.

(5) The Board shall be adequately funded and staffed to conduct its operations and shall meet at least once in three months.

(6) Board members shall be compensated in accordance with the applicable State Laws.

9. Duties of State Public Health Board

(1) The State Public Health Board shall carry out the following functions:

(a) It shall prepare an annual Comprehensive Public Health Plan for the State, with focus on vulnerable sections of society and ill-served areas of the State.

(b) It shall propose amendments or repeal of any rules relating to the administration, implementation and observance of the provisions of the Act and may suggest amendments to the Act in the Reports laid before the State legislature;

(c) It shall develop norms and mechanisms to ensure equitable distribution of health resources. It shall review coverage norms every 5 years and suggest upward revisions;

(d) It shall monitor implementation of the Comprehensive Public Health Plan through quarterly/half-yearly meetings;

(e) It shall advise the State Health Department on public health plan and approve it for implementation;

(f) It shall consider the annual budget and the annual action plan, and pass it with modifications;

(g) It shall establish a sub-committee, which shall carry out clinical and medical audits for select conditions of public health importance, and receive relevant reports;

(h) It shall appoint committees and sub-committees for relevant purposes on such

terms as it may deem fit, and may dissolve or remove any of them;

(i) It shall develop and adopt rules and regulations for recruitment and appointment of technical experts and administrative and technical staff and set its compensation package for such experts and staff to be recruited from the open market and/or on deputation basis;

(j) It shall develop mechanisms for initiating public-private partnership in implementation of public health programmes;

(k) It shall develop mechanisms for empowering the decentralized monitoring committees at all levels, both rural and urban, as envisaged under this Act;

(l) It shall seek feedback and suggestions from members of the rural and urban Monitoring sub-committees in a structured manner, through sub-committees;

(m) It shall ensure preparedness for public health emergencies in coordination with other government departments, agencies;

(n) It shall take steps towards making equitable schemes for health insurance for persons of different income levels and special needs;

(o) It shall develop mechanisms for conducting health impact assessment for developmental activities/projects and ensure corrective action by concerned authorities;

(2) The State Public Health Board shall appoint an expert committee to develop Standard Treatment Protocols that are to be laid down and followed by public and private health care providers, including publicly funded treatment provided by private medical providers for:

(a) National Health Programmes

(b) Common diseases and conditions of public health importance, including major conditions affecting women and children.

(1) It shall establish standards for urban sanitation and hygiene and ensure that the Nagar Palikas adhere to these standards.

(2) It shall ensure that the prescribed structure for health care provision to the urban poor is set up within each city/town by obtaining an annual population estimate and health plan including a budget.

(3) Through periodic/annual reviews, it shall ensure that the urban health system provides affordable

quality care to the urban poor including the migrant population.

10. Commissionerate of Health Services:

(1) The Commissionerate of Health Services may consist of as many divisions as the Government may consider necessary for the administration of Health Care Services in the State.

(2) Subject to the control of the Government (a) the Director of Health Services shall be the Chief Administrative and Executive offer of the Directorate and (b) Chief Public Health Engineer shall be in charge of the public health engineering division of the Directorate.

(3) The DHS will be assisted by such members as deputy and assistant directors and the other officers at various levels of administration as the Government may, from time to time, deem fit to appoint.

(4) Powers of the Government and of the Commissionerate of Health Services:

(a) The Government shall have the power to inspect, control and supervise the operations of the local authorities under this Act.

(b) The Government may, from time to time, define the powers to be exercised, and duties to be performed by the Commissionerate of Health Services or any members.

(c) The Government may, by notification, direct that in respect of any function to be performed by a local authority under this Act and specified in the notification, the District Panchayat organization and not the Panchayat or the Panchayat Samithi shall be the local authority in all or any areas in the district which are comprised within the Jurisdiction of a Panchayat/Panchayat Samithi.

(d) The DHS shall have the power to supervise and control the medical and health establishments including training institutions and (public) health services within the State excepting those administered by the Central Government and will have the power to recover the cost from the local authorities for carrying out measures recommended by him in such in respect in respect of such institutions and services as fall those that fall within the purview of the local authorities.

(e) The DHS may, from time to time, as the occasion requires recommend for the

adoption by any Local Authority, such measures as may be necessary for improving the public health of the people therein. Provided that, if on any account of financial or other reasons, any local authority is unable to carry out such measures or if there is any difference of opinion between the local authority and the Director, then the matter may be referred to the Government, whose decision shall be final.

(f) The DHS shall have the power to cause to make the services of the Directorate available in the local authorities, non- profit making voluntary organizations, free of charge in respect of planning, execution and supervision of health measures including sanitary schemes.

(g) In case of emergency arising or threatening from outbreak of an epidemic due to communicable disease or from any other cause endangering the life or health of the public, the DHS shall have the power :

(i) To appoint additional personnel and organize public health care services for such periods as it may consider necessary, and

(ii) The approval of the government to assume all or any of the powers and functions of a local authority under this Act and in every case, the DHS shall forwith report the matter to the government.

11. Functions of Commissionerate of Health Services

(1) Bringing about co-ordination between the urban public health system and the private sector for public health goals. It shall ensure that the urban public health system co-ordinates with the ESI, Trust and other private hospitals and dispensaries, to ensure that the referral unit as well as the secondary hospital level respectively, are available and accessible to the poor, vulnerable and migrant populations.

(2) It shall ensure surveillance of notifiable diseases, conditions of public health importance and locally endemic diseases.

(3) It shall work out incentive systems and regulatory mechanisms, with respect to both Urban and Rural Health System for channeling the available resources for public health goals.

(4) It shall ensure that standards of safe drinking water, sanitation and garbage disposal are adhered to in entire jurisdiction of co-operations/councils including the habitations of the poor.

(5) It shall record vital statistics, including births and deaths of all persons, especially maternal and neo-natal.

(6) It shall encourage community participation and through a process of such participation, develop ward level public health plans, by incorporation of zonal public health plans.

12. Health Care Establishment (Registration and Regulation) Authority:

(1) As envisaged under Section 4 of the Act, the State shall establish the Health Care Establishment (Registration & Regulation) Authority at State level and in every District, viz., The State Health Care Establishment (Registration & Regulation) Authority and The District Health Care Establishment (Registration & Regulation) Authority.

(2) The Composition of the State Health Care Establishment (Registration & Regulation) Authority shall have the participation of various stakeholders. It shall be composed of not more than 15 members

nominated by the Government, with not more than 50% being Government representatives. The State Health Care Establishment (Registration & Regulation) Authority shall include:

(a) The Health Secretary shall be the Chairperson;

(b) The Commissioner of health and family welfare shall be the Convener of the Authority;

(d) Additional Director Medical Services, (Member Secretary);

(e) One representative from the State Indian Medical Association;

(f) Secretary or Commissioner in charge of Indian Systems of Medicines and Homeopathy;

(g) One representative from the Hospital Owners Association;

(h) One qualified practitioner running a Clinical establishment and registered under the Homeopathy Council;

(i) One qualified practitioner running a Clinical establishment and registered under the council of Indian System of Medicine;

(j) One representative from Nurses' Association;

(k) A Professor from Community Medicine Department, preferably from a Government medical college or one representative from a Government clinical establishment;

(l) One representative from a registered State level consumer organization;

(m) One representative from a State level NGO or coalition/ network of non-government organizations working in the area of health rights;

(n) One representative from a State level women's group;

(o) One representative from Jan Swasthya Abhiyan or the Dai Sangathan;

(3) The constitution of the authority shall be valid for a period of five years.

(4) The Functions of State Health Care Establishment (Registration and Regulation) Authority shall include the following:

(a) To lay down minimum requirements (standards) or upgrade existing requirements periodically (every 5 years) for all the Health Care Establishments;

(b) To suggest revision of fees charged periodically;

(c) To review and monitor the implementation of the Act and recommend changes in the said Act and Rules;

(d) To act as supervisory body for monitoring the Local Supervisory Authority. This shall involve receiving quarterly reports from the District Health Care Establishment Registration Authority and the Local Supervisory Authority, giving directives to the Local Supervisory Authority, acting as apex body at state level and supporting the District Health Care Establishment (Registration & Regulation) Authority.

(e) To act as a grievance redressal forum regarding provisions stipulated under this Act where it shall entertain complaints from patients, consumers, and the public. The State Private Health Care Establishment (Registration & Regulation) Authority shall only act on receipt of complaints to the board if the complainant is not satisfied with the decision of the District Private Health Care Establishment (Registration & Regulation) Authority;

(f) To conduct regular meetings of the board;

(g) To assess and review its own performance, in the prescribed manner at the end of each year;

(5) The meeting of the State Health Care Establishment (Registration & Regulation) Authority shall be called by the Chairperson or Convenor with a minimum notice of 15 days and shall need a minimum quorum of 50% of members. If on the day when the meeting is called, quorum is not present, the meeting shall be adjourned for 30 minutes and after that if the quorum is still not present the meeting shall proceed as if the quorum is present. The intervening period between two meetings shall not exceed 90 days;

(6) Emergency meetings may be called by the Chairperson or Convenor or Local Supervisory Authority or any of the members of the State Health Care Establishment (Registration & Regulation) Authority with the sanction of the Chairperson with a three clear days notice. Emergency meetings may be called on receipt of serious complaints made to the State Health Care Establishment (Registration & Regulation) Authority;

(7) All orders and decisions of the Board shall be authenticated by the signature of the chairperson or any member authorized by the Authority;

(8) The government and non- government members appointed to the State Health Care Establishment (Registration & Regulation) Authority shall be entitled to traveling allowance and daily allowance according to the traveling allowance rules of the state government, for attending the meeting;

(9) The Composition of the District Health Care Establishment (Registration and Regulation) Authority shall be set up at the district level composed of members nominated by the State Government, according to State Government directive out of which more than 50% shall be persons who are not government officers, and shall include the following:

(a) Collector of the District or Municipal Commissioner in case of Municipal Corporation who shall be the ex-officio Chairperson;

(b) Local Supervisory Authority who shall be the Member Secretary;

(c) A member of local chapter of Indian Medical Association;

(d) A professor or senior faculty, from Community Medicine Department, preferably from a government medical college;

(e) One representative from the hospital owner's association;

(f) One qualified practitioner running a private health care establishment and registered under the homeopathy council;

(g) One qualified practitioner running a private health care establishment and registered under the council of Indian System of Medicine;

(h) One representative from a government health care establishment;

(i) One local representative from the Nurses' Association;

(j) One representative from the local consumer organization;

(k) One representative from a non-governmental organization working in the area of health or coalition/ network of non-government organizations working in the area of health rights;

(l) One representative from a women's group active in the district;

(m) One representative from JSA or the Dai Sangathan;

Provided that any person, who is not a member of the District Health Care Establishment (Registration & Regulation) Authority, whose assistance or advice may be required for the functioning of the board, may be appointed to do so by the District Health Care Establishment (Registration & Regulation) Authority. Such person shall have the right to take part in the discussion relevant for the purpose but shall have no right to vote at a meeting of the Authority;

(10) The term of the members of the Authority shall be for a period of five years;

(11) The functions of the District Health Care Establishment (Registration & Regulation) Authority shall include the following:

(a) To review and monitor the implementation of the Act;

(b) To conduct regular meetings of the District Health Care Establishment (Registration & Regulation) Authority;

(c) To communicate to the State Public Health Authority any modifications required in the rules, especially with reference to minimum requirements (standards) and revision of fees charged;

(d) To act as an appellate body for any order passed by the Local Supervisory Authority;

(e) The authority shall have the power to appoint a committee or committees from its members for the performance of various tasks.

(12) The meeting of the District Health Care Establishment (Registration & Regulation) Authority shall be called by the Chairperson with a minimum notice of 15 days and shall need a minimum quorum of 50% of members. The intervening period between two meetings shall not exceed 90 days.

Provided that in event of the Chairperson not being available and looking at the urgency of the matter or in order to adhere to the time limit, the Local Supervisory Authority may call for the meeting with 7 clear days notice to all members.

(13) Emergency meetings may be called by the Chairperson or Local Supervisory Authority or any of the members of the District Health Care Establishment (Registration & Regulation) Authority

with the sanction of the Chairperson, with a three clear days notice. Emergency meetings may also be called on receipt of serious complaints made to the District Health Care Establishment (Registration & Regulation) Authority. The decisions of the District Health Care Establishment (Registration & Regulation) Authority shall be taken by consensus or by majority vote and in case of equal vote the Chairperson shall have the casting vote.

(14) All orders and decisions of the authority shall be authenticated by the signature of the Chairperson or any member authorized by the Authority.

(15) The Government and non-government members appointed to the District Health Care Establishment (Registration & Regulation) Authority shall be entitled to traveling allowance and daily allowance according to the traveling allowance rules of the State Government, for attending the meeting.

(16) Disqualification for appointment as members to District Health Care Establishment (Registration & Regulation) Authority- A person shall be disqualified as member of the board if he/she

(a) has been convicted by a court of law for offence of moral turpitude.

(b) Vacates or is dismissed from the position by virtue of which he/she was appointed.

(c) In case of medical practitioners, if they are found guilty by a court of law or the respective medical council of medical negligence and malpractice.

(17) The constitution of the authority shall be valid for a period of five years.

