Right To Health Care
Moving From Idea To Reality

Proceedings of the Seminar held at

The Asian Social Forum, Hyderabad

3 and 4 January 2003

Cehat

Global Health Council

NCAS
FACILITATING SOCIAL CHANGE

Right To Health Care
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Proceedings Of The Two Day Seminar Organized By

CEHAT

(Center For Enquiry Into Health And Allied Themes)

in partnership with

NCAS

(National Center For Advocacy Studies)

and

GHC

(Global Health Council)

under the aegis of

'Jan Swasthya Abhiyan'

at the

Asian Social Forum

Hyderadbad

On 3rd and 4th January 2003

Preface

In keeping with CEHAT's mission of working towards right to health and healthcare a partnership program with the Global Health Council, USA and the National Centre for Advocacy Studies, Pune was initiated from early 2002. A series of brainstorming and strategy development meetings were held with a broad spectrum of organizations from the NGO, corporate, government, and grassroots organizations. In this process the theme of right to healthcare evolved and it was envisaged that a partnership using this theme would take the process forward.

The organizing of the two day seminar at the Asian Social Forum 2003 is the first major event in the building up of this partnership. This seminar was organized under the auspices of the Jan Swasthya Abhiyan (People's Health Movement – India). Over 200 people attended this seminar, which had an international panel of 15 speakers. The major thrust of the seminar was to consolidate the idea of right to healthcare and the mechanisms and processes needed to operationalise it.

The Asian Social Forum was a good opportunity to take this first step in developing a campaign and strategy for right to healthcare in India. This seminar not only brought together activists of the JSA and other civil society groups but also a wide range of persons from academics, the legal and medical profession, and government agencies.

CEHAT as an institution which functions at the interface of academics and activism is deeply committed to making the idea of right to healthcare a reality and in this context is undertaking a wide range of research which would lend support to civil society initiatives in their struggle for right to healthcare. Along with various partners, and especially the JSA, CEHAT also supports advocacy initiatives at different levels through its various activities to work towards right to healthcare. This seminar was a collaborative initiative of all such partners.

We take this opportunity to thank all those who have contributed to bringing out these proceedings. We thank Neelangi Nanal, Shelley Saha, and volunteers from National Centre for Advocacy Studies and Karve Institute for recording minutes. Shailesh Dikhale, Kiran Mandekar and Amulya Nidhi helped by making audio recordings of the entire seminar. Vijay Sawant efficiently managed the sales of publications at the seminar. Muriel Carvalho assisted by typing some material. We would like to acknowledge the efforts of the entire team from CEHAT and NCAS who worked to make this seminar a success.

This is only the first step and there is a long road ahead, which is not an easy ride. All of us who came together on the ASF platform need to continue our efforts synergistically to realize the goal of the Peoples Health Movement of Health for All Now!

– Ravi Duggal

Dec. 2003
Mumbai

The Asian Social Forum- The Asian Social Forum (ASF) was convened in Hyderabad from the 2nd to 7th of January 2003. Over 12,000 people attended the gathering and expressed their strong belief that 'Another World is Possible!' The seminar was a significant event, which built towards the World Social Forum (WSF), which took place in Brazil in late January 2003. The Forum was a response to the growing international movement critiquing neo-liberal economic policies and capitalist globalization being imposed on most developing countries. It was convened in an expression of the WSF principle of offering a space for free discourse, informed debate, mutual learning, interaction between various organizations, and participatory formulation of alternative models with the worth and viability to address the challenges of development with justice.

The main themes of ASF were:

- Peace and Security
- Debt, Development and Trade
- Nation State, Democracy and Exclusions
- Ecology, Culture and Knowledge
- Social Infrastructure, Planning and Cooperation
- Alternatives and People's Movements.

'**Right to Health Care: Moving from Idea to Reality'**, was a two-day seminar at the Asian Social Forum held on the 3rd and 4th January 2003, organized by the Centre for Enquiry into Health and Allied Themes (CEHAT) in partnership with the National Centre for Advocacy Studies (NCAS) and the Global Health Council (GHC). This seminar was organized under the broad theme of Social Infrastructure , Planning and Cooperation under the aegis of the Jan Swasthya Abhiyan during the Asian Social Forum. The aim of the seminar was to analyze and discuss issues related to establishing the Right to Health Care in the Indian context. The underlying basis of the seminar was that access to quality health care is not only an essential human need, a right of citizenship, and a public good, but also a pre-requisite to good health.

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Access to good quality health care is not only a human need, a right of citizenship and a public good, but it is also a pre-requisite to good health. While creating conditions for fulfillment of the **'Right to Health'** would be the ultimate aim,establishing the Right to Health Care could be a first step, a tangible and feasible demand, a primary responsibility of health activists. Making this right functional through an appropriate Legal and Constitutional framework, looking at International Experiences regarding Universal Access to Health Care, working out Operational and Financial mechanisms required to realize it and last but certainly not the least, Campaign Strategies that need to be adopted to move towards this goal were the focus of the seminar. A panel of 15 renowned legal and health sector resource persons and leading health activists made presentations during the seminar and over 200 participants attended it.

India is known to have poor health indicators in the global context, even in comparison with many other developing countries. While public health expenditure forms more than 80% of the total health expenditure in most developed countries, India spends less than 25% of total health expenditure from the public account[1] . For the vast majority of the population, the key barriers to good health are poverty and health system inequity.

While India continues to score poorly in health indicators, it is faced with new challenges in the form of Globalization, Liberalization and Privatization. The public health care sector is significantly affected by these developments. User fees in government hospitals, sale of public health care facilities to private providers, talk of health tourism in the National Health Policy, all seem to suggest that health care is a commodity to be bought, and a source to generate revenue, rather than a welfare provision. This policy is also translating into reduced allocations for public health, frozen recruitment of essential staff and reduction in drugs and equipment to the public health sector. In this scenario it is imperative that health and health care be looked upon as human rights issues, and efforts made for universal access to these.

The 'Right to Life' (Article 21) enshrined in the constitution, as well as the directive principles regarding Nutrition, Standard of living and Health (Article 47), and various Supreme Court Judgments in favor of Emergency and Occupational Health Care make a strong case for the right to basic health care. The proposed 93rd amendment in the constitution accepting education as a fundamental right has strengthened the case of basic social services to be accepted as a person's right. Article 12 of The International Covenant on Economic, Social and Cultural Rights, to which India is signatory, clearly recognizes the right of everyone to access the highest attainable standard of physical and mental health. In addition, it recognizes the right to create an environment which would ensure everyone medical service and attention in the event of sickness. The Alma Ata declaration of 'Health for all by 2000' signed in 1978 is yet another declaration which the government endorses. Even when all these provisions indicate that health and basic health care are people's rights, their translation into concrete services to further this right, is grossly lacking. Adequate financial allocation, political will, awareness of this right among people, and strong political mobilization will all be required in order to realize this right.

Recently the attempt to make elementary education a fundamental right has been partly successful. The PROBE (Public Report on Basic Education in India) study had an important part to play in this. The report presents a comprehensive assessment of the schooling situation in India, with a special focus on the educationally backward states. The possibility of a similar study on the availability and utilization of basic health care services at the grass roots level should

be explored to strengthen the case for basic health care to become a fundamental right.

The health committee of The National Human Rights Commission (NHRC) has also played an active role in upholding a citizen's right to health care. The regional consultation on public health and human rights, organized by the NHRC, along with Ministry of Health and Family Welfare (MoHFW) and World Health Organization (WHO) stated that denial of access to essential health care amounted to a human rights violation and the consultation gave several recommendations to remedy the situation. But without the authority to monitor violations and punish offenders, it has not been able to make much of a difference. It is necessary for the larger health movements to play the role of a watchdog, and to note and publicize incidents of denial of health care. The 'Right to Health Care' should be accompanied by adequate provision of resources, legal redressal mechanisms, the right to information, the right to participation, and the right to monitor, if it is not to remain only a symbolic declaration. There is need for strong political mobilization to ensure the implementation of these rights.

The seminar then proceeded to sharing of international experiences in realizing the right to health care. Experiences in four countries, Costa Rica, Canada, South Africa, and Bangladesh were shared. Costa Rica and South Africa both spend up to 9% of their GDP on health care, in spite of not being rich countries. In comparison India today spends less than 1%, while the WHO has recommended spending 5% of the GDP on public health. One reason for Costa Rica's good quality of coverage and access to care is that it employs a large number of auxiliary nurses and health assistants**.** These mid-level health workers with limited training are very effective at extending access to rural areas. A system of integrating public and private provision of health care is playing an increasing role in fulfilling the demands on the system, in Costa Rica. With a huge private sector in India too, universal access to quality health care would be only a dream without harnessing and regulating the private sector. Public financing and a combination of public and private provision of health care, while moving towards self, social and legal regulation of the private sector, could be the path for India.

Social insurance including social insurance should also be considered as a mechanism. In this system, citizens pay premiums beforehand, instead of at the time of sickness, and risk is shared by the entire community, with higher income groups taking a larger share of the premiums. Poverty reduction and Village Health Worker Programs[2] seem to be highly effective tools to improve health and access to health care. These are some lessons for India from international experience.

Activists shared concrete examples of the attempts to operationalise the right to health care at the grassroots level in Nagaland, a state in the North-East of India and in Thane district of Maharashtra, a state in the Western region of India. In Nagaland village health committees control the making of health plans as well as their functioning and financing. In Thane village level monitoring of health care services takes place with the help of a Health Care Services Calendar. In this way the community wields a check on service provision as well as pro-actively participates in getting better health care services.

Building a consensus around the core content of the Right to Health Care, options for organizing and managing the universal healthcare system, projection of resource requirements and financing the health care system through various mechanisms was the focus in the third theme of the seminar 'Operational and Financial Mechanisms for Right to Health Care'. The content of this right to health care would involve the right to basic health care, regular supply of rational and essential drugs according to the WHO list to all public health care units, emergency health care, enforcing minimal physical and clinical standards in public and private hospitals, enforcing standards in staffing pattern in public and private hospitals, and state responsibility that doctors serve in rural areas.

It emerged that there is a need to restructure, reform, reorganise, and regulate the health care system with structured financing. For mak-

ing operational mechanisms work, the priorities should be to constitute an autonomous health authority by an act of Parliament for tackling the problems in the medical profession regarding licensing, registration, minimum standards, integration of systems, continuing medical education, pricing mechanisms and raising substantial additional resources. In order to finance this system, an abundance of resources is needed. At present, public spending on health care is less than 1% of GDP and out-of-pocket spending is over 4%. The reorganized system would need at least 3% of GDP in total to begin with. The costs would have to be shared by governments at all levels, employers, employees, earmarked taxes and cesses[3], insurance funds et cetera. Innovations in financing can be made with the efficient and effective use of existing resources, decentralized governance, and per capita allocation of resources (i.e. block funding or global budgeting). This would create equity in access to resources; the Primary Health Care (PHC) level resources would be tripled, while CHC (community health centre) and district level resources would be doubled. Payroll taxes for health (similar to profession tax), and a health cess on health degrading products, polluting industry, and luxury products are two mechanisms to raise new resources for the health sector.

Finally, the campaign strategies to achieve healthcare for all were outlined. The prescription for health for all would be to reduce poverty and ineqity. At the same time, the campaign would aim to spread awareness, organize the poor and under-privileged to fight for basic rights, and replace the consumerist model of health care with the alternative community model. All of this would be contextualizsed in a people's movement. Strengthening and reorienting the public health system, making it more gender sensitive, making it more effective with community basing of health programmes, supporting a health worker in every village, and building awareness among people about their health rights are effective strategies towards gaining the 'Right to Health Care'. Policy planners also need to be made aware about the lack of health facilities and services at the ground level. The speakers at the seminar emphasized the need for political commitment across the political spectrum, election manifestoes to carry this program forward, and a constitutional mandate if the 'Right to Health Care' were to be realized. The session concluded by reminding the gathering that strong opposition, especially from the medical profession, is only to be expected in this process. The strategy would be to invite them to join the campaign, failing which the campaign would have to go against them. Some activities that the Jan Swasthya Abhiyan may take up in the future to realize the Right to Health Care are

1) Conducting a study to assess the availability and utilization of basic health services at the grass roots level
2) Putting forth viable operational and financial mechanisms to make the right functional and
3) Filing public interest litigation in order to bring such a right into reality. Systematic efforts would have to be made to include the issue in the election manifestos and to generate a political movement for the cause of health and healthcare.

The key ingredient to achieve Health for all is real political commitment to reach the poor and involve them in the process of change.

Without this, no major change is possible; with this, no change is impossible.

[2] Training village based persons to give first contact care, and to facilitate people's participation in procuring better public health care services for their area.

[3] A specific tax on a product

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Situation Overview of Healthcare in India
Current Practices and Needed Improvements

Health Scenario In India- India's health system is at a crossroads today, and we are witnessing a crisis in access and affordability of health care as the gap between the rich and the poor widens. Since independence, there have been significant changes in health conditions and major transformations in knowledge and technology. As a nation, we spend over Rs.100, 000 crores[1] annually on health care including over Rs. 20,000 crores on medicines. India also can boast of a highly skilled pool of medical human power, which is exported to more prosperous countries. Yet we continue to have poor health indicators, even in comparison with many other developing countries. Health services today remain inaccessible, unaffordable, inequitably distributed and inappropriate in their emphasis and approach - with women, the poor, the dalits and other vulnerable groups being the most affected. It needs to be emphasized that the barrier to better health is primarily not a technical hindrance, but poverty and an inequitable health system, which leads to the denial of a healthy life. Some of the statistics given below reveal the two nations within one that make up India today.

- Infant mortality rate (IMR) among the economically lowest 20% of the population is 109, which is ***2.5 times*** the IMR among the top 20% population of the country.
- Child mortality (1-5yrs age) rate among children from the 'Low standard of living index' group is ***3.9 times*** that for those from the 'High standard of living index' group according to recent NFHS data (IIPS, 2002).
- Every year, two million children under the age of five years die in India, of largely preventable causes and mostly among the poor. If the entire country were to achieve a better level of child health, for example the child mortality levels of Kerala, then 16 lakh deaths of under-five children would be avoided every year. This amounts to ***4380 avoidable deaths every day,*** which translates into ***three avoidable child deaths every minute***.
- Tribals, who account for only 8% of India's population, bear the burden of ***60% of malarial deaths*** in the country.

Various indicators of women's morbidity and mortality highlight their poor health status and reflect their lack of access to quality health services. Various estimates show an alarmingly high Maternal Mortality Ratio (MMR) in the range of 550-570 for India. This translates into a very large lifetime risk of maternal death, with 1 in 37 women facing such a lifetime risk. This is 4 to 5 times higher than MMR for other developing countries such as China and Sri Lanka. It is well recognized that high MMR is closely related to the lack of availability of maternal health care, especially first level referral care. We find that in India less than one-third (31.8%) of women receive full Ante Natal Care (ANC) and similarly only one-third (32.3%) of women in rural areas undergo

[1] 1 $= 46 Indian Rupees (INR or Rs)
1 crore= 10^7

safe deliveries[2]. On the other hand, private hospitals flourish, especially in urban areas, conducting unnecessary cesarean operations *(45% of deliveries being done by cesarean section in a Chennai based study, Pai)* leading to the reverse problem of iatrogenic (doctor-induced) maternal morbidity due to excessive surgeries.

The Right to Health Care - This massive paradox of health care deprivation amidst potentially adequate health care resources needs to be addressed by establishing the right of every citizen to basic health care, accompanied by operationalizing a system which would ensure universal access to health care. Given their special health needs and existing marginalisation, special focus needs to be laid on women's right to health care. Strengthened public health services would need to be combined with private health care providers under a publicly financed and regulated system. This would make full use of the available health care facilities and ensure access and affordability for all. Such a transition to ensure access to basic health care regardless of people's ability to pay would call for a complete reorganization of the health system.

Backdrop to the Seminar on 'Right to Health Care - In initial discussions on this issue, the Centre for Enquiry into Health and Allied Themes (CEHAT), the National Centre for Advocacy Studies (NCAS), and the Global Health Council (GHC) felt the need to bring together different partners with different perspectives in a constructive dialogue both at a local and global level. Over 20 organizations from various parts of the country, which included the public and private sectors, academic and government institutions, donor agencies, health NGOs, and other NGOs, gathered together in February 2002 to discuss these concerns and to find practical solutions to address this issue. The group reached a consensus that a system of universal health care, linked with entitlement to a range of basic health services is not only necessary, but is also feasible given the background of various national and international experiences. *(See Annexure)*

As a follow up, CEHAT, in partnership with NCAS and GHC, subsequently organized a two-day seminar under the aegis of Jan Swasthya Abhiyan on **'Right to Health Care – moving from Idea to Reality'** during the Asian Social Forum in January 2003 in order to generate a healthy debate on ways and means to operationalise universal access to basic health care.

The presentations and discussions in the seminar on the first day focused on: **Constitutional and Legal Framework to establish the Right to Health Care and Relevant International Experiences',** while on the second day they focused on: **'Operational and Financial Mechanisms and Campaign Strategy to attain the Right to Health care'.**

A panel of fifteen nationally and internationally renowned legal and health sector resource persons and leading health activists made presentations during the seminar to over 200 activists from various parts of the country. Discussions during the seminar focused on various legal/constitutional provisions, and mechanisms to evolve a people - centered operational health system, which would provide a basis for moving towards a broader advocacy process to establish the Right to Health Care and to an accessible, affordable and regu-

[2] RHS- RCH (Rapid Household Study on Reproductive and Child Health) 1999, Indian Institute of Population Sciences

lated health care system in India. This publication includes the background papers of the seminar and the proceedings of the seminar.