13. Powers of Health Care Establishment (Registration and Regulation) Authority

(1) The State and District Health Care Establishment (Registration and Regulation) Authority shall have the powers to register the existing and newly opened Healthcare Establishments.

(a) The Authority has powers to conduct periodic inspection of the Health Care Establishments;

(b) The Authority has the power to monitor the minimum standards implementation in the Health Care Establishments;

(c) The Authority has the power to receive complaints from the patient or any other stake holders and accordingly forward the same to the Tribunal;

(d) Issuance or grant of Certificate of need;

(e) The Authority shall file periodic reports before the Public Health Board.

14. Mechanism for Community-based Monitoring

An integrated system of community-based monitoring, planning and action shall be ensured by the State. The operationalization of this approach shall be based on interlinked committees at Village, PHC, Block, District level with respect to rural areas. There shall be a similar mechanism with Committees at basti, ward, zone and Municipal Council / Corporation for urban areas. These shall be linked with a State Health Monitoring and Planning Committee at the State level.

Section 14 dealing with Public Health Redressal Mechanism has been deleted

CHAPTER – III

PUBLIC HEALTH PLANNING

15. Comprehensive Public Health Plan

(1) State

(a) In order to promote the provision of essential public health services and functions, the State Public Health Board shall develop and monitor the implementation of a comprehensive, statewide Public Health Plan that assesses and sets priorities for the public health system. Each plan shall be operational for a period of five years, subject to annual revisions.

(b) The plan shall rely on existing or available surveillance data or other information acquired pursuant to this Act, as well as subject-specific public health plans or national guidelines or recommendations concerning public health outcomes/improvements.

(c) The purposes of the plan shall be to:

(i) Guide the public health system in targeting essential public health

services and functions through program development, implementation, and evaluation;

(ii) Strive to increase the efficiency and effectiveness of the public health system;

(iii) Identify specific geographical areas and social groups needing greater resources allocation to provide essential public health services and functions; and

(iv) Incorporate time-bound and monitorable commitments, obligations, goals and priorities, consistent with the United Nations' Millennium Development Goals and other national goals and priorities, in areas related to public health.

(d) The plan shall include the following aspects:

(i) Identify and quantify existing public health problems and disparities, both geographical and social, at the State and local levels;

(ii) Identify existing public health resources at the State and local levels, both in the public and private sectors, covering

allopathic and non-allopathic systems, including traditional providers of healthcare;

(iii) Declare goals of the plan which may be monitored at the State, district and local (town or Panchayat) levels, describing measurable indicators of effectiveness and successes;

(iv) Develop a plan for monitoring based of the above indicators

(v) Detailed description of the programs and activities that will be pursued to address existing public health problems, disparities,

(vi) Detailed description of how public and private sector health services will be integrated; and how public and private sector health resources will be shared to optimize efficiency and effectiveness of the public health system and describe strategy for coordinating service delivery within the public health system

(vii) Develop an information, education and communication (IEC) infrastructure that

shall support essential public health services and functions. This shall involve mass IEC campaigns and activities, with institutionalized involvement of educational institutions, Non-governmental Organizations, Community Based Organizations, Disabled People's Organizations and organizations working on disability, environmental and human rights organizations, religio-social organizations, association of medical practitioners, traditional healthcare practitioners, mass media (including privately owned mass media), and all other stakeholders in promotion of public health.

(viii) Formulate a human resource development plan to ensure capacity building commensurate with the public health needs

(ix) Develop and implement a capacity building plan for all the bodies and committees being set up at various levels under this Act.

(x) Estimate costs and time-lines for implementing the plan;

(e) It shall be the responsibility of the State Health Department to ensure that the coordination, planning and review bodies bring about coordination between District Health Services in the rural areas and Municipal Health Services in the urban areas.

(2) Local

(a) Local Authorities shall prepare public health plans for their area jurisdictions consistent with the comprehensive public health plan described under Section 15. Local public health plans shall:

(i) Examine data about health status and risk factors in the local community;

(ii) Assess the public and private sector resources, capacity and performance of the local public health system;

(iii) Identify goals and strategies for improving the health of the local community;

(b) The State Public Health Agency shall encourage and provide technical and financial

assistance to local public health agencies -and -work with local public health agencies to develop the plan.

(c) Effective implementation of the local public health plan shall be done through the establishment of a commensurate local public health establishment.

16. Training of Public Health Authorities

(1) The State Public Health Agency may directly, or in conjunction with educational institutions or others within the public health system, make available or assure effective programs, including basic training and continuing education, or other tools for training public health agents and others within the public health system.

(2) Various individuals within the public health system shall be required by the state public health agency to meet minimal training requirements in order to provide essential public health services and functions, as they evolve.

(3) The State Government shall make adequate provisions for state level training institutes/district training centres for this purpose.

(4) The State Public Agency shall review periodically the curricula of medical and para-medical training institutions, so as to incorporate changing public health needs.

5) The State Public Health agency shall conduct training of private health care providers on surveillance criteria and Standard Treatment Protocols for diseases and conditions of public health importance, as decided by the state.

6) The State Public Health Agency shall ensure that the standard treatment protocols affectively integrate different systems of medicines like Allopathy and Ayush.

17. Earmarking of Revenue

(1) Every local authority shall earmark not less than 30 percent of its income from all sources other than Government grants for expenditure on the advancement of public health in its local area.

(2) The State Government may, by notification, authorize any local authority to incur expenditure on any public health purpose specified in the notification.

PART III

PUBLIC HEALTH DETERMINANTS

CHAPTER I

PUBLIC HEALTH CONDITIONS

18. Conditions of Public Health Importance

Conditions of public health importance are defined from the perspective of epidemiological significance, and include chronic and emerging conditions like diabetes, hyper-tension, cancers, Reproductive Tract Infection/Sexually Transmitted diseases, Cardio-vascular diseases, maternal and infant deaths, mental health, malnutrition, tobacco, alcohol and substance abuse and aging. Other conditions include environmental pollution – including noise, air, water and soil pollution – that can lead to widespread effects not restricted to any single or narrow set of symptoms. Other conditions of public health importance include, but are not limited to the diseases listed in Schedule I-B

19. Notifiable Diseases

(1) Without prejudice to anything provided for under the Factories Act, 1948, diseases may be characterized as notifiable where stern steps are needed to be taken to prevent them from taking

the form of an epidemic or spreading from one person to another, thereby increasing the levels of morbidity and mortality. Notifiable Diseases include, but are not limited to the diseases listed in Schedule I-A and occupational diseases (including pneumoconiosis, silicosis, byssinosis, bagganiosis, asbestiosis,)

(2) The State Government may from time to time by notification, declare a disease to be a notifiable disease for the purpose of this part either generally throughout the State or in such part or parts thereof as may be specified in the notification.

Explanation: Occupational diseases shall also be notifiable diseases (including pneumoconiosis, silicosis, byssinosis, baggasosis, asbestosis,)

(3) In addition to Notifiable diseases mentioned above, certain diseases and health conditions shall be put under regular surveillance or the information shall be collated through sentinel surveillance or periodic surveys. The list of these diseases/conditions (schedule I-D) shall be based on disease burden in the community, potential to spread epidemic and availability of public health response. The said list shall be reviewed and modified at least once in 2 years.

20. Locally Endemic Diseases

Locally endemic diseases are defined from the perspective of local epidemiological significance and include chronic and emerging conditions like sickle cell anemia, flurosis, thalassemia, goitre, filariasis, leptospirosis. Locally endemic diseases include, but are not limited to the diseases listed in Schedule I-B

21. Obligations of State Government

(1) The State Government has the following general obligations at all times, within the maximum limits of their available resources, towards the progressive realization of health and well being of every person in the country.

(a) Undertake appropriate and adequate budgetary measures, as per the globally accepted norms, to satisfy, the obligations and rights set out herein, throughout ensuring transparency and equity in the allocation, planning and rational allocation and distribution of resources for health and health related issues and concerns;

(b) Take all measures and steps, for addressing bio-medical determinants as well as the underlying socio-economic, cultural and

environmental determinants of health and wellbeing to ensure the enjoyment of right to health and well-being of every person, equally and without any discrimination;

(c) Provide free and universal access to health care services and ensure that there shall not be any denial of health care directly or indirectly, to anyone, by any health care service provider, public or private, including for profit and not for profit service providers, by laying down minimum standards and appropriate regulatory mechanism;

Provided that notwithstanding the above the Governments have an immediate duty to prioritize the most vulnerable and marginalized persons and groups,-who are unable themselves to access means for adequate and appropriate health care services, and ensuring them at least the minimum conditions of health care;

(d) Ensure comprehensive involvement of civil society, especially vulnerable or marginalized individuals/ groups, including by enabling them to effectively articulate their health needs and to participate in all health related decision-making processes, including in setting health priorities and goals; and in devising, planning, implementing and

evaluating the policies and strategies for health and well-being at every level; also integrally incorporating their roles and participation in the contents of such policies, strategies and plans; and ensuring demonstrably serious consideration to diverse expert views, in the planning of health care;

(e) Where imposition of limitations on right to health of individuals becomes necessary in compelling public health or interest, ensure proportionality of such limitations by adopting the least restrictive alternative, and in any case ensure that they be of limited duration and subject to review against the reference to the rights provided for herein;

(f) Ensure that all their policies, especially the economic, agricultural, industrial, technology related, intellectual properties related, be subject to health and equity impact assessments;

(g) Ensure *inter se* convergence among programmes of all the sectors related to health and also *inter se* integration among all health care related programmes, vertically as well at every level of health care, horizontally; and

(h) Take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other countries, international organizations and other entities, such as development partners, donor organizations and multinational corporations.

(2) Within the framework of general obligations mentioned above, the core obligations of Governments towards right to health and well-being shall include the minimum essential levels of the following obligations towards the underlying determinants of health:

(a) Ensure equitable distribution of and access to essential health facilities, goods, drugs, services and conditions to all, and especially for vulnerable or marginalized groups;

(b) Ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger and malnutrition to everyone;

(c) Ensure adequate supply of safe water;

(d) Ensure sanitation through appropriate and effective sewerage and drainage systems, waste disposal and management systems,

pollution control systems, control of ecological degradation, control of insects and rodents and other carriers of infections, addressing practices resulting in unhygienic disposal of human excreta and refuse, consumption of unhygienic water or food and through other measures;

(e) Ensure access to basic housing with dignity, access to basic facilities, and protection from forced eviction, harassment or other threats; and

(f) To devise, adopt, implement, and periodically review, health policies, strategies and plans of action, on the basis of epidemiological, sociological and environmental evidence, addressing the health concerns of the whole population, which shall include methods such as right to health indicators and benchmarks, by which progress can be closely monitored, and evaluate them on the basis of outputs.

Provided that until the policies and plans are notified by the State Government under this Act, the National Health Plan, (NHP) 2002, National Population Policy (NPP) 2000, National AIDS Control Programme-III (NACP-III), National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM), or any other existing plans,

policies or programmes relating to health shall be deemed to be the plans, policies and programmes under this Act. However, within 6 months of this Act coming into force they would be assessed and where necessary, strengthened and modified, with reference to this Act, especially the rights and obligations provided for herein and its basic framework.

Provided further that within 1 year of this Act coming into force, the State Government shall adopt and implement national strategies and plans of action for ensuring access to underlying determinants of health: food, water, sanitation and housing, and in the light of the framework laid down in this Act, review, and if necessary, redraft, the currently existing schemes and programmes on them, and within 6 months thereafter, the State Governments shall accordingly adopt and implement compatible State level strategies and plans of action through their respective local bodies.

Explanation: The above obligations shall be 'core' obligations of the Governments in the sense that they shall be non-derogable and the Governments cannot, under any circumstance, justify their non-compliance with these obligations.

22. Functions of the Local Authority with respect to Notifiable Diseases, Conditions of Public Health Importance and Locally Endemic Diseases

(1) The Local Authority shall perform the following functions:

(a) Assess the community health status, identify the notifiable diseases, conditions of public health importance and locally endemic diseases, their risk factors, and establish a system for surveillance of these diseases through regular data collection and analysis, in the manner prescribed.

(b) Prepare a district and local health plan for control of notifiable diseases, conditions of public health importance and locally endemic Diseases on the basis of data collected and its analysis, with the involvement of community members in the making of the plan and in its implementation.

(c) Enumerate a list of notifiable diseases, locally endemic Diseases and conditions of public health importance and review it regularly. Such a list shall include diseases or conditions of humans or animals caused by exposure to toxic substances, microorganisms, or any other pathogens. The list may include

notifiable diseases under Occupational health acts (factories act, mines act etc).

(d) Ensure the implementation of ongoing National Infectious Disease (TB, Leprosy, Vector-borne, Polio, STD, AIDS etc) control programmes.

(e) Establish Public Health laboratories in each District and Municipal Corporation, whose functions shall include the following:

(i) Testing of water samples for hardness, total dissolved solids (TDS), harmful chemicals and presence of pathogens, for newly established water source in routine activities.

(ii) Testing of samples of milk for pathogens, harmful chemicals, adulteration and adequacy of pasteurization.

(iii) Testing of samples of foods for adulteration, harmful chemicals, and pathogens in case of occurrence of cases of food poisoning.

(iv) Analysis of samples of air for harmful substances, toxic gases and their amounts, suspended particles etc.

(v) Analysis of blood samples for screening of infectious diseases, confirmation of diagnosis in cases of outbreaks of diseases/conditions of public health importance.

(vi) Analysis of human and animal tissue to detect environmental toxins, including chemicals, heavy metals etc.

Provided that where there is no Municipal Corporation for a particular district, the laboratory shall be set up at the District Headquarters. .

23. Powers of the Local Authority with Respect to Burial and Burning Grounds

(1) The Local Authority shall have the following powers with respect to burial and burning grounds:

(a) Provide suitable place with care-takers for burial and burning or otherwise disposal of the dead bodies according to different religious customs at reasonable distance from inhabited areas. The clothing and bedding in which the dead body has been carried to the burial or burning ground shall be buried or burn according to religious tenets.

Provided that the care-taker shall not permit the burial or burning of dead bodies except on production of a certificate showing the probable cause and time of death and signed by a registered medical practitioner or a member of the local authority for the locality in which the deceased was resident.

(b) Grant license for all burial and burning grounds, in the prescribed manner.

(c) Arrange for proper registration of all dead bodies buried or burnt or other wise disposed.

(d) Arrange for thorough disinfection of the vehicles and bulky articles not disposed off, at the prescribed charges.

24. Function of health care providers in reporting

(1) All health care providers, medical examiners, pharmacists, laboratories, whether in public or private sphere, shall, subject to the right of confidentiality of a user, report all cases of persons who harbor any illness or health condition, including any notifiable diseases, condition of public health importance and locally endemic diseases, that may be potential causes of a public health emergency in the prescribed manner to the following persons:

(a) In municipal areas, to the executive authority, the Health Officer or a Sanitary Inspector

(b) In non municipal areas, to the Chief District Health Officer, a Health or Sanitary Inspector or the Village Headman.

Explanation: Reportable illnesses and health conditions shall mean infectious diseases and condition of public health importance required by the state public health agency to be reported and diseases listed in the notifiable diseases list mentioned under Schedule I-A and any other illnesses or health conditions identified by the public health authority.

Explanation: In this section, 'medical practitioner' includes a Vaidya or Hakim, whether registered or not.

(2) A veterinarian, livestock owner, veterinary diagnostic laboratory director, or any other person having the care of animals shall report animals having or suspected of having any diseases or conditions that may be potential causes or indicators of a public health emergency.

(3) Any other person who knows or suspects a case of a reportable disease or condition may provide available information concerning the case to the concerned persons mentioned in sub-section (1).

(4) Without prejudice to anything provided under the Registration of Births and Deaths Act, 1969 it shall be the duty of the health care provider to ensure effective implementation of the recording of all birth, death and cause of death to the appropriate authority, which occurs in their presence. In all other cases, it shall be the duty of the family members to record birth and death. All provisions relating to penalty shall be as provided under the Registration of Births and Deaths Act.

CHAPTER II

PUBLIC HEALTH MANAGEMENT IN SITUATIONS OF DISASTERS

25. Planning for public health emergencies caused due to disasters

(1) The State Public Health Board shall set up State Disaster Management committee under the Gujarat State Disaster Management Authority established under the Gujarat State Disaster Management Act, 2003, which shall:

(a) prepare a disaster management plan setting out –

(i) the manner in which the concept and principles of disaster management shall be applied for saving lives and preventing outbreaks of diseases;

(ii) roles and responsibilities of the Public Health department in respect of emergency medical relief and post disaster recovery and rehabilitation;

(iii) capacity to fulfill roles and responsibilities of the department;

(iv) strategies and procedures in the event of a disaster, including measures to finance the strategies; This should include chronological action plan to be followed after initial alert of the disaster, activating hospital disaster plan for medical relief, triage, declaration of public health emergency, management of life supporting services

(b) co-ordinate preparation and the implementation of plan with other departments, local authorities , communities and stakeholders;

(c) regularly review and update the plan at the state & local authority level

(2) The State Disaster Management committee shall make suitable provisions in the plan after considering the following, namely:-

(a) the types of disaster that may occur and their possible effects;

(b) the communities and property at risk;

(c) provision for appropriate prevention and mitigation strategies;

(d) inability to deal with disasters and promote capacity building;

(e) the integration of strategies for prevention of disaster and mitigation of its effects with development plans, programmes and such other activities in the State;

(f) provision for assessment of the nature and magnitude of the effects of a disaster;

(g) contingency plans including plans for relief, rehabilitation and reconstruction in the event of a disaster, providing for –

(i) procurement of essential goods and providing essential services;

(ii) establishment of strategic communication links;

(iii) dissemination of information.

26. Services in Case of Epidemics, Disasters and Conflict Situations

(1) In case of epidemics, conflict situations and disasters, natural as well as man made, all required health services shall be made available to all affected persons with no discrimination on the grounds of age, sex, economic status, place of residence, religion, caste, physical or mental ability, nationality, mental health status or HIV/AIDS status, or type of epidemic on the following principles:

(a) Prompt and comprehensive responses;

(b) Immediate response- outreach of services to all including setting up of health camps and mobile clinics within 48 hours;

(c) Multifaceted response- Physical, social and psychological;

(d) Comprehensive response taking into account public health services that may be disrupted;

(e) Ensuring provision of services other than health care, like food and water supply;

(f) Uniform compensation.

CHAPTER III

PUBLIC HEALTH EMERGENCIES

27. Detecting and Tracking Public Health Emergencies

(1) Tracking for public health emergencies shall be based on the data generated through the Integrated Disease Surveillance Plan (IDSP) operative in the State.

(2) The local public health authority shall ascertain the existence of cases of an illness or health condition that may be a potential cause of a public health emergency, investigate all such cases for sources of infection, ensure that they are subject to proper control measures and define the magnitude of the problem by assessing the distribution of the disease or health condition.

Deleted:

(3) The local public health authority shall routinely monitor industry-level information on environmental pollution generated by the pollution control board, and assess other information pertaining to public water bodies to ascertain areas that are routinely receiving environmental toxins in excess of prescribed standards. High pollution areas shall be defined as such, and steps shall be taken to mitigate pollution. Such steps shall include

monitoring of health with a view to assessing outcomes resulting from exposure to environmental pollution, coordinating with Pollution Control Board to mitigate pollution, extending specialized training to health providers in diagnosing and treating potentially environmentally-affected persons, and specially equipping local health care centers with the ability to detect and respond to environmental diseases and epidemics.

(4) To fulfill the above duties the public health authority shall follow the prescribed chronological action plan as prepared by State Disaster Management committee

(5) If an outbreak of disease is suspected, the medical officer of the concerned health facility will verify the outbreak, send the requisite sample to the public health laboratory for confirmation of diagnosis, provide standard case management for diagnosed cases and contacts through active search in the community, initiate proper control measures to prevent further spread of outbreak including vaccination, submit a report to the local authority, district health authority in consultation with BHO/CDHO.

28. Declaration of a state of Public Health Emergency

(1) A state of Public Health Emergency may be declared by the State Government/Local Authority upon the occurrence of a “public health emergency” as defined in Section 2(62)

In the event of the prevalence or threatened outbreak of a notifiable disease, or other illness or condition that could adversely effect public health in any area, the State Government /Local Authority may declare that such an area is affected by, or threatened with, an outbreak of such disease, and such declaration shall also amount to a declaration of public health emergency.

(2) Prior to such a declaration, the State Government shall consult with the State Public Health Board and National Institute of Communicable Diseases

Provided that the State Government /Local Authority may declare a public health emergency without consulting with the public health authority or other experts when the situation requires immediate and timely action.

(3) A state of Public Health Emergency shall be declared by an executive order that specifies the:

(a) Nature of the public health emergency,

(i) Administrative divisions or geographic areas subject to the declaration,

(ii) conditions that have brought about the public health emergency,

(iii) duration of the state of the public health emergency, if less than 30 days, and

(iv) primary public health authority responding to the emergency

(4) The primary public health authority specified under sub section 3(e) shall be :

(a) if emergency is due to any disaster as per the State Health Emergency and Mitigation Plan,

(b) If emergency is due to any other reasons, person so designated from the State public health board.

(5) Where a declaration of a state of Public Health Emergency is published in the Government Gazette, it shall activate the response mechanisms of the State, local and inter-jurisdictional emergency plans in the affected political sub-division(s) or geographic area(s). Such declaration shall authorize the deployment and use of any agencies and official cadres in the areas to which the plans apply and the use or distribution of any supplies, equipment, and

materials and facilities assembled, stockpiled, or available pursuant to this Act.

29. Termination of Public Health Emergency

(1) The State Government or the Public Health Authority at the local level shall terminate the declaration of a state of Public Health Emergency by an executive order upon finding that the occurrence of an illness or health condition that caused the emergency no longer poses a high probability of a large number of deaths in the affected population, a large number of incidents of serious permanent or long-term disability in the affected population, or a significant risk of substantial future harm to a large number of people in the affected population. In the case of Public Health Emergencies declared owing to environmental pollution, the State Government or the Public Health Authority at the local level shall terminate the declaration by an executive order upon termination or regulation of the source of environmental pollution, and clean-up of environmental contamination caused by the same.

(2) All orders terminating the declaration of a state of Public Health Emergency shall indicate the nature of the emergency, the area(s) that was threatened,

and the conditions that make possible the termination of the declaration.

(3) Notwithstanding any other provision of this Act, the declaration of a state of public health emergency shall be terminated automatically after 30 days after the last case detected, unless renewed by the State Government under the same standards and procedures set forth in this Chapter.

30. Emergency Powers of the State Government

(1) The State Government shall, for such period as a state of Public Health Emergency exists, exercise the following powers:

(a) Suspend the provisions of any regulatory statute prescribing procedures for conducting State business, or the orders, rules and regulations of any State agency, to the extent that strict compliance with the same would prevent, hinder, or delay necessary action (including emergency purchases) by the public health authority to respond to the public health emergency, or increase the health threat to the population.

(b) Utilize all available resources of the State government and its Administrative divisions,

as reasonably necessary to respond to the public health emergency.

(c) Temporarily transfer the personnel of State departments and agencies in order to perform or facilitate response and recovery programs regarding the public health emergency.

(2) The State Government may, for such period as the state of Public Health Emergency exists, exercise the following powers:

(a) Mobilize all or any part of the organized armed and security forces into service of the State. An order directing the armed and security forces to report for active duty shall state the purpose for which it is mobilized and the objectives to be accomplished.

(b) Respond immediately to international humanitarian aid.

(c) Provide aid to and seek aid from other states in accordance with any inter-state emergency pact made with this State.

(d) Seek aid from the Central Government in accordance with national disaster plans

(e) Appoint temporarily, by order, for such period as may be specified therein, one or more

additional Health Officers, for the treatment of such infectious disease and to prevent it from spreading, or for investigating the cause of and preventing, such mortality, as the case may be.

CHAPTER – IV

PUBLIC HEALTH IMPACT ASSESSMENT

31. Powers of the Local Authority with Respect to Burial and Burning Grounds

(1) The Local Authority shall have the following powers with respect to burial and burning grounds:

(e) Provide suitable place with care-takers for burial and burning or otherwise disposal of the dead bodies according to different religious customs at reasonable distance from inhabited areas. The clothing and bedding in which the dead body has been carried to the burial or burning ground shall be buried or burn according to religious tenets.

Provided that the care-taker shall not permit the burial or burning of dead bodies except on production of a certificate showing the probable cause and time of death and signed by a registered medical practitioner or a

member of the local authority for the locality in which the deceased was resident.

(f) Grant license for all burial and burning grounds, in the prescribed manner.

(g) Arrange for proper registration of all dead bodies buried or burnt or other wise disposed.

(h) Arrange for thorough disinfection of the vehicles and bulky articles not disposed off, at the prescribed charges.

32. Clearance of development projects based on health impact assessment

(1) All projects that fall under Category A and B1 of EIA Notification, 2006, shall under this Act require a Health Impact Assessment which will be commissioned by the Public Health Authority at the District level, and paid for by the project proponent.

(2) In addition there needs to be a supporting resolution of the Gram Sabha of all the relevant villages in support of the project, if there are any concerns, these need to be explicitly included in the EIA / HIA. The project cannot go to the public hearing stage without the express consent of the

respective Gram Sabhas. Any case of undue influence on these villagers should be dealt with very severely.

(3) The village health committee will be appraised of the situation, and will have the power to make specific queries, objections etc, that need to compulsorily be addressed in the HIA report.

(4) The District-level Public Health Authority shall conduct a public hearing at a venue as close as possible to the project site, after giving due notice of 30 days in at least two newspapers, one of which shall be in the local language prevalent in the project area, and by the printing of pamphlets to be distributed in interior villages, and making available copies of the Health Impact Assessment report at the below-mentioned offices:

(a) District Industries Centre

(b) Office of the District Collector

(c) Block Development Office or Municipal Corporation or Council

(d) Office of the Chief District Health Officer, or Health officer in the case of Municipal Corporation/Council

(e) Primary Health Centre

(f) Panchayat offices of every concerned village – this report should also contain a translation into local language and a complete and accurate executive summary.

(5) The terms of reference (TOR) and scope of the Health Impact Assessment shall be intimated to the project proponent within 30 days of receipt of application consisting of project report. The TOR shall be finalized by a Health Impact Assessment Committee consisting of the Chief District Health Officer, or Health Officer in the case of Municipal Corporation/Council, at least two independent medical experts, members of NGOs working in the health sector.