Establishing Health (and access to health care) as a Human Right- Considered from the perspective of international law, the 'enjoyment of the highest attainable standard of health' has been recognized as a 'fundamental right' by the international community since the adoption of the constitution of WHO in 1946. The 1948 Universal Declaration of Human Rights, Article 25 reads:

'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and the right to security in the event of ……sickness, disability….' (UDHR, 1948)

The important Alma Ata Declaration adopted at the International Conference on Primary Health Care organized by WHO and UNICEF in 1978, also used similar language:

'The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well being 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.'

The Right to Health includes the right to health care and the right to determinants of health such as food security, water supply, housing, sanitation etc. While the **'Right to Health'** would be the ultimate aim, the attainment of right to health care could be a first step, a tangible and feasible demand.

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

– Henry Sigerist

The basic goal of the 1983 National Health Policy was to provide **"universal, comprehensive primary health care services, relevant to actual needs and priorities of the community" (**Ministry of Health and Family Welfare (MoHFW) 1983, National Health Policy, p 3-4). The reality is that vulnerable sections like women, poor, dalits, adivasis and landless labourers are deprived of even basic health care services. If health and health care must become a right, there is a need for a paradigm shift. Comprehensive health care under an organized universal access system, similar to that of other countries, which have near universal access to health care for its people, is the only way of assuring right to health care. To achieve this, health care needs to come on the political agenda. Hitherto the rights perspective focused on civil and political rights, but social and economic rights are now being globally regarded as equally important, if not more. This requires ensuring *availability*, *accessibility*, *affordability*, and *quality* with regard to both health care and underlying preconditions of health.

- *Availability* refers to the existence of health facilities, goods, and services to meet the basic health needs of the people, including *inter alia*, hospitals and clinics, trained medical personnel, essential drugs, and so forth.
- *Accessibility* means that health facilities, services, and goods must be within physical reach for all parts of the population (without any discrimination or conditionality).

- *Affordability* requires that health facilities, services, and goods be affordable for all. (That is, there should be no constraints e.g. user fees or other payments for seeking health care.)
- *Quality* means that health facilities, services, and goods must be scientifically and culturally appropriate. This requires, *inter alia*, skilled medical personnel, scientifically approved drugs and hospital equipment, clean water, adequate sanitation, and sufficient information on environmental hazards and health risks. Cultural appropriateness signifies that health policies must be respectful of the people's culture while still improving people's health status."

Unfortunately, the recet health policy of 2002, backs off from all these commitments to the people. It has no mention of why the Alma Ata Declaration was not fulfilled, or why the Primary Health Care approach seems to be vanishing from the system. What is left is a target based approach in the public health care system, which is increasingly concentrating on selected preventive health care and family planning, and an unregulated private sector, which acknowledges no responsibility to prevent and minimize illness. This document aims at creating a common understanding of what needs to be done if 'Right to Health Care' must become a reality.

Legal and Constitutional Framework for Right to Health Care

The presentations on legal aspects of right to health care were made by Colin Gonsalves and John Samuel. Colin Gonsalves is a Supreme Court advocate and an activist with the India Centre for Human Rights and Law. He has played a key role pertaining to the legal interventions in the 'Right to Food'[1] case and in developing the 'Right to Food' campaign. John Samuel is Director, National Center for Advocacy Studies, in Pune. He has been vocal on issues impinging on various social rights, including decreasing budgets for the social sector. The following is the abstract of the presentations made, issues raised and discussion that took place in this session.

The Case for Right to Health Care - Legal Provision for the Right to Health Care in India rests on and is strengthened by four pillars-

i. International human rights law
ii. Constitutional provisions in other countries
iii. Constitutional law of our country
iv. Case laws and policy statements

International human rights law-

1. The **International Covenant on Economic, Social and Cultural Rights**, in its Article 12, clearly recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the creation of conditions which would assure medical service and medical attention to all in the event of sickness.
2. The **Alma Ata declaration** of **'Health for all by 2000'**
3. The 1948, **Universal Declaration of Human Rights** provisions, considered as constituting customary international law, talks about the Right to Health and Health Care.
4. **Convention of the Rights of the Child** (Article 24 (1)) talks of children's right to health.
5. **Convention on the Elimination of All Forms of Racial Discrimination** (Article 5 (e)(iv)) mentions undertaking prohibition and elimination of racial discrimination in the enjoyment of 'right to public health, medical care, social security and social services'.
6. **Convention on the Elimination of All Forms of Discrimination Against Women** [Article (II) (f), Article 12,] talks of eliminating discrimination against women in the enjoyment of the right to protection of health and access to health care including family planning services, safety in working conditions, and safeguarding the function of reproduction. This is an important step towards women's access to health care. India is signatory or has ratified all of the above.
7. The African Charter on Human and People's Rights, The Addition Protocol of the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), and The American Declaration of the Rights and Duties of Man, are other Inter-

[1] The case for 'Right to Food' is a Public Interest Litigation, filed in the supreme court by representatives of several states to protest against starvation deaths and rampant undernutrition, and to demand that certain measures be taken to ensure food security for all.

national Instruments which strengthen people's right to health and health care.

Provision for Universal Access to Health Care in other countries

1. The National Health System in the United Kingdom
2. Medicare-based universal health care program in Canada.
3. National Insurance in Germany.
4. Universal access to health care in all Scandinavian countries through their social security system.

Constitutional law of India

1. The **'Right to Life' (Article 21)** enshrined in the constitution makes a case for provision of emergency medical care, and protection from all threats to life.

   Article 21 : Protection of life and personal liberty *No person shall be deprived of his life or personal liberty except according to procedure established by law.*

Article 47 under the Directive Principles relates to Nutrition, Standard of living and Health

Article 47: Duty of the State to raise the level of nutrition and the standard of living and to improve public health

The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medicinal purpose of intoxicating drinks and of drugs, which are injurious to health.

The 93rd amendment in the constitution accepting **Education as a fundamental right** has further strengthened the case of basic social services to be accepted as people's right.

Case Laws and Policy Statements

1. In various Supreme Court Judgments (e.g. Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal, 1996; and Bandhua Mukti Morcha v. Union of India and others, 1982 concerning bonded workers), the Supreme Court gave orders in favour of emergency and occupational health care.

   "Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government … Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in a violation of his right to life guaranteed under Article 21"

   (Paschim Banga Khet Mazdoor Samiti and others vs State of West Bengal, 1996)

In the case of **Paschim Banga Khet Mazdoor Samity vs. State of West Bengal,** [1996 (4) SCC 37], the Supreme Court ruling, in summary, stated that there must be:

- Adequate medical facilities to give immediate primary treatment to stabilize the patient's condition.
- Upgradation of hospitals at the district level and Sub-Division level, so that serious cases can be treated there.
- Facilities for giving specialist treatment at the hospitals at the district level and the sub-division level.
- A centralized communication system so that an emergency patient can be sent immediately to the hospital where bed as well as appropriate treatment is available.
- Proper arrangement for ambulance transport of a patient from the Primary Health Center to the district hospital or sub-division hospital and from the district hospital

or sub-division hospital to the State hospital.

- Ambulances, which are adequately provided with necessary equipment and medical personnel.
- Emergency preparedness in health centers and hospitals for larger volumes of patients needing emergency treatment, during certain seasons, accidents, or mass casualty.

2. The standards for primary health care were also laid down clearly in 1946 by the Bhore committee. The Bhore committee was established in 1943 to study the health care scenario in India and give recommendations. It has given a comprehensive plan of infrastructure set-up and planning of rural and urban health care systems, which still guides policy planning in India. Standards are given by various committee reports, by ICMR, and by the National Health Policy too.

Issues regarding Legal and Constitutional framework for Right to Health Care

- Legal provisions are not effective without the support of law or finance.
- The right to health and health care in India, is a part of directive principles and not a fundamental right.
- The Supreme Court does not normally interfere with policies or financial allocation to various sectors. Hence, a Public Interest Litigation (PIL) approach to redress the situation may not work.
- Legal and Self Regulation of the Private Medical Sector is essential before such a right can become a reality as 80% of medical care today is being given by the private sector.

A promise unfulfilled- **"**Rights are toothless wonders without the support of law and finances," said John Samuel in his talk. The language of rights is deceptive if an appropriate mechanism to operationalise them is not put in place. All the policy statements after the 1993 United Nation's conference talk in the language of rights. It has been effectively co-opted by the state; however, without the allocation of funds and other facilities, it has become ineffective. In the present health care system, there is a clear diversion from the policy statements. Finances made available to fulfill a right are a good indicator of political will. For example, in the 52nd round of National Sample Survey (NSS), it is seen that there is a 32% decline in utilization of public health services, over the decade since the 42nd round of NSS. At present, the public expenditure on health care is 0.9% of the G.D.P instead of the 5% recommended by the WHO. Also, in the provision of food, the government is moving away from its commitment while 50% people suffer from hunger. Even in a state like Kerala[2] the budget allocation for health care is being reduced.

Need for regulation of the private medical sector- The right to health care would be a distant dream if we failed to harness the resources in the private medical sector. This seems a daunting challenge, as this sector is highly unregulated. Practice by unqualified or inadequately trained persons, misuse and overuse of drugs, use of over-priced and irrational drug formulations (and their **heavy** promotion by drug companies), lack of standards for number of beds, equipment, and space maintained in hospitals, employment of inadequately qualified staff, and mushrooming of affluent

[2] Kerala is a small state in south India, known for low mortality (IMR is 16 per thousand) and fertility indicators comparable to the developed countries, and high literacy (90%), especially among women. The national averages for these indicators are much worse in comparison.

private hospitals are just some of the ills plaguing this sector.

To sum up- The legal case of a Right to Health Care is well made. The real problem is in respecting, protecting, and fulfilling these rights. The lack of adequate financial allocation, political will, awareness of this right among people and political mobilization have hampered the realization of this right.

Legal Recourse to the Right to Health Care- Insufficient access to health care is a clear example of social injustice. There is elaborate and detailed research - some by the government's own surveys- to prove this. The need of the day seems to be action and not further research. There is a need for health activists and lawyers to come together and file a Public Interest Litigation (PIL) in the Supreme Court, highlighting the denial of people's right to health care and demanding that the right to basic health care be considered a fundamental human right. The chances of complete success in this PIL look less likely today, because the Supreme Court does not normally interfere with policies or financial allocation to various sectors. Even so, this PIL will create a healthy debate on the subject. It will also help create a conducive environment towards progressive realization of these rights, and also pressure the government to take some action to fulfill these rights. The right to health care has more to do with healthy pro-poor politics than law. The corollary legislation in relation to this is the right to information, the right to participation, and the right to monitor, which should all be demanded.

The Role of National Human Rights Commission in furthering People's Right to Health Care

Dr. Srinath Reddy, Professor of Cardiology, AIIMS and Convener, Health Committee, National Human Rights Commission (NHRC) spoke of its role in furthering the people's right to health care.

Challenges in procuring Universal Access to Health Care - The Right to Life strengthens the human rights approach to universal access to health care. But today, health care has been transformed from an automatic provision for those in need to a commodity available for commercial sale. Even when the friendly family physician provided the care, it was private. With advances in technology, the situation has become worse. Capitalist globalization disrupts the situation further by taking away whatever autonomy was vested in the states e.g. autonomy to decide what quantity of medicines will be available and at what prices. The doctor, instead of a caregiver has become a high profile salesperson, hand in hand with corporate hospitals. While on the one hand we are unable to provide basic health care to a large underprivileged section**,** doctors trained at the expense of the tax-payer are leaving the country for greener pastures or being employed by foreign agencies and tele-medicine is put forth as the need of the day.

The TRIPS (Agreement on Trade-Related Aspects of Intellectual Property Rights) agreement, and its effect on the process patents system for drugs and medicines in India is one more challenge for affordable access to drugs in India, which forms a key component of universal access to health care.

The TRIPS agreement- Intellectual property rights are the rights given to people over the creations of their minds. They usually give the creator an exclusive right over the use of his/her creations for a certain period of time. The World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), negotiated in the 1986-94 Uruguay Round, introduced intellectual property rules into the multilateral trading system for the first time. The TRIPS Agreement, which came into effect on 1 January 1995, is to date the most comprehensive multilateral agreement on intellectual property. Under the TRIPS agreement India will have to change from the 'Process Patent' system which is followed here in the manufacture of drugs to the 'Product Patent' system from the year 2005. Under the process patent system, any drug protected by a patent, can be produced in India provided a different process of manufacturing the compound is employed. Thanks to this provision, India has been able to supply medicines at one of the lowest prices in the world. This advantage has been threatened ever since India accepted the TRIPS agreement.

The 'Doha declaration on the TRIPS agreement and Public Health' - On 20 June 2001, the TRIPS Council held a special discussion on intellectual property and access to medicines, as part of its weeklong regular meeting. This subject was put on the agenda at the request of the African Group i.e. the African members of the WTO. After wide ranging protests against the effect on drug prices due to TRIPS, all over the world, the WTO member governments adopted the Declaration on the TRIPS Agreement and Public Health by consensus at the WTO's

Fourth Ministerial Conference in Doha, Qatar, on 14 November 2001. Its purpose is to respond to the concerns that have been expressed that the TRIPS Agreement might make some drugs difficult to obtain for patients in poor countries. It says,

We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. We recognize that World Trade Organization (WTO) members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement. We instruct the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002.

Article 31 of this declaration allows compulsory licensing and government use of a patent without the authorization of its owner. But this can only be done under a number of conditions aimed at protecting the legitimate interests of the right holder. For example: (unless there is an emergency) the person or company applying for a license must have first attempted, unsuccessfully, to obtain a voluntary license from the right holder on reasonable commercial terms, and adequate remuneration must be paid to the right holder.

The authorization granted under compulsory licensing must also meet certain requirements. In particular, it cannot be exclusive, and it must as a general rule be granted predominantly to supply the domestic market.

This agreement pertaining to supply of pharmaceuticals at low price is opposed by U.S. even when 143 countries have signed it.

The role of NHRC in furthering people's Right to Health Care- After talking about the newer challenges to universal access to health care in India**,** Dr. Shrinath Reddy related how the NHRC has played its role to further people's access to health care. The NHRC has taken the view that health and development are indivisible. Just as health is going to increase per capita income, investment in health is going to give returns in development. In this perspective, a consultation titled, **The South East Asia Regional consultation on Public Health and Human Rights** was organized by the National Human Rights Commission (NHRC), the Ministry of Health and Family Welfare (MoHFW) and the World Health Organization (WHO) in Delhi on April 12, 2001**.** Within this consultation, the NHRC stressed the need for the optimum utilization of available humanpower and resources to ensure that the people attain the right to health. Serious concern was also expressed over the insensitivity of health service providers, which often leads to delay in initiating treatment to the critically injured persons, thereby causing precious loss of life. It was opined that health should be promoted as a multi-sector area partnership among academic/ research institutions, institutions of law, public health and social sciences as well as voluntary health organizations (Non Government Organisations) and Government agencies, in order to serve national health needs. This regional consultation has recognized the following, among others, as a human rights violations-

1. **Lack of opportunities for participation** for people in the development of health care system
2. **Absence of reasonable quality of services and adequate personnel** at the primary and secondary health care level, resulting in lack of access to basic health care
3. **Difficulty of access to health care at**

various levels for the lower and middle income strata of society

4. **Lack of emergency medical care** for trauma related, medical, surgical, and obstetric emergencies
5. **Irrational and unethical medical practice**, leading to exploitation or injury to the citizen

To redress this situation, the consultation recommended the following measures to the NHRC and the Government of India (GOI) -

1. To facilitate decentralization of authority in health care system through Panchayati Raj and other local institutions by devolution of appropriate financial, administrative, and supervisory powers.
2. To establish a national public health advisory body at the Centre and State public health regulatory authority in each State, to regulate public health practices and monitor the implementation of a public health program.
3. To facilitate standardization and quality assurance in training of various cadres of health personnel, and restructuring the training so that it becomes much more relevant to public health needs.
4. To strengthen and promote effective linkages of the primary, secondary, and tertiary levels of health care in the system.
5. To develop an expert group to identify the requirements of essential emergency medical care, and recommend appropriate models and guidelines. These can then be forwarded to the state and central government for review and implementation.
6. To facilitate regulation of irrational and unethical medical practices in the public and private health sectors of the country through the development of guidelines for use of drugs, diagnostics, and therapeutic procedures, including a regulatory framework for monitoring and enforcement.
7. To put in place an updated National Drug Policy to ensure an adequate and reliable supply of cost effective drugs of acceptable quality to all citizens of India.
8. To look into provisions of TRIPs, state measures like compulsory licensing and parallel importation of drugs, et cetera to ensure provision of essential drugs.
9. The NHRC to issue notice to GOI, calling upon it to identify various areas of government action and measures taken, especially in relation to TRIPS to boost provision of essential drugs.

The recommendations have a broad scope and they include subjects like access to health care, tobacco control, and those relating to meeting nutritional needs of the population. The consultation has called for the evolution of a comprehensive national tobacco policy and establishment of a multi-sector national level nodal agency for tobacco control with strong representation from legal, medical, and scientific communities. The consultation felt the need to review not only the incentives provided to the **tobacco industry** under different acts, but also all subsidies provided to the industry as well. The right of the people to access correct information related to the bad effects of tobacco consumption must be promoted through programmes of information, education, and communication. Assistance for smoking cessation should be integrated into health care service.