(6) The Public Hearing shall be conducted by a panel comprising of the members of the Health Impact Assessment Committee, in addition to the District Collector and a representative of the local body.

(7) Minutes of the hearing will be finalized and read out at the end of the public hearing, and forwarded to the Secretary, Department of Health, for evaluation by a State Level Health Impact Appraisal Committee comprising relevant members The Committee shall forward its recommendations to the Secretary, Department of Health, for final project approval which shall be granted with conditions or denied for

reasons stated no later than the date of grant of environmental clearance from Centre or State Government as the case may be.

33. Need for additional health impact assessment

The Public Health Authority shall monitor the project for compliance with conditions stipulated in the approval granted and submit half-yearly compliance report, along with recommendations for additional assessment and mitigation of health impacts to the Department of Health, with copies to the local body and the Pollution Control Board.

34. Register of Approval

The Public Health Authority shall maintain a register of approval granted along with conditions, raw materials used, products manufactured, and details of emissions (to air, water and land) by the project activity, the hazards to health and environment therein, and such details shall be open to inspection by interested members of public and the same shall be published via internet. Interested members of public shall be allowed to take copies of relevant documents from the Register upon payment of fees as shall be decided by the Authority. Persons under

BPL category shall be provided the information free of cost.

CHAPTER – V

Public Health Rights

35. Right to Health

Every person has the right to a standard of Physical and Mental Health conducive to living a life in dignity.

36. Right to access, use and enjoy

Every person has the right to access, use and enjoy all the facilities, goods, services, programmes and conditions necessary for ensuring the right to health, including but not limited to at least the following:

(a) Right to food;

(b) Right to water;

(c) Right to sanitation;

(d) Right to housing;

(e) Right to appropriate health care, and health care related functional equipment and other infrastructure, trained medical and professional personnel, and essential drugs;

Appropriate health-related IEC, including on sexual and reproductive health, to be able to make more informed health related choices;

Explanation: The information hereunder, where needed for the purposes of fulfillment of this Act, shall not be limited to, and shall be in addition to, the information receivable under the Right to Information Act, 2005.

(f) Protection from and mitigation during environmental disasters like famines, floods, and earthquakes, disease outbreaks/ epidemics, and other public health emergencies;

(g) Protection from and abatement of hazardous and injurious substances and activities; road and transport safety; industrial hygiene and occupational safety; hygiene and safety in places and situations of large collection of people occasioning mass food production or disposal of biological wastes including at fairs, festivals, cinema, theatres, circuses, markets, shopping places, malls, lodging houses, burial and burning grounds, slaughter houses; and

(h) Health Impact Assessment (HIA) of all new development projects.

Explanation: Right to access, use and enjoy all the facilities, goods, services, programmes and conditions

necessary for the realization of the a standard of health conducive to living a life in dignity shall mean that facilities, goods, services, programmes and conditions providing all the above shall be:

(a) *available* in sufficient quantity;

(b) *accessible* to everyone, such that 'accessibility' shall mean and entail:

(i) access without discrimination on any of the prohibited grounds;

(ii) physical access; in case of persons with disabilities further ensuring adequate access to buildings, and infrastructure through reasonable accommodation measures;

(iii) economic access or affordability; and

(iv) access to information and ideas concerning health issues; in case of persons with disabilities, further ensuring access to information through reasonable accommodation measures.

(c) *acceptable* such that the facilities, goods, services, programmes and conditions must be respectful of medical ethics and socio-culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities; sensitive to gender and lifecycle requirements, as well as designed to

respect confidentiality and improve the health status of those concerned; and

(d) scientifically and medically *appropriate and of good quality,* requiring, *inter alia*, trained and skilled medical and para medical personnel, scientifically approved and unexpired drugs and hospital equipment and other infrastructure satisfying the relevant safety standards.

37. Right against discrimination:

(1) No person shall be subject to any discrimination in any form or manner, by the Government or any other person or body of persons, whether public or private, in access to facilities, goods, services, programmes, conditions, or rights for health care and for underlying determinants of health, as well as to means and entitlements for their access, use and enjoyment, on one or more of the grounds of sex, class, monetary or other economic status, place of birth, age, marital status, actual or perceived health status, sexual orientation, physical or mental disability, occupation, religion, sect, region, language, political or other opinion, caste, civil, political, social or other status or affiliation, race, or any other arbitrary ground (herein called 'prohibited grounds'), which has the intention or effect of nullifying or impairing the equal

enjoyment or exercise of the right to health, and the right to dignity, of that person.

Explanation: "Discrimination" in the above provisions and also wherever else it is mentioned in this Act shall include any act of omission or commission including any policy, law, rule, regulation, any other executive decision; practice, custom, tradition, usage; condition or situation which, in law or in fact, directly or indirectly, expressly or by effect, immediately or over a period of time, distinguishes, excludes or prefers any person or group of persons, to:

(i) impose burdens, obligations, liabilities, disabilities or disadvantages on; or

(ii) deny or withhold benefits, opportunities or advantages, from; or

(iii) compel or force the adoption of a particular course of action, by, such person or group of persons, based on one or more of the prohibited grounds of discrimination.

(2) Notwithstanding the above, with a view to ensuring full equality in practice, Governments shall proactively adopt specific measures by way of affirmative action for the protection, benefit or advancement of vulnerable and marginalised individuals and groups, to eliminate the existing discrimination and promote equality of opportunities with regard to any aspect of health

rights mentioned herein, and such affirmative action shall not be construed as discrimination.

38. Right to dignity

Every person has a right to privacy, the right to be treated with dignity and to be free from any inhuman, cruel or degrading treatment, at the hands of Government or any other person or body of persons, whether public or private, in the matter of health rights; especially in the matter of health care this shall mean that every person seeking any health care is entitled to be treated by health care providers with patience, empathy, respect, tolerance for that person's culture and values, and humanness; further, this shall mean that no one shall be subjected to any coercive health measures or subjected to indiscriminate denials.

39. Right of participation, information

Every person has a right to participate in all health-related decision-making and actions at all levels, including at the community level, which shall include right to information about all the health related measures being initiated by the Governments, including information on Health Impact Assessments (HIAs), resource allocation and all health information collected by the Governments,

and information that can enhance health seeking and healthy lifestyles.

40. Right to justice

Every person whose right to health is actually or perceived to be violated in any manner, at the hands of anyone, has a right to seek redressal of his/ her grievance through a choice of appropriate dispute resolution and grievance redressal mechanisms, including those especially set up under this Act, against such violation, and for claiming his rights, and/or reparation.

PART – IV

PUBLIC HEALTH CARE SERVICES

CHAPTER – I

Health Care System

41. Structure of Healthcare System

(1) The envisaged Health Care Services under this Act, Rules shall be rendered by every Health Care establishment.

(2) The State Government shall notify form time to time the Jurisdiction and the nature and the extent of Health Care Services to be offered by every Public Health Care establishment located in rural

and urban areas. While doing so, the State Government shall consider the inputs rendered by State and District Public Health Authority and the concerned Local Authority.

42. Certificate of Need

(1) The State Public Health Board shall formulate operational norms and standards for numerical requirement of public and private health care establishments for each population unit. The population unit for general health care services shall be the block in rural areas and a cluster of 50,000 population in urban areas. There shall be separately designated norms for rural and urban population units. These norms and standards shall specify for a population unit at least the following regarding general health care services:

(a) Optimal and maximum number of general medical, surgical and maternity beds;

(b) Optimal and maximum number of general laboratories;

(c) Optimal and maximum number of general imaging units (ultrasound, X-ray).

(2) The State Public Health Board shall formulate requirement norms for specialist health care services. The population unit for specialist health care services shall be the District. Concerning larger cities with a population of more than 5 lakhs, separate norms shall be specified for population clusters of 5 lakh population each or fraction thereof. These norms and standards shall specify for a population unit, at least the following regarding specialist health care services:

(a) Optimal and maximum number of specialist health care institutions of major types;

(b) Optimal and maximum number of specialist laboratories;

(c) Optimal and maximum number of specialist imaging units (CT scan, MRI scan).

(3) A certificate of need for the health institution shall certify that the health care facility is in accordance with the required norms and standards.

(4) A person shall not:

(a) Establish, construct, modify or acquire a health establishment;

(b) Increase the number of beds in, or acquire prescribed health technology at, a health establishment;

(c) Provide prescribed health services; or

(d) Continue to operate a health establishment or after the expiration of 6 months from the date this Act took effect, without being in possession of a certificate of need.

Provided that these provisions shall not be applicable to health care establishments that are in existence at the time of the coming into force of the Act.

(5) A person who wishes to obtain or renew a certificate of need shall apply to the concerned Health Care Establishment (Registration & Regulation) Authority in the prescribed manner and shall pay the prescribed application fee, at the time of first registration or certification as the case may be and there-in-after at the prescribed intervals.

(6) Before the Health Care Establishment (Registration & Regulation) Authority issues or renews a certificate of need, he or she shall take into account:

(a) The need to ensure consistency of health services development in terms of national, provincial and municipal planning;

(b) The need to promote an equitable distribution and rationalization of health services and health care resources, and the need to correct inequities based on racial, gender, economic and geographical factors;

(c) The need to promote an appropriate mix of public and private health services;

(d) The demographics and epidemiological characteristics of the population to be served;

(e) The potential advantages and disadvantages for existing public and private health services and for any affected communities;

(f) The need to protect or advance persons or categories of persons within the emerging small, medium and micro-enterprise sector;

(g) The potential benefits of research and development with respect to the improvement of health service delivery;

(h) The need to ensure that ownership of facilities does not create perverse incentives for health service providers and health workers;

(i) If applicable, the quality of health services rendered by the applicant in the past;

(j) The probability of the financial sustainability of the health establishment;

(k) The need to ensure the availability and appropriate utilization of human resources and health technology;

(l) Whether the private health establishment is for profit or not;

The concerned Health Care Establishment (Registration & Regulation) Authority shall, for the purpose of issuing of certificates of need act under advice from the District public health board.

(7) The concerned Health Care Establishment (Registration & Regulation) Authority may investigate any issue relating to an application for the issue or renewal of a certificate of need and may call for such further information as may be necessary in order to make a decision upon a particular application.

(8) The concerned Health Care Establishment (Registration & Regulation) Authority shall issue or renew a certificate of need subject to—

(a) Compliance by the holder with specified norms and standards for health establishments and health agencies, as the case may be; and

(b) Any condition regarding—

(i) The nature, type or quantum of services to be provided by the health establishment;

(ii) Human resources and diagnostic and therapeutic equipment and the deployment of human resources or the use of such equipment;

(iii) Public private partnerships;

(iv) Types of training to be provided by the health establishment; and

(v) Any criterion contemplated in subsection (1) (of this clause).

(9) The concerned Health Care Establishment (Registration & Regulation) Authority shall withdraw a certificate of need

(a) On the recommendation of the State Public Health Board

(b) if the continued operation of the health establishment, as the case may be, or the

activities of a health care provider or health worker working within the health establishment, constitute a serious risk to public health;

(c) if the health establishment, as the case may be, or a health care provider or health worker working within the health care establishment, is unable or unwilling to comply with minimum operational norms and standards necessary for the health and safety of users; or

(d) if the health care establishment, as the case may be, or a health care provider or health worker working within the health establishment, persistently violates the constitutional rights of users or obstructs the State in fulfilling its obligations to progressively realize the constitutional right of access to health services.

(10) If the concerned Health Care Establishment (Registration & Regulation) Authority refuses an application for a certificate of need or withdraws a certificate of need the Local Supervisory Authority shall within a reasonable time give the applicant or holder, as the case may be, written reasons for such refusal or withdrawal.

(11) A certificate of need is valid for a prescribed period, but such prescribed period shall not exceed 20 years.

(12) Any person aggrieved by an order refusing an application or withdrawing a certificate of need may, within 30 days after the date on which the copy of the order was sent to him/her, appeal to the (State/ District) Public Health Board.

Provided that no such order of refusal of application or withdrawal of certificate of need shall come into force until after the expiration of 30 days from the date on which it was made or, where notice of appeal is given against it, until the appeal has been decided or withdrawn.

43. Public – Private Partnership

(1) The Public Health system may enter into partnerships with non-governmental health care providers, including private health care establishments, subject to the provisions of this Act. Any such public private partnership entered into shall not be for more than a five-year term, and shall be subject to annual evaluations.

(2) The State Public Health Board shall develop norms for regulating public-private partnership with the overall objective of strengthening the Public health

system and harnessing private medical resources for public health goals.

(3) All such partnerships shall be accompanied by effective quality regulation based on the standards laid down under Section 133 of this Act. All non-governmental agencies participating in partnerships shall be required to operationalise the Internal Redressal mechanisms and submit reports to the Monitoring committee as envisaged in the Rules and shall be subject to the monitoring mechanisms as prescribed.

(4) In any such partnerships, there shall be no payment made by any persons with limited paying capacity at the point of service. Any payment charged from any other user or any charge recovered at a later stage, shall be made below or at a prescribed maximum cost. Any health care providers found to be charging beyond the norms for such services shall be debarred from further partnership and shall be deemed to have committed a punishable offence under the Act.