The consultation also stressed the **nutritional rights of people** especially children. It urged the government to ask the

Food Corporation of India (FCI) to submit a report within six months about loss of stored/ procured food grains over the last three years and any steps taken to monitor and reduce such loss. This was felt essential as reports of food grain rotting in go-downs continued while other parts of the country reported starvation deaths and suicides of farmers after crop-failures.

The consultation suggested that the advantages of breast-feeding, the adverse effects of child marriage and adolescent pregnancy, and the right to nutrition and provision of relevant services should all be highlighted through the media. The Department of Women and Child Welfare should evaluate the implementation of recommendations of the NHRC workshop on maternal anemia and then submit its report. The national nutrition policy should also be monitored, the consultation added.

NHRC: A platform for advocacy-"It is said that the constitution of India is very revolutionary in content, but very reactionary in practice." noted Dr. Shrinath Reddy. He said that these recommendations are revolutionary as well, but as stated earlier the NHRC with no punitive powers, can do only so much. The NHRC functionaries can only circulate it to ministries concerned, can ask for responses, record of action taken, and to some extent, compliance, but no punitive action can be taken. As the signatories are not bound to execute the recommendations, it becomes a moral statement, the implementation of which cannot be monitored. Even so, the moral authority of the NHRC should be recognized and used as an advocacy platform. It can certainly act as a facilitator in the dialogue between the people and the government. The larger health movement should not just criticize the NHRC, but rather energize it, remind it of its promises, and keep watch on what is done to implement its ideas. People should utilize these recommendations to stir up a public debate. This could be a good opportunity to expand this debate on human rights and health care where the NHRC is an ally. These recommendations obviously cannot be our main source of change. But it could be an advocacy instrument, which should be used much more effectively.

Lessons from the PROBE Study to strengthen the right to education

Jean Drèze spoke about the PROBE (Public Report on Basic Education in India) study. It is a comprehensive assessment of the schooling situation in India, with a special focus on the educationally backward states. The PROBE study was presented to understand the process through which an essential social service- Education- was declared a fundamental right very recently. Getting education recognized as a social right has instilled confidence that it is possible to get health care recognized as a social right too. A similar study regarding accessibility to basic health care might help consolidate the campaign for health care as a fundamental right. Drèze is a prominent economist working on social services from a rights based perspective. He is one of the co-authors of the "PROBE report", which contributed to the recognition of elementary education as a fundamental right. He has also played a crucial role in the development of the 'Right to Food' campaign at the national level.

The PROBE study is an example of "action-oriented research"[1] . This is an opportunity to understand this kind of research, as similar studies could be valuable in health care being declared a fundamental human right. There is a strong case, in general, for more research of this kind (distinct from mainstream academic research). However, the academic culture is quite hostile to it, partly because involvement in action is seen as a threat to the "objectivity" of the researcher. However, objectivity calls for intellectual honesty, not for abdicating one's convictions or social responsibilities. Further, action is a form of intellectual education, which is sorely lacking in academic circles. Thus, research and action need to be better integrated with each other. Not only does research contribute to more effective action, but action itself can also enhance the quality of research, by removing the blinkers we develop in the academic environment.

The PROBE report is based on a survey of about 200 villages in five states (Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Himachal Pradesh). The report makes a strong case for elementary education as a fundamental right of all children. Some special features of the PROBE report are:

- It is action oriented.
- The report draws on extensive fieldwork, in which the authors were personally involved.
- The report draws on a wide range of contributions. An editorial team of eight persons prepared the final version, but the report incorporates "boxes"[2] and other writings of about 50 different authors.
- The study was based on teamwork. Teamwork is demanding, but ultimately quite rewarding in terms of enhancing the quality of the report
- The report conveyed the voices of parents, teachers and students in an authentic manner. Here again, teamwork is essential to

[1] Action oriented research- systematic enquiry designed to yield practical results capable of improving a specific aspect of practice and made public to enable scrutiny and testing.

[2] A box is a writing encapsulated in a square or rectangle. It is particularly used for narratives, or text related to the main body of text, but which cannot go as a part of it. Boxes have been used in this report.

avoid being carried away by one's personal convictions in the interpretation of people's testimonies.

- It is reader-friendly, written in a lucid style, and illustrated with cartoons, charts, photographs, and other items.

These features contributed to the credibility and wide acceptability of the report. Even then, the report cannot claim to have made a direct, practical impact on education policy. That, in any case, was not the intention. One example of concrete impact is the contribution of the report to the wide acceptance of the need for school meals, which are now in place in many states (with a little help from the Supreme Court). The main purpose of the report was not to achieve direct, short-term changes in education policy, but rather to stimulate public debate and action, by presenting a coherent and well-informed perspective on the schooling situation in India. In that respect, it seems to have been reasonably successful.

A similar report on health is essential. However, healthcare is a more complex subject than education, and health care institutions are more complex than educational institutions. Also, the right to health is harder to define than the right to education. Even then, a public report on health would be very useful in terms of putting the right to health on the political agenda. The need for wider acknowledgement and understanding of the right to health is all the more urgent at this time when public health care facilities are in a deplorable state and threatened with further decay. India's health system is already one of the most privatized in the world (e.g. public expenditure accounts for 20% of total health expenditure in India, compared with 75% in western Europe and 85% in the UK), and there are prospects of further privatization in the near future. It is in this context that a strong assertion of health care as a social responsibility is urgently needed.

Relevant International Experiences towards Right to Health Care

Sadhana Hall, Director of the Global Partnerships Department, Global Health Council, presented case studies of access to health care in three countries - Canada, South Africa, and Costa Rica. **AHM Nouman,** the Chairperson, People's Health Movement Bangladesh Circle, presented the status of the right to health care in Bangladesh.

Canada[1] - Health is viewed as a human right. Using this philosophy as their guide, the Canadian government has developed a socialized health care system that evolved from a small experiment in the 30's and 40's, to the current Medicare system.[2] **"The Hospital Insurance and Diagnostic Services Act (1957)" and the "Medical Care Act (1968)"** set the terms for the Medicare system. The problems of extra billing and user charges were addressed by the **"Canada Health Act (1984)."** This system provides almost 32 million people spread over 10 million square kilometers with equal access to government-funded health services. The system is founded on humanistic principles, but is plagued by a flaw of human nature: there are no checks to make sure that people do not over-use or unnecessarily burden the system. The primary cause for dissatisfaction is the pattern of extensive queuing in the health care system. Long waits for medical attention result from overuse of the health care system. Another source of dissatisfaction is the apparent breach of one of the Canada Health Act's five principals; universality. Studies have shown the existence of class disparities in the provision of health care in Canada. The lower classes reported more difficulty accessing insured care; especially off-hours and specialty care. The Canadian system is facing sky rocketing costs and declining satisfaction levels.

Costa Rica- A history of commitment to health and social reform has yielded for Costa Rica the best health outcomes of any country in Latin America. These outcomes are the result of a well-developed, publicly funded, comprehensive health care system built on the principals of universal coverage and equity. The public sector is the predominant health care sector in Costa Rica. The Costa Rican Social Security Fund (CCSS) provides universal health care insurance to employed Costa Ricans. Not only is the insurance coverage universal, but also the access to comprehensive health care is nearly equal throughout the country. Costa Rica is the only Central American country to provide antiretroviral treatment to all HIV positive patients through its social security system.

South Africa- South Africa's vision for health care is a decentralized system that offers an accessible and free basic package of primary health care equally to all of its citizens. These goals are presented in the National Health Bill of 2001, which establishes the structure for the implementation of a national health care system based on Primary Health Care (PHC), and operated by District Health Systems (DHS). In South Africa's private sector, prepaid health plans accounted for 76.6% of

[1] Please see annexures for detailed account of health system in each country.

[2] Blouin, Chantal. "Canadians' Health Care Concerns Cannot Stop at Our Borders." The North-South Institute. http://www.straightgoods.ca/ViewFeature.cfm?REF=724. Nov. 10, 02.

the private expenditure on health in 2000. Medical schemes are the dominant third-party intermediary with 73% of the private expenditure, but out-of-pocket expenditure on health as a percentage of the total expenditure on health in 2000 was only 12.6%.

The most formidable adversary to their health care reform is the HIV/AIDS epidemic. Two years ago, the South African government reported that 4.7 million, which is one out of every nine, South Africans were HIV positive. Other obstacles to health care reform are that the health system is already saturated with issues demanding attention, there is an entrenched private health sector, HIV/AIDS is disrupting any continuity in health system development, it is not an upper wealth nation, and there is not enough social solidarity. There is inadequate funding, poor access to information, an outward migration of medical professionals, and insufficient leadership to sustain the system. Considering the small time span within which South Africa had to develop the National Health System, it has made significant progress.

Bangladesh - Bangladesh was also a signatory to the Alma Ata declaration; however, the promises made in the declaration were not fulfilled. This gave rise to the People's Health Movement, as the People's Health Assembly process came to be called in Bangladesh and the birth of their vision about the health care system, the People's Health Charter. A total of 3% of the budget, a mere US$3.6 per person is allocated to the health sector in Bangladesh. A vicious cycle of poverty and poor health operates. Twenty-six percent of the population have no access to basic health care facilities, 56% of children under the age of five are underweight, more than 94% of the children are victims of different grades of Protein Energy Malnutrition, and about 70% of the children and women suffer from iron deficiency. There has been some success in securing food security and crucial income for the hard core poor. But the failures have outweighed these small successes. The law and order situation in the country is deteriorating, and there is growing insecurity among the socially weak and vulnerable groups. The biggest achievement of the People's Health Movement in Bangladesh has been to build a campaign around the issues of health and health care and bringing them on the people's agenda. Their experiences show that poverty reduction and village health worker programs would be the most effective tools to improve health and access to health care.

Lessons from these International case studies for India-

- Costa Rica and South Africa both spend almost 9% of their GDP on health care, in spite of not being rich countries. India should increase public expenditure on health care from the present 0.9% to at least 3 -5% of its GDP. (The WHO has recommended that every country should spend at least 5% of the GDP on provision of health care)
- Costa Rica has abolished the national army and opened funding for social programs. India should also think of reducing its defense budget and increasing expenditure on social goods. Even a marginal shift from the defense budget could boost finances considerably for the health sector.
- As seen above South Africa has successfully used pre-paid health insurance schemes, which accounted for 76.6% of the private expenditure on health in 2000. This has delinked payments from the episode of illness. India too should consider social insurance, whereby payment

is in the form of a premium paid earlier and not at the time of illness and there is sharing of risk by the entire community, with higher income groups taking a larger share of the premiums

- A process of moving towards a hybrid privatized system was taking place in the Canadian Health System. An expert committee, set up to review the health care system and suggest recommendations, has advised not to regress from the Medicare system toward a more privatized system. On the other hand, the National Health Policy 2002 of India talks of an increasingly privatized health care system, where 70% of the health care is already given by an unregulated private sector. Even in a much more regulated health care system of Canada, privatization is not considered desirable. Taking lessons from this, India should not resort to measures of increasing privatization such as introduction of user fees, public hospitals sold to private institutions at extremely low rates, voluntary organisations encouraged to take up PHCs to run, et cetera.
- In Costa Rica, a large reason why the quality of coverage and access to care are so strong is that the CCSS (Costa Rican Social Security Fund) employs a large number of auxiliary nurses and health assistants. These mid-level health workers with little training are very effective at extending access to rural areas. The Bangladesh experience too shows that along with poverty reduction, village health worker programs would be the most effective tools to improve health and access to health care. India had started and witnessed a failure of the government health worker programme (1978 CHG scheme) but various voluntary bodies have successfully run health worker programmes. Taking lessons from those voluntary programs, the Government of India should revive its Village Health Worker Scheme.A system of integrating public and private provision of health care is playing an increasing role in fulfilling the demands on the healthcare system in Costa Rica. With a huge private sector in India, universal access to health care would be only a dream without harnessing and regulating the private sector. India should move towards public financing and strengthened public along with regulated private provision of health care, at the same time continuing its efforts at reforming the private sector.
- The Canadian Medicare system which provides free access to health care is today under pressure and satisfaction levels are dropping. In spite of this, the enquiry committee set up to review problems in this system boldly opposed attempts at introducing co-payments to make the system more accountable. Other options are being worked out. India can consider opting for a form of Social Insurance that incorporates measures to increase personal accountability. This should be worked out from various experiments that have taken place locally, one of which, an experience from Karnataka was shared by Dr. Sudarshan.
- The Costa Rican Social Security Fund (CCSS) provides universal health care insurance to employed Costa Ricans. Employment in the formal sector is high in Costa Rica, and hence, this gives near universal coverage. This is an example of a creative health plan that works for a particular country's economic infrastructure. In India, where the majority of the work force is in the informal sector, we should think of other innovative measures to promote universal coverage.

Core Content of the Right to Health Care

The following issues emerged during the discussion on the core content of the Right to Health Care.

- Right to basic health care[1].
- Regular supply of rational and essential drugs according to the WHO list to all public health care units
- Right to emergency health care
- Enforcing minimal levels of clinical and physical standards in public and private hospitals
- Enforcing standards in staffing pattern in public and private hospitals
- Breaking down the discrimination for urban and rural areas.
- Responsibility on individual States that the doctors serve in rural areas

Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology. It means that health care is made universally accessible to all individuals and families in the community, and these recipients are actively involved in the healthcare system. This healthcare system must be maintained at a cost that the community and country can afford at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, and of the overall social and economic development of the community.

Primary health care is the first level of contact that individuals, families, and communities have with the national health system. This brings health care to the homes and offices of individuals, and constitutes the first element of a continuing health care process.

(Alma-Ata Declaration, International Conference on Primary Health Care, 12th September 1978)

Basic Care Framework- Based on the definition of Primary Health Care, basic care framework incorporates the following-

- Family physician services — supported by paramedics and community health workers
- First level referral hospitals with basic specialties and ambulance services
- Epidemiological services, including information management and health education
- Maternity services for safe pregnancy, abortion, delivery, and postnatal care
- Immunisation services against vaccine preventable diseases
- Pharmaceutical and contraceptive services
- Education concerning prevailing health problems
- Promotion of food supply and nutrition
- Adequate supply of safe water and basic sanitation
- Prevention and control of locally endemic diseases

An important suggestion that came up in the workshop was that care for mental health be explicitly mentioned as a part of primary health care.

[1] Basic health care, as the term is used here, is first contact care (Primary Health Care) along with first level referral facilities.

Operational and Financial Mechanisms to attain Right to Health Care

Ravi Duggal, H. Sudarshan, Brian Lobo and Fr. Sebastian spoke in this session.

Status of Health Care in India, today- Ravi Duggal presented the financial and operational framework for a system of universal access to health care. He is the Coordinator of CEHAT, (Centre for Enquiry into Health and Allied Themes), and has done extensive research on mechanisms of health financing. He started by speaking about the current status of Health care in India. Salient features of the public health care system in India are:

- Entitlements are by policy and not by rights
- Focus at the primary care level is on preventive and promotive care, with curative care mostly unavailable at the grassroots.
- Health care facilities are grossly underprovided, financially and by way of amenities
- Poor investments in health care by the government
- Declining public expenditures on health care over the years. Especially plan expenditure on health care is reducing in rural areas.
- Declining new investments in health care
- Sapping of the healthcare system[1]

Private health care system- The biggest problem with the private sector by far is that it is primarily curative, with rampant irrational practices and the pharmaceutical industry acting as the driving force.

Rural-Urban disparities and declining trends in public expenditure are evident in India, as seen in the table below:

	Rural Areas, per thousand population	**Urban Areas, per thousand population**
Hospital beds per thousand population	0.2	1.9
Doctors per thousand population	0.6	3.4
Public Expenditure on health care	Rs.80, 000/-	Rs.560, 000 /-
Out of pocket expenditure on health care	Rs.750, 000/-	Rs.1, 150,000 /-
IMR	73 / 1000 Live Births	47 /1000 Live Births
U5MR	103/1000 Live Births	63 /1000 Live Births
Births Attended	33.5%	73.3%
Full Immunizations	37%	61%
No. of Ante Natal Care visits		

[1] SAP indicates the new Structural Adjustment Policy which is commonly believed to have adversely affected provision of social services.

An Alternative Operational and Financial Mechanism-

What needs to be done to create an Operational Mechanism?

- There is need for restructuring, reforms, organizing and regulating the health care system with structured financing
- Creating an autonomous health authority to monitor standards. Developing a referral system
- Standards and regulation

Operational Mechanism –

Steps that must be taken to make the above work

- Priorities should be set for making it work
- Constituting a health authority by an act of Parliament for tackling the medical profession, licensing, registration, minimum standards, integration of systems, continuing medical education, pricing mechanisms and raising substantial additional resources. Tackling the medical profession
- Licensing, registration, minimum standards
- Integration of various systems of medicine
- Continuing medical education to be made compulsory
- Regulation to control prices, instead of leaving everything to the market.
- Raising substantial additional resources

Innovations in Financing

Steps that must be taken to gather the required resources to implement the above

- Estimate Resource Requirements. Present public spending on health care is less than 1% of GDP and out-of-pocket is 4%. Reorganized system will need totally 3% of GDP to begin with. Government should increase its share of allocations.
- Costs should be shared by all levels of the government, employers, employees, earmarked taxes and cesses, insurance funds et cetera.
- Using existing resources efficiently and effectively
- Decentralized governance (*Panchayati Raj)*
- Per capita allocation of resources (Block funding or global budgeting) leads to equity in access to resources. Such a strategy would triple availability of resources to Primary Health Centres and double that of Community Health Centre and District Hospitals, even with existing resources.

Other Innovations in Financing

- Generating additional resources
- Increased allocations within the existing budget
- Payroll taxes for health, like profession tax
- Health cess (tax) on health degrading products, polluting industry, and luxury products
- Compulsory public service by those graduating from public medical schools
- Social security levies on land revenues

In Summary:

- Rural – Urban disparities across the board need to be reduced
- Reduced investments and expenditures on health care in the 1990s as a consequence of structural adjustment have impacted health access and health outcomes. The Government of India should spend at least 3% of GDP on health care.
- Allocative inefficiencies coupled with SAP (Structural Adjustment Policy) only makes the crises of public healthcare

worse. Processes of privatization, globalization and liberalisation should be challenged.

- Overall health outcomes are not very good because of user charges, privatization, and worsening access to healthcare. Special efforts must be made, such as implementing social insurance for the establishment of universal access to health care.

- There is a lack of accountability in the public as well as private sector. This should be increased with the help of regulation and people's monitoring of health services.

Much work in the field of health care is done by voluntary agencies with a view to make services available. There is a need for a right to healthcare perspective, meaning that health care services should be viewed as people's right and fulfilling this right should be a key function of the state. This would not only help bring it on the political agenda and make it an electoral issue, but when viewed as a right its fulfillment cannot be left to the market. Instead finances would have to be generated and organized to fulfill the right.

The Experiences of the Task Force on Health and Family Welfare, Karnataka

Establishing a task force with the objective of making recommendations to reform the Karnataka Health System was a unique initiative taken by the Karnataka government. Dr. Sudarshan was the chairman of this Task Force and he shared his experiences with the group. The task force functioned in a participatory process of consultation with inputs from 'The People's Health Movement,' as the Jan Swasthya Abhiyan has come to be referred as in Karnataka and various research studies, including 'Impact of Externally Aided Projects on Health Status'.

The report of the task force contains several issues of concern, but surprisingly, the biggest problem is the issue of corruption. Decentralized administration and Panchayati Raj have also given rise to decentralized corruption. "Everyone from Group D employees to the Health Minister are involved in corruption. Instead of 300 MLAs, now 1x $10^{5\ \text{people's}}$ representatives are eating the cake," said Dr. Sudarshan in the course of his presentation.

Another issue is that only a small percentage of the health budget of Karnataka (less than 1 %) is spent on purchase of drugs. The pharmaceutical industry has the greatest influence in deciding which drugs to purchase – which often leads to dangerous and obscure drugs being released into the healthcare environment. For instance, last year, the Karnataka government has spent 1/3rd of its drug budget on Nimesulid (Nise), which is a drug, not approved for use in the United States and Europe.

Fortunately, the Lokayukta (the official ombudsman) of Karnataka, is a proactive person. He has established 'Grievance Redressal Courts' or Adalats at the Taluka level in order to control corruption. These 'Adalats' of the Lokayukta, are very well attended and cases are often disposed of on the spot. People have also co-operated in the anti-corruption movement, in a large way by coming out in the open with accusations of bribe. These accusations addressed corruption at all levels, from minor bribe cases of Rs 10/- up to 30 crores drug scams.

The report submitted by this task force to the Indian government gave several recommendations, some of which were:

- An integrated State Health Policy, which jointly deals with Health, Pharmacy, Population et cetera.
- A Health Establishment Bill and mechanisms of social insurance as ways to operationalise the recommendations.

The report was accepted by the Government, and a High Power Imple-mentation Committee was set up to monitor its implementation. The People's Health Movement from Karnataka is also monitoring the implementation. About 30 to 35% of the recommendations have already been implemented. This is a unique success story where lack of political will has been an important hindrance in universal access to basic health care, and the people were successful in fighting it. Such attempts should be made in other states.

'Social Insurance as a Mechanism for Ensuring Access to Health Care'

Dr. Sudarshan also related an experience in community financing as a step towards social insurance. The partner organizations taking part in this program were the Ministry of Health & Family Welfare, Government of India, the United Nations Development Programme, the Department of Health & Family Welfare, the Government Of Karnataka, the Karuna Trust (a voluntary organization) and the National Insurance Company.

The objectives of the social insurance program were:

- Developing & testing a model of Community Health Financing for rural poor
- Increasing access to public health care by rural poor
- Ensuring equitable distribution of health care through social insurance
- Empowering rural poor for better health

Approach of the social insurance scheme-

- Right to Health approach taken
- Efforts made for empowerment and representation of rural poor through Village, Sub Center, and PHC Committees
- Right to Information Bill and Act were stressed
- Citizen's Charter for envisioned health care prepared

Resources generated from-

- Micro-credit savings by Self Help Groups, for out-patient care
- Pre-paid Insurance for Inpatient care, i.e. Hospitalization

Services included-

- Community Herbal Gardens, for common ailments
- 1,00,000 Scheduled Castes & Scheduled Tribes and 20,000 Other Backward Castes below poverty line were covered
- Facilities were provided at a Taluka Hospital, two Community Health Centres and Primary Health Centres.
- Care given at the NGO-run Hospital and PHCs were also covered under this Insurance scheme
- Ambulance and diet services at the NGO-run Hospital were made available

Salient Features of these Insurance schemes are-

- Very low premium, Rs.30/- per person per year
- Premium costs shared by community, milk co-operatives, SHGs (Self help groups), UNDP and GPs (Gram Panchayats)
- No exclusions - all age groups are included
- Hospitalization provided to any illness covered
- Rs. 50/- paid to patient for daily wages lost and Rs. 50/- to the hospital for extra drugs per day of hospitalization
- Ambulance services and referrals - diagnosis and treatment are also covered
- Maximum of 25 days of hospitalization covered
- Amount paid to patients every day through the revolving fund at each Hospital
- The National Insurance Corporation (NIC) settles the claims once a week

Progress Achieved

- Access to public health care by rural poor has improved. Essential drugs have been

made available for those below the poverty line.

- This experiment has been extended to two more tehsils, the smaller administrative unit within a district
- Government has decided to extend it to all the talukas in Karnataka in phases
- NIC may reduce the premium next year

Lessons from these and other such experiments should be noted in order to have a viable and sustainable social insurance scheme in India.

Operationalizing the Right to Health Care at the grassroots Level

"The true measures of implementation are not through the court, but through the civil society" expressed Brian Lobo, lawyer and activist of Kashtakari Sanghatana, a people's organisation working in Dahanu, Thane District in the western state of Maharashtra. Regulation and insurance are the substantive aspects of health care, he said. Other aspects include the right to information, redressal mechanisms, and community monitoring. Hence real participation of people in monitoring of the healthcare system is essential. The following legal and constitutional provisions entitle the people to their right to demand, implement, and monitor healthcare.

1. The 73rd amendment of the Constitution empowers Gram Panchayat (Village Council) to plan and implement provisions in social sector.
2. Under the Central Act, Gram Sabha is able to control institutions of the social sector.
3. The PESA (Panchayats Extension to Scheduled Areas act), also empowered the Gram Panchayat. It gives the Gram Panchayat 'the power to exercise control over institutions and functionaries in all social sectors'. Unfortunately it is no longer functional in Maharashtra,
4. Every village has village health committees, which represent the village. They are expected to monitor the services made available. E.g. In Kerala, the Gram Panchayat has the powers to even dismiss the PHC staff as a disciplinary action for nonfunctioning.

Given below are two success stories regarding people's monitoring of health services:

Communitization of law *- In Nagaland, village health committees supervise, guide, and support the staff in the making of health plans and the procurement of medicines. They have control over salaries and can also recommend granting of earned leaves. In addition, they make rules for day-to-day functioning. Community takes disciplinary, punitive actions. For successful management of PHCs by the community, it should be given statutory powers.*

People's monitoring of Public Health Services in Dahanu- *The experience of people's monitoring of village level health services through the* ***'Health Services Calendar Program'*** *in Dahanu taluka, is also interesting. Here, people have maintained a public register of health services actually received by the community. This is done in the form of a pictorial calendar on which the health functionaries are supposed to sign on the day of visit. The calendar gives information about the services to be provided through the public health system, days when they will be provided, and the person responsible to provide that service. Regular meetings are held with health professionals at the PHC and they are answerable to people in the case of nonfunctioning. A substantial improvement in the provision of health services was seen at the Primary Health Care level through this program.*

Problems in peoples' monitoring of public health system-

- **Absence of grievance cells** - Grievance cells are essential for optimum functioning of this system.
- **Inadequacy of non-medical health**

people to deal with health functionaries - One of the problems in peoples' monitoring of the public health system is that the non-medical people feel inadequate while dealing with health functionaries.

- **Presence of facilitators essential** - Beyond village level, involvement of health NGOs as facilitators is essential.
- **Punitive action against erring personnel may not help** - There is a need for accountability on the part of health personnel, but punitive measures are not effective when 80% of health personnel are not functioning satisfactorily. It is also necessary to understand the problems of the health personnel working in rural areas. Often the doctor who goes to the rural area is also victimised. He does not have any social life in the villages. He is often living in a very different cultural milieu. Once a month when he comes to the city, he gets admonished from his seniors, and there is no appreciation for his efforts. Instead of dwelling on punitive steps, there need to be positive reinforcements to ensure that these rights are implemented, and health professionals too enjoy working there. Efforts must be made within these rural communities to dialogue with the health professionals and assimilate them in the local culture. The threat of suspension from his/her job should act as a deterrent, but not used as the principal way to make the doctor work.
- **Health functionaries at the highest level (doctors and policy makers) not affected by grassroots initiatives** - The ANM (Auxiliary Nurse Midwife) is typically one of the most oppressed among the health functionaries. The reason for this is that people often pressurize her rather than the doctor to get services. This is because she is the most accessible person, who is mostly responsible for all the outreach activities. It is also easier to confront her as she is often a part of the community and a junior person, rather than the doctor, a senior and respected person. Ultimately, the doctors and policy makers are not affected. Besides, demanding punitive action brings bitterness, and it becomes difficult to establish links with the same functionaries, while what we are really interested in is to build links and make friendships and not be given services under fear or coercion.
- **Absence of stakeholders in middle class**- All monitoring has limitations because in the absence of a health insurance scheme, the middle class is not concerned about monitoring of the public sector since they are not significant stakeholders in it.

In view of all these problems, what emerges as important is to mobilize individuals through mass organizations in order to bring the health problems into their political and social agendas.

Role of the Voluntary Sector in Universal Provision of Healthcare

Father Sebastian spoke about the context in which the voluntary health sector is providing health care services. He is the director of the Hyderabad based, Catholic Health Association of India (CHAI) CHAI has been dedicated to good quality health services and has also played an important role in the Jan Swasthya Abhiyan process. He expressed that it is important to recognize the collective contribution of the voluntary sector for the overall health and well-being of the country's citizens.

A unique contribution of community and voluntary healthcare organisations is that they provide "ethical care" by facilitating health personnel in their communities to provide high quality care. In particular, voluntary organizations are strong players in this movement because of their flexibility. They are free to develop a service programme that best suits the needs of recipients.

Various issues and the context regarding health care provision today are summarized below:

1. Globalization:

The health sector has suffered due to globalization, liberalization and free market medical practices, which increased the cost of diagnosis, treatment, and care. Global integration (with local disintegration) will dictate the global health fund agenda unless attainment of health is viewed as a basic right for the people. The recognition of health as a basic human right has been denied through years of exploitation, poor governance, the withholding of information, the lack of education and misallocation of funds.

2. Allopathy vs. Traditional medicines

Allopathic medicine emphasizes hospitalization, drug therapy, and surgery. For basic diseases, these options are not always needed.

Sixty percent of the health care needs of the Indian people are basic, and hence do not need hospitalization.

An allopathic system tries to underscore the practice of traditional medicine.

3. Private Financing of Health Care

According to the World Bank Development report, out of the 6% of the GDP spent on health, private sector accounts for 4.7% (or 78.5% of the total health expenditures) – of which 4.5% is out of pocket expenditure and the remaining 0.2% comprises contributions made by private employers and insurance.

Most individual household expenditures go towards curative services.

Even within primary services (which are supposedly free in Government facilities), 82% of the expenditure comes from households.

4. Role of Voluntary Sector in promoting Universal Accesses to Health Care will be:

- To identify the key issues for community and voluntary healthcare organisations
- To identify the practical actions which could be taken to address the issues
- To research and publicize the collective contributions of community and voluntary healthcare organisations
- To identify and agree on the critical components of 'true partnership with statutory agencies'
- To scan the existing health situations in Asia. To describe, to analyze and to propose measures for the future.

Campaign Strategy for Right to Health Care

N.B.Sarojini, T. Sundararaman, and Ravi Narayan shared their experiences and views in this session. All three were also representing the Jan Swasthya Abhiyan. They spoke about possible Campaign Strategies for Right to Health Care and the role of Jan Swasthya Abhiyan in it.

Dr. Sundararaman, a Professor of Medicine, at the Jawaharlal Institute of Post Graduate Medical Education and Research, Pondicherry is currently the director of the State Health Resource Center in Chhattisgarh. He started his talk by giving the context in which this seminar was taking place. He reminded the audience that two years back a huge 'National Health Assembly' was organized through the People's Health Assembly process. Now an even bigger Asian Social Forum gathering has taken place. "Now, it is time to go beyond the big gatherings and work in parallel to such events for change at the grassroots" he said. Many such gatherings become an aggregation of middle class people, coming together and passing resolutions. But the impact that this makes on public opinion is limited. Despite increasing protests it has not been possible to command attention of newspapers to the issues of people's right to health care. The issue of universal access to health care should not stay limited to conferences but must become part of the electoral issues.

The key question is how can this be achieved. Today, five star hospitals, such as Apollo and Reliance speak with authority on the health policy and new and newer technology is being put forth as the solution to our problems. Tele-medicine is offered as a solution to reach specialist knowledge to remote areas. "Why don't we instead, talk about 'A Swasthya Sathi in every village, a health worker in every village'?" asked Dr. Sundararaman. This slogan, he said could be creatively used to launch a movement where the poor and the sick come together to participate and lead the fight for better health. The health movement is not a movement on their behalf- it must become their movement. The concept of a health worker needs to be built on. It would be good to start with Dr. David Werner and the Jamkhed concept, but the need of the day is to go much beyond. It must be kept in mind that we stand for not just curative care, but comprehensive care from the 'Public Health Care System'.

Today 'Health Sector Reforms' is a taboo phrase, because it talks only of privatization in the name of reforms. If we want health in our villages, we need to provide referral services such as facilities to perform Caesarean sections at least at the block level. The core of a pro-people reform is strengthening the public health system and making it more effective. And this must be done with community basing of health programmes. The health worker in every village mobilization should initiate and contribute to this reform by seeing health care services as entitlements that the health workers help the community to secure. By giving the health worker in every village such a meaning and context we can really build a major mobilization of people for the right to health care. The massive networking of movements that PHA initiated and ASF continued must be matched by equal enthusiasm in building a partnership of the sincere elements in this to reach every village.

Women's Access to Health Care as a Fundamental Right

N.B. Sarojini spoke about women's right to an accessible health care system, sensitive to women's problems. She is the Convener of Medico Friend Circle and the founder member of SAMA, a resource group for women and health in New Delhi. She expressed that "Health for all" by the year 2000, a proclamation that has enough potential quite unfortunately has taken a backseat with disastrous result in terms of women's lives. At the outset, she felt it was important to state her position, to help communicate what is exactly meant by *'women's access to health care as a fundamental right'*. Women's access to health care is not only the physical access to health services. This is not to argue that physical access is unimportant; but to point out that there is more to it. This broader concept of health *('the all encompassing wellbeing'*) and the access to it is what is meant, when referring to health as a *'fundamental right'*.

Sarojini started by exploring the hurdles that come in the way of women's access to public health services, which can be listed as infra-structural, attitudinal, social, and economic. All these obstacles were examined both from the macro and micro-level perspectives. Through these dual perspectives the role of both the state and the family in perpetuating the women's subordination; and the latter falling prey to the norms of patriarchal, sexist society can be seen. To begin with there is sheer lack of adequacy of Primary Health Centers (PHC) and those existing lack the minimum necessary drugs. Though theoretically they are supposed to cover 30,000 populations, practical experience reveals something quite different. Often a woman in a rural set-up has to travel a minimum of 10 kms distance for basic health care; For Tuberculosis (TB) drugs, people in the tribal belts have to travel 100-150 kms. This becomes all the more problematic for the women who cannot travel alone due to the existing social situation. Moreover, being deprived of any kind of economic resources, traveling such a long distance just for the sake of one's own medicine becomes problematic and often loses importance. The paradox lies in the fact that twice as much money in the budget is allocated to family planning, as in the overall health sector. Even within the health budget, most of the money goes for contraception whereas women's primary health needs are not taken care of. Sarojini felt that this is because women are not thought to have an existence outside their reproductive functions.

Hence, there is not only an inadequacy of health facilities but also an insensitiveness to understand women's issues in general and health issues in particular. This is so because the government planners, medical personnel, who are made to *'treat'* these 'women' do not share the same universe with them and hence often find their complaints as *'vague'* and '*fancy story-telling*.'

Moreover, to talk of women as a 'group' often becomes problematic due to the differential treatment that the so-called *deviants* (single woman, lesbian, deserted) receive. Here, it would not be out of place to even talk of the differential treatment that mental-health patients and victims of violence undergo. To this one can always add upon the existing inequalities rising from caste, class and the low status of women in general. The women are hence not in a position to decide both at the macro and the micro-level and there is no space open to them where they can ask for better services for themselves. Moreover, patriarchy and the inbuilt gender stereotypes have ingrained in women to shape up subordinate outlook towards their own health needs.

Sarojini expressed the need for a multi-pronged campaign at various levels, right from the grassroots to the highest levels of policy and planning, including the international arena. On the one hand the government cannot abdicate from its duty; on the other hand it must take the views, wants and needs of all those for whom primary health care is to be provided.