(5) Preferably, there shall be no contracting out of the management of Public health facilities at any level. Any contracting out shall be based on permission from the State Public Health Board, based on provision of satisfactory reasons for such an

exceptional measure, by the relevant Public health authority under whose jurisdiction such a partnership is proposed. This contracting out would be for a maximum period of five years with annual revisions, based on strict conditions of partnership. A violation of any term of the contract shall result in the termination of such partnership. Contracting in of medical staff by public health facilities shall be permitted where requisite staff is not available, with the intention of strengthening the public health facility.

Explanation: Contracting in shall mean when the public health system either uses the facilities or avails the services of the staff belonging to private system on payment.

Contracting out shall mean the handing over or outsourcing full or part of services, management to private parties. Contracting in implies greater control with public system. Contracting out means reduction of such control.

(6) In all blocks / wards where such partnerships are entered into, the utilization of PHCs / CHCs providing similar services shall be reviewed by the concerned Monitoring committee on an annual basis. In a case where the utilization of defined services from the public health facility has declined

by more than 10 % in any year, an official enquiry shall be conducted into the causes of the same and depending on the results of the enquiry; no further partnerships shall be approved in such a block / ward in the subsequent year.

(7) Transfer of any assets from public to private ownership may be done only after being authorized by the State Public Health Board, which may be given only after scrutiny based on the norms laid down under sub-section(6).

(8) There shall be an annual review of every public-private partnership, on the basis of which it shall be allowed to continue.

(9) During selection of providers for partnership, preference shall be given to not-for profit / voluntary sector providers over for-profit providers.

(10) All private providers involved in such partnerships shall provide relevant minimum wages and social security to their employees. In case any complaint of inadequate payment of wages or social security is received, an enquiry shall be conducted into such complaint by the local supervisory authority. If such a complaint is proved during the enquiry, such provider would be debarred from further partnership.

(11) No Government doctors and staff shall be engaged in any form including as consultants, in non-governmental for profit health care facilities involved in a Public Private Partnership. All non-Governmental for profit health care facilities where government doctors or staff are engaged in any form including as consultants shall be debarred from partnership with the public health system.

44. Participation in National and State Health Programmes

(1) Every private health care establishment registered under this Act shall participate in the National Health Programmes, follow national guidelines for national health programmes, notify diseases and perform statutory functions for detection and prevention of communicable diseases and occupational health problems.

(2) All medical personnel in private health care establishment shall be aware of the various notifiable diseases mentioned under this Act, including infectious and communicable diseases, and the national programmes for control of diseases. They shall integrate their efforts with the official programmes/ activities for the same. During outbreaks, epidemics and disasters they shall

extend full cooperation and work in partnership with the government machinery.

(3) Every private health care establishment shall maintain records of all cases of notifiable diseases and concerned authorities shall be intimated in accordance to current law or specifications given by the government from time to time.

(4) Every private health care establishment shall perform statutory duties in respect of communicable diseases to prevent the spread of the disease to other persons, and report the same to the concerned public health authorities immediately.

CHAPTER - II

APPLICABILITY

45. Applicability of Part IV

This part shall be applicable to all types of Health Care Services provided by any Health Care establishment.

CHAPTER - III

REGISTRATION AND COMPLIANCE CONDITIONS OF HEALTHCARE ESTABLISHMENTS

46. Registration

(1) No Healthcare Establishment shall commence any activity relating to any kind of Healthcare Services either for promotive, preventive, curative or rehabilitative purposes after the commencement of this Act, unless such Healthcare Establishment is duly registered under this Act.

Provided that every Healthcare Establishment engaged either partly or exclusively in any activity relating to the rendering of the aforementioned healthcare services immediately before the commencement of this Act, shall apply for registration within 60 days from the date of such commencement.

Provided further that every Healthcare Establishment engaged in any activity aforementioned shall seize to be engaged in any such activity on the expiry of 3 months from the date of commencement of this Act unless such Healthcare Establishment has applied for registration and is so registered or such application is disposed of, whichever is earlier.

(2) Every application for registration under sub-section (1) shall be made to the Healthcare Establishment Registration Authority in such form and in such manner and shall accompany by such fees as may be prescribed in the Regulation.

(3) No Healthcare Establishment shall be registered under this Act unless the concerned Healthcare Establishment (Registration & Regulation) Authority has specified that such Healthcare Establishment is in a position to render the envisaged Healthcare services and facilities possessed such as skilled manpower and equipments and maintain such standards as may be prescribed.

(4) For the purposes of this part, Healthcare Establishment means the whole or part of a public or private institution, whether for profit or not; where inpatient or outpatient treatment; diagnostic or therapeutic interventions; nursing, rehabilitative, palliative, convalescent, preventive or other health care services or any of them are provided. Healthcare establishment includes clinical establishment meaning any premises used for person suffering from any sickness, injury or infirmity and shall include hospital and maternity homes.

47. Standards and quality of Care

(1) Every Healthcare Establishment shall adhere to the following minimum standards:

a. Functional Programme for the establishment that shall consist of a prescribed set of services that are to be made available through the functional programmes of the health care establishment in accordance to the nature, specialty and size of the establishment, and shall include a prescribed set of emergency and lifesaving drugs. The list of services and the respective charges shall be displayed in local language in a prominent place in the health care establishment or made readily available in the form of a booklet in local language.

b. Minimum physical and process standards that shall be in accordance to nature, size and specialty of the establishment. Physical standards shall include prescribed minimum floor space per bed in the health care establishment, space for operation theatre, sterilization, space for out patient care, emergency care/ casualty room, treatment and dressing room, minimum size and number of toilets, space for medical records and storage facilities, entrance zone, diagnostic zone, service zone and infrastructure for adequate safety of patients. Process standards shall include prescribed clinical

standards, managerial standards and such other standards as are deemed essential to running the health establishment.

c. Maintenance and preservation of Medical Records as prescribed by the rules and shall include preservation of medical records such as out-patient case paper, in-patient case records, investigation records, discharge papers and follow up records. Such records shall contain relevant personal details, medical history, history of the illness (es), diagnosis and status of health, investigation findings, treatment prescribed and follow up, and specifications for duration of storage of records. All records shall be made in duplicate and a copy of all such records shall be given to the patient.

d. Recording and preserving vital records, as prescribed by the rules and shall include the records of births, deaths, miscarriages, abortions, still births, ultrasonography conducted, record of children born and removed to the custody or care of a guardian or relative or orphanage or alternative arrangement, record of people with disability, any notifiable diseases encountered to be reported.

e. Minimum essential equipments, as prescribed by the rules that are required to run the establishment, and shall include equipment for adequate safety and quality of care for patients.

f. Human Resources, that shall include a prescribed number and qualifications of medical, nursing, para-medical and administrative staff required in the private health care establishment, in proportion to the number of beds available in the facility. With regard to the employment of nurses, two categories of nurses shall be recognized, Qualified Nurses and Trained Nurses, as defined by the Act.

g. Special provisions prescribed for certain categories of health care establishments including Radiotherapy, Nuclear Medicine Centre and Ultrasound Clinics.

h. Safety, protection and healthy working conditions of hospital staff, as prescribed by the Rules and shall include provision of adequate vaccination and other equipment to hospital by management, for protection of self from infections and other health hazards.

i. Adhere to National Guidelines on Hospital Waste Management based on the Bio-Medical Waste (Management & Handling) Rules, 1998 rules

Provided that separate standards may be prescribed for rural and urban areas, for different bed-wise sizes of hospitals and according to different specialties of care available therein. Towards this purpose, the standards may be classified into Core and Critical. Critical standards in any given circumstances, warrant 100% compliance. However, the Core standards warrant a minimum of 80% compliance.

48. Right to Healthcare Services

(1) Every person shall have the right of equal access to all guaranteed Healthcare Services and Essential drugs as envisaged in Schedule II and III respectively, free of cost.

Provided that registration fees not more than Rs. five (which may be reviewed by the State Health Department from time to time) may be charged at only one point for services referred to under sub-section (1), for persons other than persons with limited paying capacity.

(2) In addition to guaranteed services all other services shall be available free of cost to persons with limited paying capacity.

(3) In the case of the user being referred to a higher level of health care establishment, by any public health care establishment, the person in charge of the referring health facility shall provide the user with a referral slip stating the reasons for not admitting or treating the user, and the health care establishment to which such reference has been made.

(4) In the case of emergency and critical patients, transport shall be arranged for by the referring Health Care Establishment.

(5) All referrals shall be treated with priority, and all establishments to which cases have been referred shall send a report on the patient referred to the referring Health Care Establishment.

CHAPTER – IV

RIGHTS AND DUTIES OF HEALTHCARE CONSUMERS

49. Choice of System of Medicine

(1) All users shall have the right to be administered treatment or facilities according to the system of

medicine chosen by them, subject to the availability of such treatment in a particular health care establishment. In case of the chosen system of medicine not being available in the establishment that is approached, the user shall be referred to the nearest available establishment that provides such services.

(2) Systems of medicine as contemplated in sub-section (1) includes Allopathy, Ayurveda, Homeopathy, Unani and any other recognized Indian System of Medicine and proven local health traditions being provided in Gujarat.

50. Rights and duties of Patients

(1) **Survival, integrity and security:** Every person has the right to survival, physical and mental integrity and security of his or her person, such that he/ she shall be entitled to safe and sensitive health care, in accordance with the standards/ protocols prescribed hereunder; and shall be entitled to not be subjected to any service, testing, treatment, procedure or medical intervention or research which endangers or violates such survival, integrity and security in any manner; the right to be free from harm caused by the poor functioning of health services, medical malpractices or negligence; and

the right to a clean and healthy environment in the hospital, with least risk of hospitalrelated infections.

(2) **Right to seek:** Every person has the right to approach and seek health care facilities, goods, services, programmes and conditions, equitably, without discrimination;

(3) **Right to receive:** Every user has the right to receive, use and enjoy, and right not to be denied, health care appropriate to that person's health needs;

(4) **Right to emergency treatment and care:** No person shall be denied, under any circumstance, including inability to pay the requisite fee or charges, prompt and necessary emergency medical treatment and critical care, including emergency obstetric treatment and care, by any health care provider, establishment or facility, including private provider, establishment or facility, that is qualified/ certified to provide such care or treatment;

Further, in a case of medico-legal nature (MLC), no health care provider or health care establishment shall delay treatment merely on the grounds of receiving police clearance or a police report.

Explanation: A medico-legal case means any medical case which has legal implications, either of a civil or criminal nature, and includes but is not limited to cases relating to accidents, assault, sexual assault, suicide, attempt to murder, poisoning, injuries on account of domestic violence, injuries on workers during course of employment, in some of which the service provider may be required to prepare documents in compliance with demands by authorized police-officer or magistrate.

(5) **Right to reproductive and sexual health care:**

(a) With regard to reproductive health services, every adolescent girl and adult woman has the following rights:

(i) right to comprehensive obstetric health care & services with continuum of care, including ante natal care and post natal care;

(ii) right to safe abortion/ termination of pregnancy;

(iii) right to equality of opportunities in all health matters; and

(iv) right against discrimination in all health matters including less favourable treatment of women for reasons of pregnancy and maternity;

(b) In addition to the above, all adolescents and adults, both male and female, shall have the following rights:

(i) right to reproductive and sexual self-determination and autonomy and right against all coercive measures in population and family planning; this right would include choice of safe and effective methods of contraception, including emergency contraception and safe, voluntary sterilization; and the right to safe and effective methods of assisted reproductive technologies (ARTs);

(ii) right to appropriate counseling and treatment for all sexual and reproductive health related morbidities, including management of sexually transmitted infections (STIs)/ reproductive tract infections (RTIs).

(6) **Right to quality of care**: Every user has the right to a quality of care in compliance with standards and protocols prescribed under this Act;

(7) **Right to rational health care**: Every user has the right to receive rational health care and to not be subjected to irrational health care or over-medicalisation;

(8) **Right to choice**: Every user has the right to choose and change his/her health care provider and health

care establishment, and/ or any recognized system of medicine, including Allopathy, Ayurveda, Homeopathy, Unani, Siddha and any other recognized Indian System of Medicine (ISM) and local health traditions, provided that it is available in and compatible with the functioning and competence of the particular health care establishment; and this right shall include the right to refuse to be subjected to any system of medicine or particular medical procedures or medication prescribed thereunder by the health care provider.

(9) **Right to be treated by a named health care provider:** Every user has the right to know the name of the person who is providing health care to him/ her and therefore must be attended to by clearly identified health care provider/s.

(10) **Referral rights:** Users who must be referred to another health care establishment or facility, for medical reasons, are entitled to a full explanation by referring establishment or facility before they can be transferred to another health care establishment or facility, and in any case transfer of that user can only take place after another health care establishment has been requested by the referring establishment or facility and has agreed to accept that user; and further, only if and when

there is available and accessible referral transport service;

(11) **Right to continuity of care:** Every user has the right to continuity of care, through close and continuous cooperation between all the health care providers and/or establishments that might be involved in his/ her diagnosis, treatment and care;

(12) **Right to fair selection:** In circumstances where a choice must be made by health care providers between potential users for a particular treatment which is in limited supply, all such users are entitled to a fair selection procedure for that treatment, based on medical criteria and made without discrimination;

(13) **Right to benefits of scientific progress and technology assessment:** Every user is entitled to benefits of scientific and technological progress and advancement in relation to health care.

Provided that any new health technology with potential to be used towards health care shall not be brought into use before being subjected to a due Health Impact Assessment (HIA) for its stated benefits and its possible ill effects, and the results of such HIA shall be made available and accessible to public;

(14) **Right to terminal care:** Every user has the right to humane terminal care and to die in dignity.