Sarojini reiterated that health is a basic right of the people and it is the government that can and should provide it. She identified the task at hand as the need to move the government health structure to fulfill the needs of the people, and further demand that all plans made for the people take into account socio-economic condition like class, caste, religion and sexual preferences.

It is important to understand that health is not just about illness and treatment. So when there is abject poverty, even the best medical infrastructure will not be able to ensure that people would be able to access it, or they would be healthy. In a situation of constant stress due to overwork and low wages, a person cannot be healthy. In a degraded environment, it is not possible for a person to remain healthy. When a family is evicted from its habitat to make way for a development project, (and obviously it is not rehabilitated), can anyone in that family remain healthy? When a person of a disadvantaged caste or tribe is constantly subjected to humiliation and violence by the upper castes, there can be no expectation of him or her to be healthy. Similarly, when a woman is constantly subjected to subjugation, humiliation and violence within her own family, or she is gang raped and tortured in a communal riot, she cannot be expected to be healthy. Therefore, it is important to make linkages of all other issues that affect people's lives, with health.

Sarojini concluded by saying that the government can have millions of excuses for its inability to provide healthcare – budget constraints, population explosion, Indo-Pak tension, debt burden as well as to justify its compulsions to follow the guidelines of international lending agencies. However, it has ratified various international treaties and covenants that underlie healthcare as a basic right, and there is always a space to demand its fulfillment and question policies that undermine this right.

The Right to Health Care Campaign
Evolving the Campaign Strategy

Dr. Ravi Narayan presented the possible steps that could evolve into the campaign strategy for every citizen's right to health care. He is an Advisor at the Community Health Cell, a voluntary organisation dedicated to public health, in Bangalore. He started by reminding the audience of the WHO Definition of Health 'as physical, mental and social well being' which presupposes that individuals, families and communities have access to the information, means, opportunities to determinants that make health possible including access and control of institutions through which health related care is made possible.

The Alma Ata Declaration of 1978, on Heath for All and Primary Health Care also reiterated that Health was a Right's issue.

"The Conference strongly reaffirms that health, which is a state of complete physical, mental and social well-being, 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".

- Declarations of Alma Ata, September 1978 - WHO / UNICEF,

This has been further endorsed by the People's Charter for Health.

HEALTH AS A HUMAN RIGHT

"Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns".

The Charter calls on People of the world to

- **Support all attempts to implement the right to health**
- **Demand that governments and international organizations formulate, implement and enforce policies and practices, which respect the right to health.**
- **Build broad-based popular movements to pressure governments to incorporate health and human rights into national consultations and legislation.**
- **Fight the exploitation of people's health needs for purposes of profit".**

- People's Charter for Health, PHM: December 2000

The Jan Swasthya Abhiyan (PHM – India) has decided to evolve a Right to Health Care Campaign as a first step to establishing the Right to Health. While right to basic health care is only part of a Right to Health Campaign, since the latter has to include all the determinants of health – food, water, livelihoods and healthy environment etc., a more focused campaign on the right to basic health care or Primary Health Care could be a good beginning.

Evolving Strategy - A checklist of steps are outlined to evolve a meaningful campaign at the national level.

Step One:

***Evolving Consensus*:**

An interactive participatory process of dialogue must be initiated at all levels to evolve a consensus nationally, especially among the Jan Swasthya Abhiyan constituents, which include a diverse range of people's movements; science movements; women's organizations; health and development networks and associations.

This dialogue / events must include all the sectors and stakeholders. E.g., Providers and consumers; representatives of movements, networks, associations; representatives of legal, economic, medical, social science, social work, politics, media and other sector professionals. The dialogue to evolve consensus should also build on the learning experience from other recent public campaigns like the right to information campaign etc.

The consensus is primarily on what should be introduced in a realistic and strategic sense as a minimum component of the right to health care.

Step Two:

Evolving Strategy

The Right to Health Care campaign needs to then be evolved as a political campaign to establish it as a Right's issue. A small strategic planning group or committee needs to identify with realism and clarify all aspects of a strategy.

i. What - Components
ii. Where – Levels
iii. How – means and methods (Public Interest Litigation, public rallies, manifestos etc)
iv. Linkages – with other strategies / campaigns
v. Whom to involve
vi. Symbolic events / actions (street rallies etc)
vii. Advocacy strategy

An important component is to dialogue with the legal activists about how this right could be justiciable.

Step Three:

Advocacy with government and political system

The political failure of the government to ensure basic primary health care in over six decades since independence and by the 25th anniversary of the Alma Ata Declaration (2003), to which India was an enthusiastic signatory, will be a focus of advocacy. The purpose will be to enhance political commitment across the spectrum of political parties in India, not just the government in power. With national elections coming up next year and in a few months in states, this year, an effort must be made to proactively dialogue with political parties to get the right to health care into the election manifestos.

To stress that the right is a constitutional mandate must be at the core of the advocacy. The obstacles to the right to health care are many in the present health care system – foremost being lack of Equity, Quality and Integrity. This should also be focused upon as was done by the Task Force on Health and Family Welfare in Karnataka, which had JSA, linked participants.

Step Four:

Advocacy / Dialogue with Providers

All Jan Swasthya Abhiyan constituents, who have professional / academic / research credentials should initiate dialogue with a wide variety of professional associations, be it In-

dian Medical Association, Indian Association of Physicians, Medical Council of India, State councils, universities and academic and research institutions and networks / associations of health providers. This is necessary to build up an ethos of support to the campaign. It is important to present the campaign as an effort to re-establish the ethical and quality basis of health care and promote rational / evidence based medicine and enhance patient / consumer participation. This advocacy with the rational / ethical / quality / conscious / socially sensitive sections of the professional / provider community will also counter the potential opposition from professional sectors, who could be used by status quo forces, the medical industry or those who see a threat in this campaign to unbridled 'marketing' of health care.

Step Five:

Advocacy / Dialogue with Community / Movements / Unions

This step is to build the support base for the movement by enhancing the knowledge of the logic and component of all aspects of the campaign and enhancing demand, promotion, feedback and most important a wider ownership and support to the campaign.

The context of Panchayat Raj and the consumer movement in the country should be kept in mind and links established creatively with ongoing processes in these two sectors.

Trying to involve and integrate other health care systems and traditions would greatly enhance the demand and support base. The right to have access to herbs that are used in primary health care and which are seen as symbols of people's health traditions and people's knowledge could galvanize not only Alternative Systems of Medicines, but also the agricultural / environment movement groups.

Step Six:

The Campaign Phase

The first five steps outlined are not all necessarily in chronological sequence since different JSA constituents could focus on different steps simultaneously, even though step one and two are crucial, because without content and strategy consensus, the campaign could get confused, out of focus or distorted. Steps three to five could be done simultaneously.

Step six – the campaign phase will have its own sub-steps and dynamic components, which will not be outlined at this stage, since the purpose of this short outline is to get the campaigns process started beyond the Asian Social Forum seminar on Right to Health Care.

Concluding thoughts by Dr. Zafarullah Chaudhary (chairperson of the session) –

"From all the presentations, it is clear that it is time for action, but action is not easy. Action invites strong opposition, especially from the medical profession."

With this Dr. Zafarulla Chaudhary reiterated that the journey towards 'Health and Health Care for All' would be an uphill task. Equitable distribution of resources, generating political will and finances and above all setting standards and regulation will all be daunting tasks, but will have to be taken up. The existing research will have to be studied and used for the benefit of the people as against what is currently going on. E.g. Nimesulid (Nise) is a drug not approved for use in the U.S. and Europe, but it is approved in India. Not only has it been approved but also the Karnataka government has spent 1/3rd of its drug budget on that. As has come out in the seminar, and through other experiences the medical profession has the most corrupt people.

"They are ready to be corrupted for a pen

or a beer. If they do not come with us, we will have to go against them and that will not be very honorable for the profession."

He appealed to health activists to take the people with them. He said that it was our job to help them express their voice, to give them the relevant information, perspective and strategy to combat what was going on.

Concluding words - The seminar ended on an upbeat mood. The discussion in the past two days had given everyone enough food for thought. The exchange of ideas and the opportunity for all the Jan Swasthya Abhiyan Activists to meet and catch up with each other seemed to have created an enthusiasm for the campaign. We hope that the range of issues discussed will help a campaign to emerge on the national agenda, and universal access to health care will not remain a utopian vision any longer. The Jan Swasthya Abhiyan has accepted the responsibility to follow up on all the ideas that were presented, and initiate the campaign. Let us all give the call -

Another World Is Possible!
Health For All Is Possible!!

Annexure I

Contents of the seminar

Day I- Session I
Legal and Constitutional Framework for Right to Health Care

Name of the speaker	Designation	Topic of Presentation
Abhay Shukla	Coordinator - SATHI Cell, CEHAT	Introduction and Conceptualizing the Right to Health Care
Colin Gonsalves	Advocate, Supreme Court and India Centre for Human Rights and Law, New Delhi	Legal Justification and Action to Enforce Right to Health Care
John Samuel	Director, National Center for Advocacy Studies, Pune	Constitutional Framework and Legislation for Right to Health Care in India and other countries
Srinath Reddy	Professor of Cardiology, AIIMS and Chairperson, Health Committee, National Human Rights Commission, New Delhi	Universal Access to Health Care as a Human Rights Issue and the role of NHRC
Jean Dreze	Professor of Economics, Delhi School of Economics, New Delhi	Lessons for 'Right to Health Care' Campaign from the PROBE Report

Session II
Relevant International Experiences towards Right to Health Care

Name of the speaker	Designation	Topic of Presentation
Sadhana Hall	Director, Global Partnerships Department, Global Health Council	Universal Access to Health Care and Right to Health Care in Canada, South Africa and Costa Rica
A.H.M. Nouman	Chairperson, PHM Bangladesh Circle, Dhaka, Bangladesh	Status of the Right to Health Care in Bangladesh

Day II- Session I

Operational and Financial Mechanisms to attain Right to Health Care

Name of the speaker	Designation	Topic of Presentation
Abhay Shukla	Coordinator, SATHI Cell, CEHAT	Summary of the earlier day's session and conceptualizing the day's theme
Ravi Duggal	Coordinator, Centre for Enquiry into Health and Allied Themes, Mumbai	Financial and Operational Framework For a System of Universal Health Care
H. Sudarshan	Chairman, Task Force on Health of Karnataka Government	Social Insurance as a Mechanism for Ensuring Access to Health Care
Brian Lobo	Advocate, and Activist of Kashtakari Sanghatana, Dahanu, Thane District	Enforcing the Right to Health Care, Linking Legal Provisions with Local Mechanisms for Implementation
Fr. Sebastian	Director, Catholic Health Association of India, Secunderabad	Role of the Voluntary Health Sector in Promoting Universal Access to Health Care

Session II

Campaign Strategy for Right to Health Care

Name of the speaker	Designation	Topic of Presentation
Sarojini	Convener, Medico Friend Circle and Member of SAMA, New Delhi	Women's Right to Accessible and Gender Sensitive Health Care
T. Sundaraman	Professor of Medicine, Jawaharlal Institute of Post Graduate Medical Education and Research, Pondicherry	Campaign Strategies for Right to Health Care and the Role of Jan Swasthya Abhiyan
Ravi Narayan	Advisor, Community Health Cell, Bangalore	Campaign Strategies for Right to Health Care and the Role of Jan Swasthya Abhiyan

Annexure 2

The Right to Health Care
Moving from idea to reality

- *Abhay Shukla,* **CEHAT**

"Should medicine ever fulfil its great ends, it must enter into the larger political and social life of our time; it must indicate the barriers which obstruct the normal completion of the life cycle and remove them. Should it ever come to pass, Medicine, whatever it may then be, will become the common good of all."

- Rudolf Virchow, c.1850

Background: Inequity in health and access to health care

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

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

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

- The richest quintile of the population, despite overall better health status, is *six times more likely* to access hospitalisation than the poorest quintile. This actually means that the poor are unable to afford and access hospitalisation in a large proportion of illness episodes, even when it is required
- The richest quintile have *three times higher level* of coverage for measles immunization compared to the poorest quintile. Similarly, a mother from the richest 20% of the

population is *3.6 times more likely* to receive antenatal care from a medically trained person, compared to a mother from the poorest 20%. The delivery of the richer mother is *over six times more likely* to be attended by a medically trained person than the delivery of the poor mother.

- As high of 82% of outpatient care is accessed from the private sector, met almost entirely by out-of-pocket expenses, which is again often unaffordable for the poor.
- About three-fourths of spending on health is made by households and only one-fourth by the government. This often pushes the already vulnerable poor into indebtedness, and in over 40% of hospitalisation episodes, the costs are met by either sale of assets or taking loans.
- The per capita public health expenditure in India is abysmally low, below $5 annually. India has one of the most privatized health systems in the world (only five countries on the globe are worse off in this respect), effectively denying the poor access to even basic health care.

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

One implication that emerges from the above discussion is that the problem of large-scale ill health in India should not be seen as primarily a technical-medical issue. The key requirement is not newer medical technologies, more sophisticated vaccines or diagnostic techniques. The fact that the prosperous sections of the population enjoy a reasonably good health status implies that *the technical means to achieve good health do broadly exist in our country today* (though there is definitely a need to better adapt these to our country's conditions and traditions, and certain improved techniques might help in specific contexts).

In fact, for the vast majority, the key barriers to good health are not the lack of technology but poverty and health system inequity. Poverty, a manifestation of social inequity, leads to large sections of the population being denied adequate nutrition, clean drinking water and sanitation, basic education, good quality housing and a healthy local environment, which are all prerequisites for health. At the same time, we have a ***highly inequitable health system*** which denies quality health care to all those who cannot afford it (the fact that even those who **can** afford it do not always get rational care is another important, but somewhat separate issue!). In this paper, which is primarily addressed to those working in the health sector, we will focus on the critical *health system* issues, with a rights-based approach. Let us see how we can view this entire situation from a rights based perspective.

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

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

framework where every person, including the most marginalized, is assured of basic health care and *can demand and access this as a right.*

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

Promoting the Right to underlying determinants of health

This involves working for the right to 'the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health' (WHO, 2002). Agencies engaged in the health sector cannot deal with most of these issues on their own, though they need to highlight the need for better services and conditions, and can advocate for improvements in these areas in a rights based framework. Organisations working in the health sector should support and ally with other agencies working directly in these areas, to help bring about relevant improvements.

Promoting the Right to Health Care

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

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

The justification for establishing the Right to Health Care

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

The constitutional and legal justification

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

> **47**. Duty of the state to raise the level of nutrition and the standard of living and to improve health:- The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties …

In an important judgement (*Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal and another, 1996),* the Supreme Court of India ruled that -

In a welfare state the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. … Article 21 imposes an obligation on the State to safeguard the right to life of every person. … The Government

hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. *Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in a violation of his right to life guaranteed under Article 21.* (emphasis added)

Similarly in the cases *Bandhua Mukti Morcha v. Union of India and others, 1982* concerning bonded workers, the Supreme Court gave orders interpreting Article 21 as mandating the right to medical facilities for the workers.

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

The social and economic justification

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

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

The human rights justification

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

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

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

Health Rights – people's response to Globalisation Liberalisation - Privatisation

The negative impact of Globalisation-Liberalisation-Privatisation policies on various

social sector services, especially since the early 1990s has been widely experienced. With the growing withdrawal of the state from the social sector and encouragement to the private medical sector, raising the issue of health rights has become extremely relevant today. The ongoing abdication of basic obligations by the Public Health system needs to be countered by a strong movement to establish Health rights. Only a determined effort to establish these rights can roll back the trend of weakening the Public health system, and can provide a framework for rejuvenation of this system with increased accountability.

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

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

Right to a set of basic public health services

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

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

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

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

In summary, the movement to establish the Right to Health Care aims to *substantially strengthen, reorient and make accountable the Public Health System*. The 'public' has to come back centre-stage in the Public Health System!

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

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

At the same time there is an urgent need for a comprehensive legislation to regulate qualification of doctors, required infrastructure, investigation and treatment procedures especially in the private medical sector. Standard guidelines for investigations, therapy and surgical decision making need to be adopted and followed, combined with legal restrictions on common medical malpractices. Maintaining complete patient records, notification of specific diseases and observing a ceiling on fees also needs to be observed by the private medical sector. The Govt. of Maharashtra is in the process of enacting a modified act to address many of these issues, and the National Health Policy 2002 stipulates the enactment of suitable regulations for regulation of minimum standards in the private medical sector in the entire country by the year 2003. This would include statutory guidelines for the conduct of clinical practice and delivery of medical services. There is a need to shape such social regulation of this large medical sector within the larger, integrated framework of Right to health care.

Right to essential drugs at affordable cost

Attaining this right would consist of two components:

1. Availability of certain basic medications free of cost through the public health system (see above)
2. A National Essential Drug Policy ensuring the production and availability of an entire range of essential drugs at affordable prices

The Union as well as state Governments need to publish comprehensive lists of essential drugs for their areas. A ceiling on the prices of these drugs must be decided and scrupulously adhered to, with production quotas and a strict ban on irrational combinations and unnecessary additives to these drugs.

Right to patient information and redressal

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

Superseding the CPA, a much more patient-friendly grievance redressal mechanism

needs to be made functional, with technical guidance and legal support being made available to all those who approach this system. This would provide an effective check on various forms of malpractice. In case the services mandated under this right are not given by a particular facility, the complainant need not take recourse to lengthy legal procedures. Rather, the grievance redressal mechanism with participation of consumer and community representatives should be empowered to take prompt, effective and exemplary action.

Right to monitoring and accountability mechanisms

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

Health rights related to various vulnerable sections of the population and in special situations

It is obvious that the establishment of any system of rights is relevant only if it benefits the most vulnerable or deprived sections of the population, and addresses the needs of people facing situations where their basic rights are likely to be denied. All the above types of provisions need to be implemented keeping in view some of the following key rights (an illustrative, not exhaustive list):

- Women's Right to Health Care, including provision of services related to both reproductive and non-reproductive health problems specific to women, and appropriate general health services for women;
- Children's Right to Health Care, with a focus on nutritional supplementation, control of infectious diseases in childhood and reduction in infant and child mortality;
- Health Rights of HIV-AIDS affected persons, including facilities for detection, counselling, non-discriminatory treatment and access to anti-retroviral drugs;
- Right to Mental health care, with a focus on strengthening primary mental health care, non-discriminatory quality treatment and community based rehabilitation systems;
- Right to Health Care for unorganised workers, who lack effective health care coverage and face a range of occupational hazards, with a clear liability on employers;
- Right to Health Care for urban deprived communities, including putting in place Urban primary health care systems and effective referral mechanisms;
- Health rights in conflict situations, where due to communal or other forms of violence persons from particular communities may be denied access to basic health services or may be discriminated against;
- Health rights of communities facing displacement or involuntary resettlement, depriving them of their customary environment and livelihood, and placing them in often hostile new surroundings which may include threats to health and poorer access to health care

This list may be further expanded to include the elderly, disabled persons, migrants and other categories of vulnerable people. Any system of health rights would need to explic-

itly address the special health needs of such groups, which would require provision of special services and forms of protection against discrimination.

Ways ahead – building a campaign on the Right to health care

Some of the possible areas of activity of a broad coalition like Jan Swasthya Abhiyan, which could develop a campaign on the issue of Right to Health Care, are suggested below.

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

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

Analysing international experience on the Right to Health Care

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

Cuba with a socialist constitution accords the right to health to its citizens, according it a status equivalent to civil and political rights.

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

Similarly, there has been an entire process of developing the concept of right to health and health care in the international human rights discourse. Various United Nations health rights instruments refer to health related rights. The UN International Covenant on Economic, Social and Cultural Rights (ICESCR), UN Convention on Rights of the Child (CRC) and the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) are some such significant conventions, in which India is a signatory.

Given this background, one of the critical tasks ahead of us is to make an in-depth study of these experiences and utilise this for developing the judicial form and implementation-related content of the Right to Health Care in the Indian situation.

Organizing regional public hearings on the Right to Health Care

One way of developing such a consensus and mobilising various social organisations is

to organise regional public hearings, on the issue of Right to Health Care. The NHRC could be a partner or 'mediator' for such public hearings, which could involve presentation of cases of Denial of health care. With the involvement of State Public health officials and policy makers in such hearings, the stage could be set for addressing the core issues, demanding accountability and putting in place monitoring mechanisms to ensure basic health rights.

Discussing detailed proposals to implement the Right to Health Care

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

Legal actions towards implementation of the Right to Health Care

Next, there is a need to take appropriate legal action to establish this basic right. Submitting a National petition on Right to Health Care to the National Human Rights Commission, with extensively documented cases of denial of health care could be a logical first step. Filing of specific PILs, focussed on key health rights may also be necessary to exert legal pressure and to provide leverage to the campaign. Political lobbying for passage of state level legislations, such as Public Health Acts, may be essential to actually establish legal entitlements, which can be activated by any ordinary citizen.

Making the Right to Health Care a Fundamental Constitutional Right

Finally, we need to move towards the medium-term objective of establishing Health Care as a Fundamental Right in the Indian Constitution. This would be a prolonged and challenging process, and would involve political mobilisation and influencing public and political opinion on a large scale, besides formulating an appropriate bill based on legal inputs. This would need to be complemented by State level legislations and effective strengthening of the Public health system. Putting in place effective monitoring mechanisms, and widespread public awareness about the entitlements would be essential for this right to become operational in any meaningful form. One conception of the minimum content of the fundamental right to health care is outlined in the accompanying box.

Proposed minimum content of the fundamental right to health care

1. *Making the right to health care a legally enforceable entitlement by legal enactment*
2. *A national health policy with a detailed plan and timetable for realization of the core right to health care*
3. *Developing essential public health infrastructure required for health care; investing sufficient resources in health and allocating these funds in a cost-effective and fair manner*
4. *Providing basic health services to all communities and persons; focusing on equity so as to improve the health status of poor and neglected communities and regions*
5. *Adopting a comprehensive strategy based*

on a gender perspective so as to overcome inequalities in women's access to health facilities

6. *Adopting measures to identify, monitor, control and prevent the transmission of major epidemic and endemic diseases*
7. *Making reproductive health and family planning information and services available to all persons and couples without any form of coercion*
8. *Implementing an essential drug policy*

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

While the course and outcome of all our efforts would depend on the much larger political environment, the slogans of 'Right to Health' and 'Right to Health Care' should continue to be the rallying-cry on our banner. Whether we are confronting the State or are trying to envisage models for the future and shape people's counter-hegemony, the vision of the Right to Health and Health Care should form one of the components of our dream for a more just and humane society.

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

Suggesting a system for Universal access to health care

While trying to achieve these specific rights in the first phase, our overall goal should be to move towards a system where every citizen has assured access to basic health care, irrespective of capacity to pay. A number of countries in the world have made provisions in this direction, ranging from the Canadian system of Universal health care and NHS in Britain to the Cuban system of health care for every citizen. In the Indian context, while the right to health care needs to be enshrined in the Constitution as a fundamental right, there is a need to develop a complementary system of Universal access to health care.

The existing massive private medical sector in India, which commands over three fourths of the doctors and provides a similar proportion of outpatient care, needs to be addressed and tackled in any system to provide Universal health care coverage. One possible scenario to make this right functional could be a system of Universal social health insurance. The services could be given by a combination of a significantly strengthened and community-monitored public health system, along with some publicly regulated and financed private providers, under a single umbrella. The entire system would be based on public financing and cross-subsidy, with free services to the majority population of rural and urban working people including vulnerable sections, and affordable premium amounts (which could be integrated with the taxation system) for higher income groups.

One key aspect would be that this should be a ***Universal system (not targeted)***, which would ensure coverage of the entire population and also retain a strong internal demand for good quality services. (Of course, certain very affluent sections may choose to pay their share of taxation / premium and yet opt out and access private providers.) Another issue is that there should be ***no fees*** *or nominal fees at the time of actual giving of services.* Finally, the patient should be assured of a range of services with minimum standards, whether given from the public health system or publicly financed and regulated private providers. The entire

system could be managed in a decentralised manner, with consumer's monitoring of quality and accessibility of services.

This entire model would of course imply a *significantly higher public expenditure on health services*. However, with decentralised management and a focus on rational therapy, it has been estimated that it should be possible to organise the most basic elements of such a system by devoting about 3% of the GNP towards public health care to start with. This should then be progressively raised to the level of *5% of GNP spent on Public health to give a full range of services to all*. This level of funds could be partly raised by appropriate taxation of unhealthy industries, reallocations within the health sector (including reorganising existing schemes like ESI) and ending all subsidisation of the private medical sector. This of course needs to be combined with changed budgetary priorities and higher overall allocation for the health sector. Incidentally, the new National Health Policy claims on paper the intention to more than double the financial allocation for the public health system and bring it to the level of 2% of the GDP, and to increase utilisation of public health facilities to above 75% by the end of this decade. This admirable yet vague intention needs to be converted into concrete action by means of strong and sustained pressure from various sections of civil society, coupled with concrete proposals to functionalise universal access to health care.

In this context, ensuring the Right to Health Care for all is not an unrealistic scenario, but has become an imperative for a nation, which as the 'world's largest democracy' claims to accord certain basic rights to its citizens, including the right to life in its broadest sense.

Annexure 3

Legal Position Paper On Right to Health Care (Part -I)

It is a well-accepted fact that majority of the people in the world today are living at appallingly low levels of nutrition and health. Health and nutrition are becoming issues that non-governmental agencies are increasingly being asked to tackle during the course of their work. Governmental agencies are spending lesser amounts on public health care, leading to a situation where the populations are accessing private health care services, which can be unaffordable.

A person's health is related to several other aspects of her/ his life, and good health becomes a pre condition to the enjoyment of other rights as well as the individual participation in social, political, economic life. A World Health Organization Report on Health and Economics from 1989, states that, globally government spending on health averaged less than 10 dollars per person per year. Most developing countries have large populations that live in endemic poverty. Health care systems in these countries do not serve these populations. Infrastructure investment in health is not a priority spending area for governments.

There are many factors that influence health and are integral to it. These include access to nutritious food, clean environments-air and water, source of livelihood that is constant, etc.

In this context it becomes imperative to closely examine what the burden of the State in providing health care is and to make the right to health care a fundamental right to act as a pressure on the State to provide quality health care services.

The concept of the State being responsible to provide health care facilities has its origins in the Charter of the United Nations and has been held in several individual constitutions.

United Nations Charter hold that "…the United Nations shall promote

a. higher standards of living, full employment, and conditions of economic and social progress and development; and

b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; …"[1]

Article 25 further outlines the protection of health and also details the protection of health of vulnerable populations, such as women and children.

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.

(2) 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"[2]

The World Health Organisation, in its Con-

[1] Universal Declaration of Human Rights Articles 23 (1)

[2] ibid, Article 25

stitution, states clearly, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[3]

However it is only in the International Covenant on Economic, Social and Cultural Rights that one explicitly sees that health is recognized as a fundamental right of every human being.

International Covenant on Economic, Social and Cultural Rights:[4]

Article 7 (b)

" Safe and healthy working conditions;"

Article 10 (2)

" Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits."

Article 11 (1)

"…recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions…"

Article 12

"1. …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 still-birth-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."

This is the most comprehensive and direct statement on the right to health at the international level. Article 12 (2) outlines the specific goals that must be attained with regard to the enforcement of this right.

Several countries, in their constitutions, have held the right to health in varying degrees. Perhaps the most comprehensive of these is the South African Constitution that takes into account several rights that are necessary for healthy living apart from access to health care services. It also clearly states the right to access reproductive health care.

Chapter 2, The Bill of Rights in the South African Constitution states as follows-

"Section 24 Environment

Everyone has the right -

(a) to an environment that is not harmful to their health or well-

being; and…

Section 27 Health care, food, water and social security

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[3] Constitution of the World Health Organization, opened for signature July 22, 1946

[4] International Covenant on Economic, Social and Cultural Rights

Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966; entry into force3 January 1976, in accordance with article 27

(1) Everyone has the right to have access to -

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

(3) No one may be refused emergency medical treatment"[5]

Similarly, the Constitution of Uzbekistan holds the right of citizens to skilled medical care, social security in the case of old age and disability. It also guarantees the access to skilled medical care.

{In Force since: 7 Feb 1997}

Constitution of the Socialist Republic of Vietnam:

Chapter V: Fundamental Rights and Duties of the Citizen

Article 61

"The citizen is entitled to a regime of health protection.

The State shall establish a system of hospital fees, together with one of exemption from and reduction of such fees.

The citizen has the duty to observe all regulations on disease prevention and public hygiene…"

Constitution of Mongolia

Chapter Two: Human Rights and Freedoms Article 16 "2) the right to healthy and safe environment, and to be protected against environmental pollution and ecological imbalance.

5) The right to material and financial assistance in old age, disability, childbirth and childcare and in other cases as provided by law.

6) The right to the protection of health and medical care. The procedure and conditions of free medical aid shall be determined by law."[1]

[5] Constitution of the Republic of South Africa Adopted on: 8 May 1996}{Amended on: 11 Oct 1996}

Legal Position Paper On Right to Health Care (Part - II)

The Constitution of India also has provisions regarding the right to health. They are outlined the Directive Principles of State Policy- Articles 42 and 47, outlined in Chapter IV, and are therefore non-justiciable.

Article 42

"**Provision for just and humane conditions of work and maternity relief**- The State shall make provision for securing just and humane conditions of work and for maternity relief"

Article 47

"**Duty of the State to raise the level of nutrition and the standard of living and to improve public health-** The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health"[1]

The above articles act as guidelines that the State must pursue towards achieving certain standards of living for its citizens'. It also shows clearly the understanding of the State that nutrition, conditions of work and maternity benefit are integral to health.

Although the DPSP quoted above are a compelling argument for the right to health, this alone is not a guarantee. There must be a clearly defined right to health so that individuals can have this right enforced and violations can be redressed.

The Indian judiciary has interpreted the right to health in many ways, through public interest litigation as well as litigation arising out of claims that individuals have made on the State, with respect to health services etc. As a result there is substantial case law in India, which shows the gamut of issues that are related to health.

The Fundamental Right to Life, as stated in Article 21 of the Indian Constitution, guaranties to the individual her/his life which or personal liberty except by a procedure established by law. The Supreme Court has widely interpreted this fundamental right and has included in Article 21 the right to live with dignity and "all the necessities of life such as adequate nutrition, clothing….". It has also held that act which affects the dignity of an individual will also violate her/his right to life.[2]. Similarly in Bandhua Mukti Morcha Vs Union of India, the Supreme Court has held that the Right to life includes the right to live with dignity.

The recognition that the right to health is essential for human existence and is, therefore, an integral part of the Right to Life, is laid out clearly in Consumer Education and Resource Centre Vs Union of India[3]. It also held in the same judgment that humane working conditions and health services and medical care are an essential part of Article 21.

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1 Part IV, Constitution of India adopted on 26th November 1949

2 Mullin Vs Union Territory of Delhi

3 AIR 1995 SC 636

Further in State of Punjab and Others v. Mohinder Singh[4] "**It is now a settled law that right to health is integral to right to life. Government has a constitutional obligation to provide health facilities."** Apart from recognizing the fundamental right to health as an integral part of the Right to Life, there is sufficient case law both from the Supreme and High Courts that lays down the obligation of the State to provide medical health services.

This has been explicitly held with regard to the provision of emergency medical treatment in Parmanand Katara Vs Union of India [5]. It was held that "**Every doctor whether at a government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life".**

The issue of adequacy of medical health services was also addressed in Paschim Baga Khet Mazoor Samiti Vs State of West Bengal.[6] 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.** Therefore, the failure of a government run health centre to provide timely treatment, is violative of a person's right to life. Further, the Court ordered that Primary health care centres be equipped to deal with medical emergencies. It has also been held in this judgement that the lack of financial resources cannot be a reason for the State to shy away from its constitutional obligation.

In Mahendra Pratap Singh v. State of Orissa[7], 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 also stated that, " great achievements and accomplishments in life are possible if one is permitted to lead an acceptably healthy life". **Thereby, there is an implication that the enforcing of the right to life is a duty of the state and that this duty covers the providing of right to primary health care.** This would then imply that the right to life includes the right to primary health care.

The instrument of Public Interest Litigation used by Common Cause,[8] addresses the issue of the working of commercial blood banks. The court while recognizing that blood donation is considered as a great life saving service to humanity, recognized that it must

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4 AIR 1997 SC 1225
5 AIR 1989 SC 2039
6 AIR 1996 SC 2426
7 AIR 1997 Ori 37
8 AIR 1996 SC 83

be ensured that the blood that is available with the blood banks is healthy and free from infection. The Supreme Court in this case laid down a system of licensing of blood banks. **It may be inferred from the above reasoning that the State is entrusted with the responsibility in matters of health, to ensure efficient functioning all centres relating to health care.**

More recently the Supreme Court has addressed the epidemic of HIV/ AIDS. In a case where the court had to decide whether an HIV positive man should disclose his condition to the woman he was to marry, the court has held that "the woman's right to good health to precedence over the man's right to privacy".[9] It found that the hospital did not err in disclosing his status to his fiancé. In MX VS ZY[10], the Bombay High Court found that if a person were fired from his employment solely because of his HIV positive condition, it would be condemning a person to "certain economic death".

While the provision of health services is essential to ensure good health, there are several others factors that influence a person's health. The Supreme Court has recognized this in a number of ways. This was first addressed in Bandhua Mukti Morcha V Union of India,[11] a case concerning the living and working conditions of stone quarry workers and whether these conditions deprived them of their right to life. The court held that humane working conditions are essential to the pursuit of the right life. It lay down that workers should be provided with medical facilities, clean drinking water and sanitation facilities so that they may live with human dignity.

In Citizens and Inhabitants of Municipal Ward v. Municipal Corporation**,** Gwalior the court deliberated on the question- Is the State machinery bound to assure adequate conditions necessary for health? The case involved the maintaining of sanitation and drainage facilities by municipal corporartions. It was held that t**he State and its machineries (in the instant case, the Muncipal Corporation) are bound to assure hygienic conditions of living and therefore, health.**

The Karnataka High Court has deliberated on the right of an individual to have access to drinking water. In Puttappa Honnappa Talavar v. Deputy Commissioner, Dharwad [12], the High Court has held that the right to dig bore wells therefore can be restricted or regulated only by an Act of legislature and that the right to life includes the right to have access to clean drinking water.

The High Court of Rajasthan has held that stray animals in urban areas pose a danger to people and also cause nuisance to the public.[13] The question before the court was, does the negligence of restraining the number of these animals violate Art 21 of the public at large? The court found that stray animals on the road interfere with transportation, polluted the city and therefore posed a health risk to people. It was held that **public nuisance caused by these stray animals was a violation of Art. 21,** of the public at large.