(15) Right to information:

a) Every user has the right to information about health care facilities, goods, services, programmes, conditions and technologies, how best to access, use and enjoy them, and such information must be made available to the public by the Government in the most effective manner, in order to benefit all those concerned;

b) Every user has the right to be fully informed about his/ her health status, including the medical facts about his/ her health condition; proposed health care, together with the potential risks and benefits, costs and consequences generally associated with each option of health care; alternatives to the proposed health care, including the implications, risks and effects of refusal of health care; and the diagnosis, prognosis and progress of health care; and any other information that may be pertinent to the user in taking a decision, providing consent or to understand his/ her current and possible future health status.

Provided that any of such information may be withheld from the user but only exceptionally when there is good reason to believe that this information would without any expectation of obvious positive effects cause him/ her serious harm;

c) Every user has the right that the information be communicated to him/ her in a way appropriate to the latter's capacity for understanding, with minimum use of unfamiliar or complicated technical terminology, and where the user does not speak the common language, some effective method of language interpreting should be available;

d) Every user has the right to choose who, if anyone else, should be informed on their behalf.

e) Every user has a right to obtain a second opinion from another health service provider.

f) When admitted to a health care establishment, users have a right to be informed of the identity and professional status of the health care providers providing them services and of any rules and routines of the establishment which would bear on their stay and care.

(16) **Right to medical records and data:**

(a) Every user has a right that complete medical records pertaining to his/ her case, containing the health status, diagnosis, prognosis, all the details of the health care provided including the line of treatment, be maintained by the service provider and be kept in protected conditions till 2 years of the last date of service/s provided, and any disclosure of the records or information contained in them to anyone else shall be subject to his/ her rights to confidentiality, privacy and disclosure as elaborated herein under sub-section (18);

(b) Every user has the right of access to his/ her medical files and technical records and to any other files and records pertaining to his/ her diagnosis, treatment and care (including X-ray, laboratory reports and other investigation reports) and to receive a copy of his/ her own files and records or parts thereof; and

(c) Every user has a right to request for and to be given a written summary of his/ her diagnosis, treatment and care and in case of an inpatient, the complete discharge report at the time of discharge, which must also

include the advised follow-up actions to be taken by the user.

(17) **Right to autonomy/ self determination and prior voluntary informed consent:**

(a) Every user has a right to consent as a prerequisite for any health care proposed for him/ her, such consent being a prior and fully informed consent formed without the exercise of any influence, duress, coercion or persuasion by the service provider proposing it;

(b) Every user has a right that the service provider empowers and facilitates the exercise of his/ her right to consent in the above manner;

(c) Every user has the right to refuse or to halt a medical intervention and on his/ her exercising such right, the implications of refusing or halting such an intervention must be carefully explained by the service provider to the user, provided that the refusal or halting comes to the knowledge of the provider;

(d) When a user is unable to express his or her consent due to medical reasons and a medical

intervention is urgently needed in the user's interest, the consent of the user may be presumed, unless it is clear from a previous declared expression of will within the knowledge of the provider that consent would be refused in the situation;

(e) Every user who lacks the full capacity to give consent, due to his/ her being a minor or due to any mental disability, temporary or permanent, shall, to the extent of incapacity, have the right to supported (or substituted, only where absolutely necessary) decision-making on his/ her behalf, through a *de jure* or *de facto* guardian, next friend or personal representative, whose bonafides and credentials are clear to the service provider;

Provided that the service provider shall personally assess in each case if a user lacks the full capacity to consent, by assessing his/ her evolving capacity and intellectual maturity in the case of a minor; and his/ her state of mind at the relevant time of decision-making in the case of person with mental disability, such that there is no *per se* loss or denial of right to self-determination and voluntary informed consent in all cases of minors and persons with mental disabilities;

Provided further that when a person lacks full legal capacity to consent, and it is not possible to get substituted/ supported consent in time, or the person who can give such consent on behalf of the user unreasonably withholds such support or consent, but the proposed intervention is urgently needed, the service provider may proceed without any consent, to the best of his professional competence and judgment, if he/ she is of the opinion that the intervention is in the interest of the user; alternatively, in cases where there is no urgency, the service provider shall refer the matter to the head of the institution who shall take the decision in consultation with the service provider or through another mechanism that may be duly established at the institutional level for such purposes;

Provided further that even where he/ she lacks full capacity to consent, the user (whether minor or adult) has a right to be involved by the service provider in the decision-making process to the fullest extent and in proportion to which their capacity allows;

(f) Every user also has similar right to consent for the preservation and use of all substances of his/ her body (though consent may be presumed when the substances are to be used in the current course of diagnosis, treatment and care of that user); and for participation

in clinical or scientific teaching and/ or research;

Provided that as an exception to the requirement of involvement being in the interest of the user, an incapacitated person may be involved in observational research which is not of direct benefit to his or her health, provided that person offers no objection, that the risk for burden is minimal, that the research is of significant value and that no alternative methods and other research subjects are available; and

(g) In any case, no user shall be provided any health care for experimental or bio-medical or clinical research purposes, except according to guidelines laid down by the Indian Council for Medical Research (ICMR) and unless:

(i) It is in association with a health establishment that has been registered with the State Health Board as required therein;

(ii) The Institutional Ethics Committee as laid down by the prescribed guidelines, has given prior written authorization for the commencement and continuation of such health care; and

(iii) The user has been given prior information in the prescribed manner that the health care is for experimental or research purposes or part of an experimental or research project, and he/ she has given informed consent as per the requirements of relevant earlier provisions herein.

18) **Right to confidentiality, information disclosure, privacy:**

a) Every user has the right that all information about his/ her health status, medical condition, diagnosis, prognosis and health care and all other information of a personal kind (identified or identifiable to him/ her), must be kept confidential, even after his/ her death, and such confidential information can only be disclosed if the user gives explicit consent or any law expressly provides for this; it may be used for study, teaching or research only with the authorization of the user, the head of the health care establishment concerned and the Institutional Ethics Committee of the establishment.

Provided that consent may be presumed where disclosure is to other health care providers involved in that user's treatment;

b) Every user has the right that all the identifiable user data must be totally protected, and appropriately stored for protection of the user's confidentiality, including the human substances from which identifiable data can be derived;

c) Every user has a right to privacy such that there can be no information disclosure resulting in or amounting to violation of or intrusion into the user's private or family life, unless and only if it can be justified as necessary to the user's health care, when the user's consent must be taken as per the earlier relevant provisions for consent herein;

d) Every user has a right that he/ she may be subjected to any health care in a manner that proper respect is shown for his/ her privacy and dignity, and that a particular health care intervention may be carried out only in the presence of those persons who are necessary for the intervention, unless the user consents or requests otherwise; and for women users they may be carried out only if a female service provider is also present, unless the user herself waives this right or unless it is not feasible at all in given circumstances;

e) Users admitted to health care establishments have the right to expect physical facilities which ensure privacy and dignity, particularly when health care providers are offering them health care or carrying out examinations of personal nature.

19) Rights towards the application of users' rights:

a) In the exercise of all the above rights, users shall be subjected, where necessary, only to limitations and least restrictive alternatives that are compatible with human rights instruments and in accordance with procedures prescribed by law;

b) The users shall also be protected by adequate due process in all other respects as required by this Act or other applicable State laws;

c) Users must have access to such notice of rights, information and advice as will enable them to exercise the rights set forth in this document;

d) Appropriate, adequate and comprehensive information on the available health care services, written in a manner understandable by a non-technical person and in local language, shall be displayed in a prominent

place in the health care establishment or facility, which shall in any case include all the information required to be disseminated under this Act;

e) Users have a collective right to representation and participation within health care institutions at each level of health care in matters pertaining to the planning and evaluation of health care services, including the range, quality and functioning of the services;

f) Where users feel that their rights have not been respected they should be enabled to lodge a complaint and have it investigated, mediated or adjudicated upon, which must entail, in addition to recourse to courts or any quasi judicial mechanism that is available, independent mechanisms at institutional level within the health care establishment where he/ she sought or received health care.

Explanation 1: An application for grievance against a private healthcare establishment may be made for a grievance regarding the violation of any rights specified in Pat IV of the Act.

Explanation 2: An application for grievance against a public health care establishment may be made for a grievance regarding:

(a) Non-provision of guaranteed services

(b) Defective or sub-standard quality of guaranteed services

(c) Costs and financial loss incurred due to non-provision of service from Public health care establishment, leading to availing of private medical services under compulsion

(d) Costs and financial loss incurred due to medicines or supplies being prescribed by the public health care provider, to be purchased from outside the public health care establishment

(e) Grievances regarding inadequate personnel, infrastructure or supplies experienced related to provision of care

(f) Grievances regarding any malpractice, including extortion of money in excess of standard charges

(g) Grievances regarding any sexual harassment of the user by health care providers and staff of heath care establishment

(h) Violation of any rights specified this Act

(i) Negligence, with relation to provision of services

(l) Access to Health Records

(i) The user shall have complete access to all of his health records, and shall have the right to be provided with a report of the diagnosis, the medical treatment, and state of his/her medical condition and investigation reports (including X-ray and lab reports).

(ii) A health care provider may examine a user's health records for the purposes of-

a. treatment with the authorization of the user; and

b. study, teaching or research with the authorization of the user, the head of the health care establishment concerned and the Institutional Ethics Committee established under Section 64

20) Duties of users: Every user has the following duties:

(i) To provide health care providers with the relevant and accurate information for health care, subject to the user's right to confidentiality and privacy;

(ii) To comply with the prescribed health care, subject to the same having been administered after duly observing the user's rights as enumerated above;

(iii) To take care of health records in his or her possession;

(iv) To respect the rights of health care providers by treating them with respect, courtesy, and dignity and refrain from any abuse or violent or otherwise abusive behaviour towards them or the rights provided to them; to similarly respect rights of other users;

(v) To utilize the health care system properly by following all the rules of the relevant establishment or facility, that are brought to the user's knowledge, in all other respects and not indulge in any other abuse or obstructionist action;

(vi) To not lure any care provider or staff in the health care establishment or facility with favours in terms of cash or kind for any personal gains or illegal purpose;

(vii) To sign a discharge certificate or release of liability if he or she refuses to accept recommended treatment; and

(viii) To recognize his/her role not merely as an end-user but as a proactive stakeholder and facilitator of the health care services provided to him/ her.

CHAPTER - V

RIGHTS AND DUTIES OF HEALTHCARE PROVIDERS AND ESTABLISHMENTS

51. Rights and duties of healthcare providers

(1) Every Healthcare Provider in any Healthcare Establishment shall be ensured with the following rights pertaining to –

(a) No health care establishment shall discriminate against a health care provider in matters concerning employment and conditions of employment on age, sex, economic status, place of residence, religion, caste, physical or mental ability, mental health status or HIV/AIDS status.

Provided that, subject to any applicable law, the head of the concerned health facility may in accordance with any determined guidelines, impose conditions on the service that may be rendered by a health care provider on the basis of his or her health status

(2) Every health care establishment shall provide measures to–

(a) Prevent injury or damage to the person or property of health care providers during the course of his employment; and

(b) Prevent disease transmission including protection from HIV-AIDS, Hepatitis-B and other communicable diseases

(c) Ensure the personal safety of health care providers.

(3) A health care provider shall not be forced by the State or any private party to reveal private confidential information or perform any act that is against medical ethics. All information on the health of a user shall be deemed to be confidential, unless required to

be disclosed in public interest or public health.

(4) A health care provider, in consultation with the head of the health care establishment, may refuse to treat a user who is physically or verbally, abusive, who sexually harasses him/her, or who acts contrary to 64 of this Act.

(5) Every Healthcare Service Provider shall respect and adequately respond to the patients or Healthcare Consumers' rights as detailed above.

(6) Responsibility of specific health care providers shall be defined based on health department manuals, government resolutions/orders, guidelines, policy papers, directives and other official documents.

(Annexures specifying the responsibility of specific health care providers may be placed)

52. Duties of Healthcare Establishments

Display of Information in the Health Care Centre:

(1) Appropriate, adequate and comprehensive information written in a manner and language

understood by a non technical person of the concerned area on the health care services shall be displayed in a prominent place in the health care centre.

(2) Information mentioned in subsection (1) shall include information on —

(a) Types and availability of health care services, and

(b) Schedules and timetables of visits of specialist staff, if any, and

(c) Schedule of rates for major categories of services, including

(i) outpatient consultation charges,

(ii) inpatient bed charges (which includes all charges, except charges for consultants and specialist medical procedures)

(d) Details of the drugs available free of cost/at subsidized rates in the health center

(e) Preparations and details of all formulations available in the inventory of the hospital.

(f) Charter of users rights and responsibilities,

(g) Full contact details of the vigilance committee, internal redressal mechanism, hospital user welfare committee, hospital administration with clear mention of the time of availability of the same.

(h) Procedures for making an application for a grievance, and

(i) Any other aspects of health care services, which may be of use to the public.

(3) Appropriate, adequate and comprehensive information about the available health care services shall be displayed in a comprehensive manner in Gujarati at a prominent place

(a) In the health care centre, and

(b) In the Village Gram Panchayat, Anganwadi and the Village School

(4) Information mentioned in subsection (1) shall include information on —

(a) The types of health care services available including guaranteed health care services;

(b) Schedules and timetables of visits of specialist staff, if any;

(c) Charter of users rights and responsibilities;

(d) Procedures for making an application for a grievance, within the institution, to the monitoring committee as well as the district tribunal level;

b. Any other aspects of health care services which may be of use to the public;

(5) As part of community based activities, it shall be the function of the concerned field based functionary to provide to the community on a regular basis, information on healthy living conditions, health care services available and community health requirements.

(6) The person in charge of a health care establishment shall ensure that a health record containing such information as may be prescribed is created and maintained at that health care establishment for every user of health care services.

(7) Such information shall include information on

(a) Services provided by the health care center,

(b) Complaints received under this Act- state of complaint, and orders given

(c) The number of patients reimbursed from the private sector

53. Universal Safety Precaution

(1) Every health care establishment shall provide free of cost, universal precautions to all persons working or present in such institution who may be occupationally exposed to HIV, including employees, interns, attendants and contract workers, and appropriate training for the use of such universal precautions.

(2) Every healthcare provider and every other person who may be occupationally exposed to or may occupationally transmit HIV shall use Universal Precautions as prescribed in the course of their work.

Explanation: Universal precautions shall mean infection control measures that prevent exposure to or reduce the risk of transmission of pathogenic agents including HIV and includes education, training, personal protective equipment such as gloves, gowns and masks, hand washing, and employing safe work practices

54. Internal redressal mechanism

(1) All Public Health Care establishments and all private health care establishments with more than 10 beds, both in the rural and urban areas shall have an internal redressal mechanism as provided below.

(2) A specific member of the staff at each level of health care establishment shall be appointed as person in charge of internal redressal for the purpose of receiving applications for grievances from any aggrieved person.

(3) On the receipt of an application for grievance, the persons in charge of internal redressal shall

(a) Provide the aggrieved person with a written response for his / her application, along with the action taken/proposed to be taken, and an application number which may be used as reference by the applicant.

(b) Contact the concerned health service provider and remedy the situation, when possible; and

(c) Provide to the aggrieved person, printed information in Gujarati and Hindi on all the remedies available to him / her, including the right to file an application for a grievance at the district tribunal.

(4) The person in charge of internal redressal shall submit extracts from the register of grievance on grievances made, action taken or not taken, to the respective monitoring committee at the end of each month.

(5) The Ward /Health Officer shall obtain report of grievances and submit them to the Monitoring Committee at the appropriate level.

CHAPTER – VI

SPECIAL HEALTHCARE NEEDS OF THE IDENTIFIED GROUPS

55. SPECIAL PROVISIONS RELATING TO HEALTHCARE NEEDS

(1) The State Government shall ensure special provisions in the case of the following groups:

(a) Reproductive and Sexual Health of Women and Girls

(b) Aggrieved persons in cases of Domestic Violence

(c) Compliance of sexual assault

(d) People living with HIV/AIDS

(e) Mentally ill persons

(f) Persons from Tribal Region

(g) Internally displaced persons

(h) Elderly persons

(i) Persons living with disability

(j) Migrants

(k) Workers

(l) Sex workers

In this specific regard, the State Government may by a notification in the official Gazette, make relevant rules and regulations.

PART V

56. **Disputes Resolution through Public Dialogues and Public Hearings** ***(Swasthya Jan Sunwais)***: The State shall facilitate forums for amicable and non-adversarial disputes resolution at community level by establishing

mechanism of public dialogues and public hearings on health *(Swasthya Jan Sunwais)* in the following manner:

a) The *Swasthya Jan Sunwais* shall be conducted at primary health centre (PHC), block and district levels twice in a year, and once a year at State and national level as events open to all citizens, which would enable the general public and various groups and organizations to give free and independent feedback about health care services;

b) The *Jan Sunwais* shall be announced with at least one month's public notice, with PRIs and community based organizations being entrusted with the task of publicizing them, preferably preceded by group interviews in some of the concerned villages / PHCs, where both positive incidents and possible negative events should be documented.

c) The panel for these *Jan Sunwais* shall include, appropriate level PRIs and nominated civil society representatives (from community organizations, people's organizations, or NGOs involved in monitoring of health services) while the Respondents would be the appropriate level Government health officials whose presence would be mandated as essential and representatives of private health care establishments and providers

who volunteer to present themselves to the people's scrutiny and verdict.

57. **Issues before *Swasthya Jan Sunwais*:** The *Swasthya Jan Sunwais* would be the appropriate forums to raise the following, amongst other, kinds of issues through voluntary testimonies presented by individuals or groups:

(i) People's perceptions, both positive and negative, about existing health care services and providers;

(ii) Specific experiences of denial of health services or violations of rights enumerated herein;

(iii) Status of access, availability, acceptability and quality of health care infrastructure and staff and services;

(iv) Specific problems faced by vulnerable and marginalized individuals and groups in accessing health services;

(v) Suggestions for improving service delivery, which will make services more accessible;

(vi) Involvement of community in their health care;

(vii) People's perceptions about behavior/attitude of health care providers and their availability in the health centers; and

(viii) Other concerns and health needs of the community.

Provided that advance copies of the testimonies would preferably but not essentially be served on the concerned

respondents to enable and facilitate prompt response by the *Jan Sunwai* Panel.

58. **Outcome and follow-up of *Swasthya Jan Sunwais*:** After hearing both sides, the *Swasthya Jan Sunwais* panels would record the issues and where possible immediately recommend actions regarding cases of denial of health care or violation of rights enumerated herein or suggest follow-up actions by the parties; similarly it would recognize service providers acknowledged for providing exemplary good services. All recommendations of the panels would be followed up for appropriate actions, including by entry in the formal service records and annual evaluation reports of the concerned service providers in Government health care establishments. The Government shall throughout ensure that the *Swasthya Jan Sunwais* are conducted peacefully and with the objective of amicably resolving issues in non-adversarial manner, without any intimidation of those presenting their testimonies and where needed providing them necessary protection; for this the Governments shall appropriately educate and sensitise people and service providers.

59. **Grievance redressal through In-house Complaints Forums at the institutional level:**

(1) Without prejudice to the above rights, and in addition to the above, every user who had accessed the services of health establishment/ institution with more than 10 employees (including contractual and part-time employees) shall in any case have the right to have his/ her complaints examined within such health establishment/ institution internally and to have it dealt with in a thorough, just, effective and prompt way by the establishment/ institution, and to be informed about their outcome.

(2) In case of Government owned or controlled health establishment, the authority under which the establishment functions, and in the case of private health establishment, the head of that establishment, shall:

(a) Set up an "In-House Complaints Forum" for this purpose within the health establishment, but with equal number of independent, outside members from civil society organizations, preferably users' rights groups or consumer groups, or eminent citizens, media persons, respected lawyers, of the area, and shall appoint a person of senior rank with full administrative powers, working full time in the institution, as the Complaints Officer;

Provided that where an institution carries on its activity in one or more places with 10 or more employees in any of such additional places, a separate Complaints Officer shall be appointed for each of such places.

(b) Establish a procedure for the lodging of complaints with the Forum and for its investigation, arbitration or adjudication, including a contact mechanism for emergencies;

(c) Include provisions for the acceptance and acknowledgment of every complaint directed to a health establishment, whether or not it falls within the jurisdiction or authority of that establishment;

(d) Display the names and contact details of Complaints Officer and members of the Forum and the procedure for a complaint resolution in a manner that is visible to any person entering the establishment and such information must be communicated to users on a regular basis;

(e) Where necessary, provide assistance, advice and advocacy on behalf of the user through a panel of independent persons established by the establishment, for consultation regarding the most appropriate course of action for the user to take;

(f) Allow for referral of any complaint that is not within the jurisdiction or authority of the health establishment, to the appropriate body or authority;

(g) The Complaints Officer may order *suo moto* inquiry into violations of the provisions of this Act by the institution or any person in the institution;

(h) The Forum shall act in an objective and independent manner when inquiring into complaints made under this Chapter;

(i) The Forum shall inquire into and decide a complaint promptly and in any case within seven working days.

Provided that in cases of emergency the Complaints Officer shall decide the complaint within one day.

(3) The Forum, if satisfied, that a violation of the Act has taken place as alleged in the complaint, shall:

a) direct the institution to take measures to rectify the breach or violation complained of; to take specific steps or special measures or both towards compliance with health rights; or to refrain from or discontinue certain action/s amounting to violation of health rights;

b) counsel the person alleged to have committed the act and require such person to undergo training and social service; and

c) upon subsequent violations, recommend to the institution to, and the institution shall, initiate disciplinary action against such person/s responsible for the violation.

(4) The Complaints Officer shall inform the complainant of the action taken in relation to the complaint and shall be responsible for ensuring that the complaints, their nature and number and the action taken are published on the institution's web site or web page where such a web site or web page exists and are reported to the concerned Government on a six-monthly basis.

Provided that the Complaints Officer and the other members of the Forum shall ensure the maintenance of confidentiality of complainants and parties to a complaint.

60. Cause of action for complaints related to health, before designated district courts:

A complaint may be made by any user (or in case of the user’s death, by user’s representative, or in case of systemic complaints or complaints of violation of any of the health rights of group or class of individuals by any

concerned organization with proven bona fide credentials, or the concerned monitoring committee of the district), as enumerated hereinabove, before a district court designated (hereafter referred to as court or designated court) by State Government to hear health related complaints for the district within whose jurisdiction the health care establishment/ provider is situated, or the cause of action, wholly or in part, arises, including:

(a) Denial or non-provision of guaranteed services by a public health care establishment;

(b) Denial of emergency treatment and/ or critical care by any health care establishment or provider, public or private, for or not for profit;

(c) Defective or sub-standard quality of care or guaranteed services by a public health care establishment;

(d) Inadequate personnel, infrastructure or supplies related to provision of care by a public health care establishment;

(e) Absenteeism of the health care related staff in any public health care establishment;

(f) Any medical malpractice, including extortion of money in excess of standard charges, for any health care service, or denial of service in contravention of regulatory mechanism for

ensuring access to health care, by any health care establishment or provider, public or private, for or not for profit;

(g) Costs and financial loss incurred due to non-provision or denial of any guaranteed service by public health care establishment, leading to availing of private medical services under compulsion;

(h) Costs and financial loss incurred due to medicines or supplies being prescribed by the public health care provider, to be purchased from outside the public health care establishment, where the drug is covered under service guarantee;

(i) Negligence, with relation to provision of services by any health care establishment or provider, public or private;

(j) Sexual harassment or any other kind of abuse of the user by health care providers and staff of heath care establishment, public or private;

(k) Non-compliance with or mis-performance of the obligations of the Governments or any of the authorities as enumerated under this Act;

(l) Any violation of any other rights of users on part of the Government/s, authorities or private sector health service providers.

Provided that except for (f), (g), (h) & (i) above, there shall be no requirement for proof of actual prejudice, damage or loss suffered by the complainant and notwithstanding the absence of such proof. There shall be strict liability on part of the alleged offender/s even if only the allegation/s of the act of commission or omission is/are proved in such cases, which shall be sufficient. However, in case actual prejudice, damage or loss is also proved, that shall be taken into account for the purposes of the reliefs granted or the quantum of relief.

61. Remedies:

(1) **Orders of designated district courts**: On being satisfied of the correctness of the complaint, the designated court shall issue any of the following orders to the State or the concerned health care establishment or provider:

a) To pay such amount as may be awarded by the court as compensation and damages to the user (or user's legal representatives in case of death of the user), for the violation of his/ her rights, including mental torture and emotional distress;

b) To pay such amount as may be awarded by the court as reimbursement to the user of a public health care establishment for having to use private services or for having to purchase medicine or supplies prescribed by the public health care provider, from outside the public health care facility or establishment;

Provided that in both the above, the alleged offenders may be held jointly and severally liable for any compensatory damages or other costs awarded;

Provided further that a portion of the compensation so awarded may be ordered to be recovered personally from the concerned health care personnel who was/ were responsible for the violation;

c) Order an inquiry to be carried out in respect of the concerned health care personnel or establishment or Government department or office, and/ or issue notice to the concerned statutory council with which they are registered for appropriate action under the respective statutes, and/or direct criminal action to be initiated by the police, which may be in addition to and notwithstanding initiation of any internal departmental inquiry;

d) Recommend appropriate disciplinary action to be taken against concerned head of

establishment or institution in cases where it is clearly proved that the denial of care was due to non-performance or mis-performance of duties on part of the establishment or institution;

e) Where complications or adverse consequences have been caused to a user due to mismanagement of a health condition, or medical negligence, direct the responsible establishment and/ or provider to take prompt and appropriate steps for its restoration/ correction, at no further cost to the user, including by referral where necessary;

f) Pass order/s directing the person who has committed the violation to undergo a fixed period of counselling related to the violation committed and a fixed period of social service;

g) Direct the Government or the health care establishment or provider to take specific steps or special measures or both to protect or fulfil any of the health rights; or to refrain from or discontinue any law/ policy/ action that may amount to violation of health rights;

h) Direct the Government or the health care establishment or provider to take steps to

ensure that the alleged or similar health right violation is not repeated in future;

i) Pass appropriate directions to the concerned health care establishment, with respect to grievances that are systemic and regular in nature;

j) Direct the concerned Government or establishment or institution to make regular reports to the designated court regarding implementation of the court's orders, especially those passed under (h), (i) & (j) above.

k) Pass any interim order or recommendation in nature similar to the above to protect the rights of the complainant during the pendency of the complaint and such that the complaint does not become infructuous;

l) Make such other recommendations as may be necessary for the better implementation of this Act in respect of the concerned health care establishment;

Provided that the designated court may, in cases of emergency, be available and accessible 24 hours and in the interest of justice, pass urgent orders without considering the representations of the parties to the complaints or without hearing them as the case may be, including directing admissions, operations, treatment or

any specific medical intervention, and the provision of universal precautions.