With regard to maintaining a clean environment, which is critical to a person's health, there are many questions that Courts have deliberated on. For example in Municipal Council, Ratnam v Shri Vardichan [14], where the

[9] AIR 1999 SC 495
[10] MX v. ZY, A.I.R. 1997 Bom. 406
[11] A.I.R. 1984 S.C. 802, 808
[12] AIR 1998 Kar 10
[13] Sanjay Phophaliya v. State of Rajasthan, AIR 1998 Raj 96
[14] 1980 (4) SCC 162

Court had been called upon to decide whether municipalities are obligated to maintain certain conditions to ensure public health. It was held by the court that a public body constituted for the principal statutory duty of ensuring sanitation and health is not entitled to immunity on breach of this duty. Further, "pollutants being discharged by big factories… are a challenge to the social justice component of the rule of law".

Also in Santosh Kumar Gupta v Secretary, Ministry of Environment, New Delhi[15], contended that the policy, controls/regulations and their implementations are inadequate thereby causing health hazards. In its judgments, the High Court of Madhya Pradesh has laid down that pollution from cars poses a health hazard to people and that the State must ensure that emission standards are implemented maintained.

In the land mark MC Mehta v Union of India[16], the Supreme Court has held that environmental pollution causes several health hazards, and therefore violates right to life. Specifically, the case dealt with the pollution discharged by industries into the Ganges. It was held that victims, affected by the pollution caused, were liable to be compensated.

There is sufficient case law on the issue of health in State run institutions such as remand homes for children and "care homes". In Sheela Barse v Union of India and Another [17], a case pertaining to the admitting of non-criminal mentally ill persons to prisons in West Bengal, the Supreme Court has held that "(1) Admission of non-criminal mentally ill persons to jails is illegal and unconstitutional…. The Judicial Magistrate will, upon a mentally ill person being produced, have him or her examined by a Mental Health Professional/ Psychiatrist and if advised by such MHP/Psychiatrist send the mentally ill person to the nearest place of treatment and care." It has further directed the state to improve mental health institutions and integrate mental health into primary health care, among others.

Further in Sheela Barse v Union of India and others[18], the Supreme Court has entrusted to High Courts the duty to monitor the conditions of "mentally ill and insane" women and children in prisons and pass appropriate orders from time to time.

In the most recent case involving the death of 25 inmates of a mental health institution in Erawadi, Ramnathapuram District[19] as they were chained to poles or beds and could not escape from a fire that broke out, the Supreme Court has directed the state to implement the provisions of the mental health act as well s undertake a survey of all institutions that provide mental health facilities and ensure that they are maintaining standards of care.

From the above discussion of cases it is evident that the judiciary has clearly read into Article 21, Right to Life, the right to health. It in fact has gone deeper into the meaning of health and has substantiated the meaning of the right to life.

The question that must be discussed more thoroughly is whether an amendment to the Constitution, which will state the fundamental right to health, is desirable. Enumerated rights have an edge over wider interpretations

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[15] AIR 1998 MP 43
[16] A.I.R. 1987 S.C. 1086
[17] 1993-(004)-SCC -0204 -SC
[18] 1995-(005)-SCC -0654 -SC
[19] 2002-(003)-SCC -0031 -SC

of existing rights, as States can be held accountable for violations. However, with the extensive case law that is available is it not possible to use what is available to ensure that health care, facilities and condition ensuring health are fundamental rights of every citizen? If the case law reflects the ability of the courts to read the meaning of 'health' in very wide sense (everything from the responsibility of the municipal corporation to provide sanitation facilities down to access to emergency medical treatment has been interpreted in the right to health) then why not use the instrument of case law to confer rights? It is this question that must be examine in the light of the recent amendment guaranteeing primary education for all. The process that led up to the amendment must be looked at critically as well as how its implementation is currently taking place.

Also, closely associated with health are the issues of nutrition and clean drinking water, which must be available through out the year. The judiciary has read into Article21, the right to food. These are complementary rights, the guaranteeing of the right to health, will have no meaning without the others.

Any amendment guaranteeing the right to health should have a focus on primary health care, which is preventive and curative. It should also have specific focus on the health of women- more specifically reproductive health, children, and the disabled- both physically and mentally.

Keeping this in mind there must be more detailed examination of an amendment to the Constitution, guaranteeing the right to health.

Annexure 4

Canadian Health Care
The Universal Model Evolving

Greg Connolly, **Global Health Council**

For over thirty years Canada has taken pride in its universal health care program, Medicare. This experiment in health care systems is founded on the principal that every citizen should have equal access to high quality health care. But what was the nation's pride has become nation's most controversial program. Skyrocketing costs and plummeting satisfaction levels forecast a dire future for Canadian Medicare. Public consensus calls for fundamental changes to the system. An eighteen-month study ending in Roy Romanow's report, *Building on Values: The Future of Health Care in Canada*, attempts to answer the calls for reform by making a comprehensive series of suggestions for the renewal of the Medicare system. A group of medical economists are advising that Canada should introduce a Catastrophe Insurance/Medical Savings Account model into the health care system. This dynamic time in the Canadian health care system is yielding important lessons for the other nations of the world, who for many years have looked to the Canadian model for health care.

The Canadian Medicare System

"Our proudest achievement in the well-being of Canadians has been in asserting that illness is burden enough in itself. Financial ruin must not compound it. That is why Medicare has been called a sacred trust and we must not allow that trust to be betrayed."

- Canadian Justice Emmett Hall

In Canada, health is viewed as a human right. Using this philosophy as their guide, the Canadian government has developed a socialized health care system that evolved from a small experiment in Saskatchewan in the 30's and 40's, to the current Medicare system.[1] This system provides almost 32 million people spread out over 10 million square kilometers with equal access to government-funded health services.[2]

The policy of a universal health care system was solidified in the 1960's with the passage of two key acts. "The Hospital Insurance and Diagnostic Services Act (1957)" and the "Medical Care Act (1968)" dictated the terms for the Medicare system. However, due to low compensation and a lack of incentives, medical service providers, such as doctors and nurses, manipulated loopholes in the legislation to increase their salaries. Some providers introduced extra-billing, which was the direct charging of extra fees to patients for insured services. User charges were another exploitation of the system. These were fees charged to the patients, which were not covered by insurance. For example, a patient could have been charged a user fee before being given access to care by a doctor. The problems of extra-billing and user charges were addressed by the "Canada Health Act (1984)." This legislation penalized such behaviors by allowing the national government to withhold payments to provincial health departments equal to the

[1] Blouin, Chantal. "Canadians' Health Care Concerns Cannot Stop at Our Borders." The North-South Institute. http://www.straightgoods.ca/ViewFeature.cfm?REF=724. Nov. 10, 02.

[2] IDB Summary Demographic Data for Canada. http://devdata.worldbank.org/external dgprofile.asp?RMDK=82656&SMDK=1&W=0.

amounts predicted that were charged in extra billing and user charges. Once the providers paid the provincial health ministers back the extra charges, then the Government would release the withheld funds. This alleviated the problems of extra-billing and user-fees.

The hierarchy of the Canadian Medicare System cascades as such: House and Senate, Governor in Council, Minister of Health, Provincial Health Ministers, Provincial Health Insurance Nonprofit, Provider, Consumer. As a means of understanding this mechanism, consider the following profile:

Philip Brodeur, of Quebec, breaks his arm. He reports to the ER, which, unfortunately is crowded. Eventually he is treated, his paperwork is filed, and he goes home. His paperwork is then processed by the hospital, and sent to the public provincial nonprofit health insurance agency, called the Ministere de la Sante et des Services Sociaux (Ministry of Health and Social Services). The insurance agency then sends a payment to the doctor, and a payment to the hospital. The amount payable to the doctor is based on the service provided, and the hospital is reimbursed for the materials used. At the end of the year, the public insurance agency reports the annual provincial health costs to the national Ministry of Health. The Ministry of Health then sponsors an audit of the provincial health insurance nonprofit. If all information reported is accurate, then the Minister of Health, under the authority of the Governor in Council, reimburses the provincial health nonprofit for all of the publicly insured health care expenses incurred in the province that year. The Governor in Council then reports the national annual spending on health care to the House of Parliament and the Senate, which determines the national budget for the Medicare system and the tax rate for health care. The system's greatest achievement is that Philip LaFayette would have ideally received the same high level of medical care if he were a businessman in Toronto, or a commercial fisherman in British Columbia.

The treatment of health care as a basic right is responsible for the high standard of health in Canada, as shown by the following indicators from 1999: The life expectancy at birth was 78.2 years; the fertility rate was 1.6 births per woman, the infant mortality rate was 6.1 per 1,000 live births, and there was negligible malnutrition for children under 5 years.[3] But despite these signs of a healthy population, the health care system is ailing.

Challenges to the Medicare System

"The fundamental flaw of the [Canadian] Medicare system is that patients bear no direct costs for the medical services they receive."

– David Gratzer

The state of the Canadian Medicare system has become the nation's foremost political issue. Despite the successes of the system complaints, flaws, and suggestions are procuring the most attention. The system is founded on humanistic principals, but is plagued by a flaw of human nature: in a free-care system, there is virtually no personal accountability.

The increasing level of national dissatisfaction in the Canadian Medicare system is alarming to health care professionals and policy makers. In 2001, only one in five Canadians thought the Medicare system was working well. In 1998, 80% of Canadians thought the system needed at least fundamental changes; and three years later, 18% believed

[3] IDB Summary Demographic Data for Canada.http://devdata.worldbank.org/externaldgprofile.asp?RMDK=82656&SMDK=1&W=0.

the system required complete rebuilding. Also in 2001, 26% of Canadians claimed that their access to health care had deteriorated over the previous two years.[4]

The primary cause for dissatisfaction is the pattern of extensive queuing in the health care system. Long waits for medical attention result from overuse of the health care system. Consider the following queuing estimates to see the source of dissatisfaction:

"It takes nearly 25 weeks to get an appointment with an ophthalmologist in Canada, almost 21 weeks to receive orthopedic care, more than 18 weeks to get a heart by-pass, over 16 weeks to see a neurosurgeon, and nearly 12 weeks for a gynecological exam."[5]

Another source of dissatisfaction is the apparent breach of one of the Canada Health Act's five principals; universality. Studies have shown the existence of class disparities in the provision of health care in Canada. One study, conducted by the Commonwealth Foundation in 2001, found that 23% of Canadians with below national average income thought the health care system needed to be rebuilt, whereas only 13% of those with above national average income thought the system needed to be rebuilt.[6] Likewise, 47% of those earning under $25,000 wanted a private health insurance option for Medicare, whereas only 39% of those earning over $75,000 wanted such an option.[7] These results show that the lower socioeconomic groups are not as satisfied with their access to services as are the upper socioeconomic groups. The lower classes reported more difficulty accessing insured care; especially off-hours and specialty care. This could possibly be attributed to the upper class members' greater abilities to advocate for themselves.[8] The lower classes also had trouble obtaining uninsured elective health services, such as dental, optometry, medical equipment, and prescription drug services because they would have to pay for these services from their own funds. Many in the upper classes now have private insurance to cover these expenses, but the poor usually cannot afford supplemental insurance.[9]

The cost of health care is climbing rapidly, not only for consumers, but also for the entire system. The national cost of health care in 1998 was 55.6 billion dollars, which is 6.32% of the Gross Domestic Product.[10] This is a smaller fraction of the GDP than the US system spends on their health care system; however, the Canadian system has hidden costs, such as the loss of productivity due to queuing.[11] A study by Foot and Stoffman found that, "Canada's health spending nearly doubled between the mid-1980's and mid-1990's, but there was no evidence that people

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[4] Blendon, Robert, et. Al. "Canadian Adults' Health Care System Views and Experiences, 2001." http://www.cmwf.org/programs/international/can_sb_552.pdf. The Commonwealth Fund. New York, NY: 2001.

[5] Weber, Joseph. "Canada's Health Care System Isn't a Model Anymore." *Business Week.* August 31, 1998.

[6] Blendon, Robert, et. Al. "Canadian Adults' Health Care System Views and Experiences, 2001." http://www.cmwf.org/programs/international/can_sb_552.pdf. The Commonwealth Fund. New York, NY: 2001.

[7] Crowley, Brian Lee, et. Al. "Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System." *Atlantic Institute for Market Studies*.

[8] Crowley, Brian Lee, et. Al. "Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System." *Atlantic Institute for Market Studies*.

[9] Blendon, Robert, et. Al. "Canadian Adults' Health Care System Views and Experiences, 2001." http://www.cmwf.org/programs/international/can_sb_552.pdf. The Commonwealth Fund. New York, NY: 2001.

[10] Crowley, Brian Lee, et. Al. "Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System." *Atlantic Institute for Market Studies*.

[11] Danzon, Patricia, M. "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" *Health Affairs*. Spring 1992.

were healthier as a result."[12] These findings imply that the extra spending has gone to ineffective administration of the system. In individual provinces, where most of the administering is done, 30% of the annual provincial budgets are portioned to health care. Unfortunately, these discouraging figures are on the early slope of a gathering wave.

Canada's birth rate is low, and its mortality rate is also low. This recipe will yield a glut of seniors when the baby-boomers reach those years, accompanied by a small work force to support them. By 2030 the population of seniors will be equivalent to 40% of the working population, which must cover their health costs. Canadians over 65 currently use about half of all health care expenditures.[13] Foot and Stoffman observe:

"By the time you are in your late 70s, you will use hospitals five times more than your life-time average rate of use. If you survive until your late 80's, you will use hospitals 12 times more than your lifetime average."[14]

The amount of usage of the health care system is exactly the problem. There is not one group in the system to blame; they all contribute to its inefficiency. Beginning with the first-tier of the system, we can see that consumers are overconsuming. In a free-care system, expense is not a consideration; only convenience matters. For example, when given the option to receive immediate attention in the ER, or wait for a less expensive appointment with a physician, the tendency is to choose the ER because it is more convenient. "In 1997, the Regina Health District found that from 43-49% of the ER patients in its three hospitals were nonurgent cases."[15] In the 1973 *New England Journal of Medicine* article, "Distribution," by Enterline et al., it was found that before Medicare, patients called their doctors for free consultation on minor problems, but immediately after Medicare was introduced, phone calls dropped, and personal free visits increased by the same percentage. In another *New England Journal of Medicine* article titled, "Effects," also by Enterline, et al., it was found that physicians in Quebec believed that since the introduction of Medicare, frivolous patient complaints rose by 75%.[16] Also in Quebec, in the first two years after Medicare was introduced, the amount of time physicians spent with each patient dropped by 16%, and the number of patients seen per day increased by 32%.[17] This shows that the number of patients increased dramatically, but also, doctors' behaviors changed.

In the Medicare system, doctors are paid on a fee-for-service basis. Due to the high national cost of health care, each service is assigned a relatively low rate of compensation. Low compensation, and overwhelming demand for services, are disincentives for providers. As a result, there are few Canadian medical students; and of the ones who become doctors, many leave Canada for the greener pastures of the American health care system. Canadian doctors have one primary way to raise their incomes; raise the number of patients they see.

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[12] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[13] Crowley, Brian Lee, et. Al. "Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System." *Atlantic Institute for Market Studies*.

[14] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[15] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[16] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[17] Danzon, Patricia, M. "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" *Health Affairs*. Spring 1992.

A major trend in physician overprovision is requiring multiple patient visits, when fewer visits would suffice. Not only is the doctor/patient relationship strained by the shorter, incomplete visits, but also the patient is removed from the work force and made to suffer from his or her ailments longer by having to make multiple visits. Here is an example of overprovision:

"In Ontario, it was reported that over 200 family physicians had billed the government for more than $400,000 each in 1994-95 (Bohuslawsky, "Patient Overdose"). These high-billing doctors had pushed through an average of 67 patients a day, or one every eight minutes."[18]

The RAND Health Insurance Experiment, conducted on 2,000 families in the U.S., between 1974-1982 tested for overprovision as a result of health systems. One group of patients with free-care coverage paid on a fee-for-service basis, like the Canadian model. The other group of patients with free-care coverage had HMO plans, in which the providers got paid a capitated (flat) fee. Expenditures in the fee-for-service group were 28% higher, and hospital admissions and days spent in the hospital were 40% higher than for the HMO coverage group.[19] The only difference was that doctors had an incentive to overprovide for the fee-for-service group. A more disquieting version of this experiment was conducted by Blomqvist. He found that in California, when surgeons were paid on a fee-for-service basis, the number of hysterectomies (removal of the uterus) was five times higher than when surgeons were paid a flat salary.[20] Although these experiments were conducted outside of Canada, and now have some years behind them, they still reveal the negative trends of overprovision, which are applicable to the Canadian system.

Overprovision and overconsumption are manifestations of a system that needs fixing. Hospital administrators, and politicians are also responsible for the problems in Canadian health care. Hospital expenses account for 40% of provincial health costs. For this reason, hospital reform has been the focus of health officials for almost a decade.[21] Other attempted repairs such as reducing medical payments, and limiting the time doctors can spend performing surgery, have come up short.[22] Politicians tend to point out obvious faults, and pour money into fixing them. This looks good to the public, whereas addressing the messy roots of problems looks bad. Perhaps this is partly responsible for why attempted solutions are treating the symptoms, and not the system.

Reform

In April 2001, the Canadian Prime Minister appointed former Saskatchewan Premier Roy Romanow to head a Commission on the Future of Health Care in Canada. The ensuing 18 month, $10 million investigation, which gathered information and public input from tens of thousands of Canadians, culminated on November 28, 2002 with the release of Romanow's final report, *Building on Values: The Future of Health Care in Canada.*

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[18] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[19] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[20] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[21] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[22] Weber, Joseph. "Canada's Health Care System Isn't a Model Anymore." *Business Week.* August 31, 1998.