Provided that the designated court shall, as soon as may be, after the passing of such urgent orders in emergency, consider the representations of the parties or give them an opportunity to be heard as the case may be, and pass further appropriate orders.

(2) **Reasoned order:** The designated court shall pass orders that contain brief reasons for the passing of such orders.

(3) **Costs:** The designated court may, subject to any Rules made in this behalf, make such orders as to costs of complaint as are considered reasonable.

(4) **Binding effect:** An order of the designated court shall be binding on the parties to the complaint. Further, all authorities including civil authorities functioning within the jurisdiction of the court shall be bound by the orders of the court and shall assist in their execution.

(5) **Consequences of Breach of designated court's Temporary Orders:** All temporary injunctions and interlocutory orders passed by courts shall be deemed to be orders under Order XXXIX Rule 1 of the Code of Civil Procedure, 1908 and the breach of such an order shall be dealt with by applications to the court which application shall be treated as an

application under Order XXXIX Rule 2A of the Code of Civil Procedure, 1908.]

(6) **Appeals**: For purposes of appeal the orders or judgment passed by the designated courts shall be treated as orders or judgment of ordinary district court of that level.

(7) **Timeframe for designation of courts:** The State Governments shall within 60 days of the commencement of this Act designate a particular court in each district to hear the complaints related to death for the district and train and sensitise the judge of that court on people's health and laws related to health, who shall commence hearing all health related cases in the district.

(8) **Dispensing of lawyer's appearance and waiver of court fee**: There shall be no requirement of the complainants to engage lawyers to appear on their behalf in these courts and there shall be minimum technical requirements of filing and hearing of complaints and a complete waiver of court fee except a nominal amount of processing fee for the filing of complaints, and the State Governments shall lay down the rules for ensuring these.

(9) **Information on website:** The State Governments shall within 30 days of commencement of exercise of functions of the designated courts, establish a website or web page on the internet which shall

provide inter alia information relating to the functioning of the said courts, the procedure for filing and sending complaints, the number, nature and of complaints received, and decisions and directions given by the courts.

Provided that the provision of the information on the website shall ensure the maintenance of the confidentiality of complainants and other parties to the complaints, unless waived by the parties themselves.

62. Enforcement of monetary orders of the courts:

(1) **Recovery as arrears of land revenue:** Where any amount is due from any person under an order made by the court under this Act, the person entitled to the amount may make an application to such court, and such court may issue a certificate for the said amount to the Collector of the District (by whatever name called), and the Collector shall proceed to recover the amount in the same manner as arrears of land revenue.

(2) **Maintenance of insurance cover by private health establishments:** Every private health establishment shall maintain insurance cover sufficient to indemnify a person for damages that he or she might suffer as a consequence of a wrongful act by any member of its staff or by any of its employees.

(3) **Health Reparation Funds:** The Central and State Governments shall, within 1 year of the notification of this Act, set up funds, to be known as National Health Reparation Fund and State Health Reparation Fund, at national and respective State levels, to disburse the amounts awarded as compensation to be paid by the Government or Government body.

PART VI

MISCELLANEOUS

63. Reports to the State Legislative Assembly

(1) It shall be mandatory for the Ministry of Health and Family Welfare, Gujarat, to place its reports, including reports from the State Public Health Board before the State Legislative Assembly with description of actions taken, not taken and future plans for improvements on a yearly basis.

The State Public Health Board shall submit a report to the Department of Family and Welfare.

(2) An independent report from the State Health Monitoring and Planning Committee outlining key issues requiring improvement and recommended

actions shall also be tabled in the Assembly on an annual basis.

64. Power to make Rules and Regulations:

(1) The State Government may, by notification in the Official Gazette, make Rules, Regulations and Orders to carry out the provisions of the Act.

(2) Every such Rule, Regulation or Order made thereunder, not inconsistent thereto and in accordance with the Authority granted shall have the force of Law.

(3) In particular, and without any prejudice to the generality of the foregoing power, such Rules, Regulations, or orders may provide for all or any of the following matters namely;

(a) Prescribing powers of the State Public Health Authority.

(b) Prescribing duties of the State Public Health Board.

(c) Prescribing duties of Local Authorities.

(d) Prescribing duties of Commissionerate of Health Services.

(e) Prescribing powers and procedural formalities to be complied by the Health Care Establishment (Registration and Regulation) Authority.

(f) Prescribing powers, Role and Responsibility of Monitoring Committees.

(g) Prescribing Powers, Jurisdiction Composition, and procedural formalities to be complied by the Public Health Redressal Mechanism.

65. Power of Local Authorities to Make By-laws:

The concerned local authority may make by-laws, not inconsistent with this Act or the rules there under or with any other law, for carrying out all or any of the purposes of this Act.

66. Rules to be laid before the State Legislature:

Every rule, every regulation and every order made under this Act shall be laid, as soon as it is made, before the State Legislature, while it is session,for it's approval and if the Legislature decides to make any modification in the rule or decides that the rule should not be made, then the rule shall thereafter come into effect only in such modified form or be of no effect, as the case may be, so

that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

67. **Offence and Penalties:**

(1) Whoever contravenes any of the provisions of this Act or of any rule, regulation or order made under it shall, if no other penalty is elsewhere provided in this Act or the rules for such contravention, on conviction, be punished with fine which may extend to 5000 rupees and in the case of a continuing offence to a further fine of 50 rupees in respect of each day on which the offence continues after such conviction.

(2) Notwithstanding anything contained in sub-section (1), whosoever contravenes the provisions of section 93 (non-registration) of this Act, shall ,on conviction, for a first offence ,be punishable with a fine of fifty thousand rupees, or in the case of a second or subsequent offence (continued non-registration or failure to register again after expiry of registration) with imprisonment for a term which may extend to four years or with fine which may extend to one lakh rupees ,or with both and shall in addition be liable to a fine which may extend to

five hundred rupees for everyday for which the offence continues after conviction.

(3) Offences by Corporations- Where a person committing an offence under this Act is a company or other body corporate, the Government or an association of persons (whether incorporated or not), every person, who, at the time of the commission of the offence, was a director, manager, secretary, agent or other officer or person specified in the registration form and concerned with the management thereof shall, unless he proves that the offence was committed without his knowledge or consent, be deemed to be guilty of such offence.

68. Jurisdiction:

No court other than that of a Presidency Magistrate or a Magistrate of the first class shall take cognizance of or try any offence under this Act.

69. Cognizance of Offences under the Act:

No person shall be tried for any offence under the provisions of this Act or of any rule, or by law made under it, unless a complaint is made within three months of the

commission of the offence by the police, or the executive authority or the health officer or by a person expressly authorized in this behalf by the local authority, the executive authority or the health officer.

Provided that nothing contained in this section shall affect the provisions of the *Code of Criminal Procedure, 1973, in regard to the power of certain Magistrates to take cognizance of offences upon information received or upon their own knowledge or suspicion.

70. Powers of Police Officers to Arrest Offenders under the Act:

Any police officer who finds a person committing an offence against any of the provisions of this Act or of any rule or by law made there under, may arrest such person, if his name and address are unknown to the officer and such person on demand declines to give his name and address or gives a name and address which the officer has reason to believe to be false.

71. Powers of Executive Officer and Public Health Staff to Arrest Offenders under the Act:

(1) The executive officer of a local authority or any member of the public health establishment of a

local authority, not below the rank of a health or sanitary inspector, who finds a person committing any of the offences specified in sub section (2) in the area over which the local authority has jurisdiction, may arrest such person, if his name and address are unknown to the executive officer or member aforesaid and such person on demand declines to give his name and address or gives a name and address which such officer or member has reason to believe to be false. Any person so arrested shall be handed over to the officer in charge of the nearest police station as expeditiously as possible.

(2) The offences referred to in sub-section (1) are –

(a) Offences against any of the provision of this Act or of any rule or by law made there under and

(b) Offences falling under any of the provisions that are in force in the area over which the local authority has jurisdiction.

72. Bar of Suits and Prosecutions in Certain Cases

No suit, prosecution or other proceeding shall lie against any local authority or any executive authority of a local authority, or against the Government or any officer or

servant of a local authority, or of the Government, for any act done or purporting to be done under this Act, without the previous sanction of the Government, or if the act was done in good faith in the course of the execution of duties or the discharge of functions imposed by or under this Act.

73. Punishment for Malicious Abuse of Powers:

Any executive authority or a local authority or any officer or servant of a local authority or of the Government, or any person appointed under of this Act, who maliciously abuses any powers conferred on him by or under this Act, shall be punished with imprisonment which may extend to one year or with fine which may extend to one thousand rupees or with both.

Provided that no prosecution shall be instituted under this section without the previous sanction of the Government.

74. Method of Serving Notices:

(1) When any notice is required to be given under this act or under any rule, by law, regulation or order made under it, such notice shall be given.

(a) By giving or tendering the notice to such person; or

(b) If such person is not found, by leaving such notice at his last known place of abode or business or by giving or tendering the same to some adult member or servant of his family; or

(c) If such person does not reside in the local area and his address elsewhere is known to the executive authority, by sending same to him by post, registered; or

(d) If none of the means aforesaid be available, by affixing the same in some conspicuous part of such place of abode or business.

(2) When the person is an owner or occupier of any building or land, it shall not be necessary to name the owner or occupier in the notice and in the case of joint owners and occupiers, it shall be sufficient to service it on or send it to one of such owners or occupiers.

75. Delegation of Powers by the Government:

The State Government may, by notification and subject to any restrictions, limitations and conditions specified therein, authorize any person to exercise any one or more of the powers vested in them by this act and may, in like manner, withdraw such authority.

76. Act to Override Other Enactments:

If any provisions relating to public health contained in any other enactment in force in the state of Gujarat are repugnant to any provision contained in this Act, the latter provision shall prevail and the former provision shall, to the extent of the repugnancy be void

77. Power to Remove Difficulties

(1) If any difficulty arises in giving effect to the provisions of the Act, the State Government may, by order in the Official Gazette, make such provisions not inconsistent with the provisions of this Act as it appears to be necessary or expedient for removing the difficulty.

Provided that no such order shall be made after the expiry of a period of two years from the commencement of this Act

(2) Every order made under this sub-section (1) shall, as soon as or after it is made, be laid before each House of Parliament.

78. Indemnity to persons acting under this Act:

No suit, prosecution or other legal proceeding shall be instituted against any person for anything which is done in good faith or intended to be done under this Act, rules or By-Law's.

****

JAY NARAYAN VYAS

No. MIN/HFW/T/NGO/NRG/
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Health & Family Welfare, Tourism,
Holy Places, Pilgrimage Development,
NGOs, NRG
Government of Gujarat,
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Phone : (079) 23238109, 23243502 (O)
Fax : 23250135

17th April 2009

Dear Dr. Kanani,

Apropos to the discussions we had with the delegation of Indian Medical Association led by you on 16th April 2009, I am happy to confirm the following –

(i) It is a proposed draft with no intention to implement in the present format.
(ii) State Government shall have wider consultation with all stakeholders including IMA GSB.
(iii) Consensus emerging out of this discussion shall prevail in the process of making a law.

I hope this satisfies you and your members and would look forward to your active involvement and cooperation in working out the modifications.

I am advising the Principal Secretary (Health) to place a copy of this letter also on the website.

Best Wishes,

Sincerely,

Jay Narayan Vyas

To
Dr. Mansukhbhai R Kanani
President
Indian Medical Association, Gujarat State Branch
Amar Hospital
Shri Veer Bhadrasinhji Shopping Centre
Nilambaugh
Bhavnagar 364 001

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Date : 17/4/2009

To,
Honorable Shri Jaynarayan Vyas
Minister of Health & Family Welfare
Govt. of Gujarat

Sub: Your letter dated 17 April 2009

Respected Sir,

Indian Medical Association, Gujarat State Branch (IMA GSB) appreciates your prompt response to our request regarding the draft on "Gujarat Public Health Act-2009"

We are pleased to note that the Health Ministry does not intend to implement the said draft in the present format.

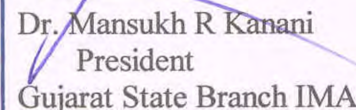
We are also happy to note that I.M.A. G.S.B. is recognized by the State Government as an important stakeholder.

With a growing sense of mutual trust we are sure that this process will evolve satisfactory consensus in this issue.

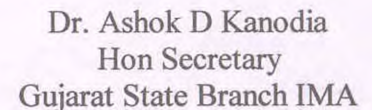
We request you to ensure that the copy of your letter is displayed on the website clubbed with the draft.

Assuring you of our cooperation.

Your Sincerely



Dr. Mansukh R Kanani
President
Gujarat State Branch IMA



Dr. Ashok D Kanodia
Hon Secretary
Gujarat State Branch IMA

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