The question addressed was the almost frantic question reverberating throughout Canada, "What shall we do to sustain our health care system?" The most striking recommendation that Romanow made was a drastic input of national funds into the Canadian Medicare system. The report was a profound message that Canada should not regress from the accomplishments of the Medicare system toward a hybrid privatized system; Canada should commit to restoring its national health care system to meet the ideals that it set out to achieve many years ago.

Romanow's report makes the recommendations that he feels Canadians would agree with for restoring the medicare system.[23] Each recommendation is thoroughly explained, given a timeline, and given an estimated cost. But it is the cost that has alarmed Canadians. Romanow recommends that the government cover a minimum of 25% of the cost of insured health services by 2005/2006 and it should sustain this funding floor in the future. In addition to this, Romanow has called for an initial surge of funds to get Canada back on a track for sustainability. The additional funding should be above forecasted federal funding by $3.5 billion in 2003/2004, $5 billion in 2004/2005, and $6.5 billion in 2005/2006, which is a surge of $15 billion.[24] In his statement to the nation about his final report, he emphasizes this passage:

"But I want to make one thing absolutely clear. The new money that I propose investing in health care is to stabilize the system over the short-term, and to buy enduring change over the long-term. I cannot say often enough: that the status quo IS NOT AN OPTION! If the only result of these past 18 months of collective effort by Canadians is simply more dollars for health care, our time will have been wasted."[25]

These renewal funds will go to the following five new programs to regenerate the sustainability of the Medicare system:

- *A Rural and Remote Access Fund ($1.5B total over 2 years):* to improve timely access to care in rural and remote areas.
- *A Diagnostic Services Fund ($1.5B total over 2 years):* to improve wait times for diagnostic services.
- *A Primary Health Care Transfer ($2.5B over 2 years):* to support efforts to remove obstacles to renewing primary care delivery.
- *A Home Care Transfer ($2B over 2 years): to provide a foundation for an eventual national homecare strategy.*
- *A Catastrophic Drug Transfer ($1B beginning in FY 2004/5):* to protect Canadians in instances where they require expensive drug therapies to remain healthy.[26]

Romanow expands on some of these recommendations in his speech. He makes several recommendations for improving access and quality of care. One suggestion is an improved data collection system to help provinces collect health outcomes information, and to report regularly to other provinces so that the nation acts together to improve. A

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[23] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

[24] "Romanow Report Proposes Sweeping Changes to Medicare." Commission on the Future of Health Care in Canada. http://finalreport.healthcarecommission.ca.

[25] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

[26] "Romanow Report Proposes Sweeping Changes to Medicare." Commission on the Future of Health Care in Canada. http://finalreport.healthcarecommission.ca.

national personal electronic health record will improve efficiency, accuracy, and security in keeping patient records. A coordinated wait list management system between health care centers will provide more reliable wait time estimates and reduce wait times. Attention to long-term human resources strategies will attune administrators to the evolving needs of supply and demand in the health sector.[27]

To address the challenges posed by the rapidly advancing pharmaceutical industry and rising drug costs, Romanow makes three suggestions: There should be a catastrophic drug transfer to help provinces provide funding for prescriptions in cases where drugs become crucial to a consumer's health. Currently many Canadians have no drug coverage, and the majority of those without coverage are poor. The establishment of a national drug agency could monitor the pharmaceutical industry to improve costs, safety, and knowledge about drugs. And the drug patent legislation should be refined to allow for purchasing of generic versions of drugs immediately after new drug patents run out.[28]

One of the thematic grievances about modernized health systems is the loss of home care services. In Canada, where doctors are paid on a fee-for-service basis, home care is especially neglected. But research has found the obvious, that home care is very valuable to improving health for many people. In parti-cular, home mental health care, post-acute home care, and palliative home care demand attention. Romanow suggests the establishment of a national home care system.[29] This will become increasingly important as the population ages.

Romanow makes many smaller recommendations; forty-seven of them in total. In addition to recommendations, he issues observations, warnings and requests, which make his final report an approachable, sensible, and sensitive document. He warns politicians that inter-provincial bickering over health care is deleterious and he requests cooperation. This request has already been denied, especially by Quebec. Quebec traditionally prefers to be more autonomous than other provinces, and is upset by the centrality of Romanow's recommendations. The province would very much like the extra funding Romanow proposes, but would like it with no strings attached so that it can use the funds in its own way. Alberta is also unhappy with Romanow's request that all provinces report the precise usage of its federal funds.[30] These provinces feel that they can better attend to its peoples' health care needs with less patriarchal central monitoring.

Another warning that Romanow issues is that if Canada does not renew the sustainability of Medicare, then the system will succumb to the privatized sector. He states:

"The grave risk we will face is pressure for access to private, parallel services – one set of services for the well off, another for those who are not. Canadians do not want this."[31]

Romanow holds strongly to the ideals of

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[27] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

[28] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

[29] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

[30] "Health minister promises help on national reform." The Burlington Free Press. Wire Reports. Dec. 8, 2002. Pg. 4B.

[31] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

the Canadian system; universality, equity, and quality. His commission's nationally engaging, comprehensive, transparently presented investigation, and its clearly written, persuasive final report present to Canadians what is nearly the most accessible evaluation of the medicare system possible. While there have been many other suggestions for improving the Canadian health care system, Romanow's recommendations seem to construct a track toward sustainability.

Implications

At the end of his statement to the nation, Roy Romanow issues this pointed counsel:

"Many of the so-called "new solutions" being proposed for health care – pay-as-you-go, user and facility fees, fast-track treatment for the lucky few, and wait-lists for everyone else – are not new at all. We've been there. They are old solutions that didn't work then, and were discarded for that reason. And the preponderance of evidence is that they will not work today."[32]

Romanow clearly has his biases. Although his recommendations are supported by evidence, it would be unfortunate to dismiss other "new solutions." One new solution that is gradually garnering support from medical economists, is what Romanow would perhaps refer to as a pay-as-you-go model. A new Catastrophe Insurance/Medical Savings Account model of health care coverage could have profound implications for Canada. And even if this model is not eventually utilized to rebuild Canada's health care system, exploring it will surely hold lessons. The Catastrophe/MSA model has also been looked at in the US as a way to reduce health care costs in a completely privatized system. For this reason, it will be valuable for other countries, such as India, which has a highly privatized system, to consider the Catastrophe/MSA model.

The Catastrophe Insurance/Medical Savings Account Model

"We generally rely on insurance to protect us against events that are highly unlikely to occur but involve large losses if they do occur—major catastrophes, not minor regularly occurring expenses. We insure our houses against loss from fire, not against the cost of having to cut the lawn."[33]

– Milton Friedman

Health insurance around the world has become an integral part of health care systems. Yet, it has evolved its own definition of insurance. Health insurance policies that cover everything from family planning to geriatrics are costly, and may not be the best means to paying for health care. From the U.S.'s privatized health care system, to Canada's universal health care system, to systems in developing nations, a new model is emerging to challenge the current health insurance paradigm.

Many health economists are recommending a restoration of health insurance to its original purpose. It is far more cost-effective for an employer, or country, to purchase a high-deductible catastrophe medical plan for its dependents, rather than purchasing a comprehensive plan, which covers a lot of services not used. The money saved from switching to a catastrophe medical plan, would be deposited into a Medical Savings Account (MSA). An MSA is a tax-exempt account that can be

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[32] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

[33] Friedman, Milton. "How to Cure Health Care." *The Public Interest*. Winter 2001. http://www.thepublicinterest.com/archives/2001winter/article1.html.

used to pay for approved medical services of the holder's choice. The result is, instead of putting money into a comprehensive insurance plan, where unused money goes to the insurance company, the account holder pays for his own services and keeps the unused money. This new catastrophe insurance/MSA model has promising implications backed by empirical evidence.

The previously mentioned RAND Health Insurance Experiment also tested consumer paying models. One group received free care, like in the Canadian system. The other group was given money, and had to pay for their medical services (user fee group). It was found that the free care group was 28% more likely to use medical services, 67% more likely to see a doctor, and 30% more likely to be admitted to the hospital, with 20% more days per year of restricted activity than those who were in the user fee group. It costs 45% more to have a free care system. *And there was no difference found in the overall health of either group.*[34]

Similarly, Lohr et al. (1996) found that a cost-sharing scheme, like the catastrophe/MSA model, reduced the use of both necessary and unnecessary medical services. Yet there was no decrease in the health of the individuals surveyed. Their hypothesis is that unnecessary medical visits can be adverse to your health, resulting in necessary visits. When you eliminate both, there is no net change in health.[35]

The natural conclusion to draw from these studies is that when consumers must spend their own money on health care, they spend it more prudently than when they are spending the government's or insurance company's money.

The Canadian government could introduce a catastrophe insurance/MSA health care system, in which it pays for catastrophe insurance for each citizen, and gives each citizen an MSA stipend based on his or her health, age, and socio-economic class. The catastrophe insurance would relieve the anxiety-producing risk of major medical expenses. And the MSA's would reintroduce a competitive market to the health care system.

A competitive market drives progress through efficiency and incentives. Consumers would benefit most because the affects of change are amplified most at the end of a cascade. They would likely spend less on health care because they would be accountable for their own expenses. These expenses could include currently uninsured services, such as dental, home care, and medical supplies. This freedom would be beneficial to the sick and the poor who currently have trouble paying for prescriptions and other uninsured services.[36] Fewer visits to the doctor would allow consumers more time to participate in the work force. At the end of each year they could withdraw the money in their MSA's as taxable income, or they could roll it over into their accounts for the next year. Less spending would mean lower national health costs, leading to lower taxes for consumers. Less consumption would resolve the queuing problem and raise consumer satisfaction by giving them faster access to medical services. They would also likely be more discerning over who provides their medical services.

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[34] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

[35] Ramsay, Cynthia. "Medical Savings Accounts: Universal, Accessible, Portable, and Comprehensive Health Care for Canadians." *The Frasier Institute – Critical Issues Bulletin*. May 1998.

[36] Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

The catastrophe insurance/MSA model would restore doctor/patient relationships. Patients would choose their providers carefully and know about their doctors before they went in for appointments. Lower demand on services would give doctors more time to spend with their patients. This would give them time to develop relationships with their patients, educate their patients, and address medical complaints that in the current system would require multiple patient visits. Increased patient selectivity would bolster competition between physicians to provide better care to attract more patients. This incentive would raise provider salaries, which in turn would make medicine a more attractive career field. Medical school admissions would likely rise, and the resultant doctor to patient ratio would improve, thus potentially leading to better national health.

Several nations are already using catastrophe insurance/MSA options to optimize their national health. The private sector in the U.S. is gradually implementing such plans, to high reported levels of success. Singapore and China have catastrophe insurance / MSA options. Shaunn Matisonn of the National Center for Policy Analysis discusses South Africa's experience with such plans:

"For most of the last decade [the nineties] …South Africa enjoyed what was probably the freest market for health insurance anywhere in the world…In just five years, MSA plans captured half the [private insurance] market…attract[ing] individuals of all different ages and different degrees of health."[37]

Success in other nations, empirical evidence, and advising from medical economists strongly support the new health care systems model of catastrophe insurance with MSA's. The dust storm of politics over the current state of Medicare, makes such a change difficult to see in the near future for Canada. However, this model could emerge as a solution for other countries.

Conclusion

The Canadian Medicare system has been a grand experiment in health care systems. It has succeeded for many years, and it has set an example for the rest of the world, both in its successes and its failings. Current trends allude to its eventual collapse. In order for Canada to regain the sustainability of its touted health care system, there will need to be fundamental changes to its structure. Roy Romanow's very thorough report, *Building on Values: The Future of Health Care in Canada*, makes a complete collection of recommendations for refurbishing the health care system that was once Canada's jewel. If the recommendations are followed closely with minimal political interruption, then it seems that they could lead Canada back onto the track for sustainability in its health care system. The forthcoming, honest, comprehensive methodology used by the Commission on the Future of Health Care in Canada during its study should provide a model to other countries for how to properly evaluate and confront national health care issues. Meanwhile, a growing group of health economists are adhering to the catastrophe insurance/MSA model. Other nations can learn a great deal from the ideas and methodologies that are emerging in this period of transition for the Canadian health care system.

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[37] Friedman, Milton. "How to Cure Health Care." *The Public Interest*. Winter 2001. http://www.thepublicinterest.com/archives/2001winter/article1.html.

Works Cited

Blendon, Robert, et. Al. "Canadian Adults' Health Care System Views and Experiences, 2001." http://www.cmwf.org/programs/international/can_sb_552.pdf. The Commonwealth Fund. New York, NY: 2001.

Blouin, Chantal. "Canadians' Health Care Concerns Cannot Stop at Our Borders." The North-South Institute. http://www.straightgoods.ca/ViewFeature.cfm? REF=724. Nov.10, 02.

Crowley, Brian Lee, et. Al. "Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System." *Atlantic Institute for Market Studies.*

Danzon, Patricia, M. "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" *Health Affairs*. Spring 1992.

Friedman, Milton. "How to Cure Health Care." *The Public Interest*. Winter 2001. http://www.thepublicinterest.com/archives/2001winter/article1.html.

Gratzer, David. "Code Blue: Reviving Canada's Health Care System." ECW Press. Toronto: 1999.

"Health minister promises help on national reform." The Burlington Free Press. Wire Reports. Dec. 8, 2002. Pg. 4B.

"Huge health care upgrade proposed in Canada." The Burlington Free Press. Wire Reports. Nov. 29, 2002. Pg. 13A.

IDB Summary Demographic Data for Canada.http://devdata.worldbank.org/external/dgprofile.asp

Ramsay, Cynthia. "Medical Savings Accounts: Universal, Accessible, Portable, and Comprehensive Health Care for Canadians." *The Frasier Institute – Critical Issues Bulletin*. May 1998.

"Romanow Report Proposes Sweeping Changes to Medicare." Commission on the Future of Health Care in Canada. http://finalreport.healthcarecommission.ca.

Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada." Nov. 28, 2002. http://finalreport.healthcarecommission.ca.

"The Canada Health Act." Government of Canada. http://laws.justice.gc.ca/en/C6/text.html.

Weber, Joseph. "Canada's Health Care System Isn't a Model Anymore." *Business Week*. August 31, 1998.

Annexure 5

Costa Rican Health Care
A Maturing Comprehensive System

Greg Connolly, **Global Health Council**

A history of commitment to health and social reform has yielded for Costa Rica the best health outcomes of any country in Latin America. These outcomes are the result of a well-developed publicly funded comprehensive health care system built on the principals of universal coverage and equity. While the fundamentals of this system were becoming entrenched, several predictable challenges arose. Costa Rica is confronting those problems with outside aid in a period of reform, which began in 1994. Now, the World Bank has decided to support Costa Rica with its Second Health Sector Strengthening and Modernization Project, which will build off of existing initiatives and trends toward improvement of the health care system. While Costa Rica occupies a tight niche as a small country of middle wealth and high social solidarity, the development of its health care system still holds lessons for some of the most complex nations of the world.

The Costa Rican Health Care System

Framed by Nicaragua to the north, Panama to the south, and the Pacific Ocean and Caribbean Sea, the small country of Costa Rica (area 51,100 sq. km)[1] stands out from its neighbors with a deep history of commitment to social reform and a thriving economy. With a population of only 3,810,179, 59% of which live in urban areas,[2] the nation is not only small, but also it has been able to hold social solidarity. This solidarity arose from the nation's agricultural history in which the upper and lower classes were dependent upon each other.[3] In the past decade the ratio between the income of the upper 20% and the lower 20% held stable.[4] The democratic government composed of executive, legislative, and judicial branches, and a four-year rotating presidency, has also shown remarkable stability. Sustained economic growth has built a GDP per capita of USD$8,500 in 2001 with the primary industries being services, industry, and agriculture. The development model, "Based on promoting exports and tourism and modernizing state institutions in the 1990's,"[5] has landed Costa Rica in 41st position in a 1999 development survey of 162 of the world's wealthiest countries.[6]

A primary contributor to Costa Rica's success has been its focus on the well being of its people. For Costa Rica, health and education are priorities for the success of their nation. The World Bank highlights this priority:

> "The Government of Costa Rica sees the health sector as an essential determinant of the country's economic and social development, giving it a priority that is manifested in sustained high levels of spending

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1 Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 1.

2 "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 1.

3 Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.

4 "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 4.

5 Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 3.

6 "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 1.

and active policy attention at the highest levels."[7]

The attention to health has brought this middle-wealth country's health indicators in line with those of OECD countries.[8] In 2001 the average life expectancy at birth in Costa Rica was 76.6 years.[9] In 2000, 97% of births were attended by skilled professionals, 89% of the pregnant women were given prenatal care, and 93% of children under 1 had health insurance.[10] From 1990 to 2000 life expectancy increased by 0.8 years, the fertility rate dropped, and the population grew due to an influx of Nicaraguan immigrants.[11] In 2000 there were 16 physicians and 3.2 nurses per 10,000 population.[12] In 1999 there were 12,000 people living with HIV/AIDS, giving an adult prevalence rate of 0.54%.[13] However, Costa is the only Central American country to provide antiretroviral treatment to all patients through its social security system.[14] The leading causes of death were cardiovascular disease and neoplasms, which is comparable to many OECD countries.[15] Spending on health care has increased steadily over recent years, and in 2000 it composed 9% of the national GDP.[16]

These outcomes are the result of one of the world's most successful "universal" health care systems. "Universality" in the Costa Rican system means that 100% of the population is given equal comprehensive public health insurance with equal access to services. The success of the system is built upon a history of stalwart determination by the national government to ensure high quality health care for its entire people. In 1941 social security legislation was passed in Costa Rica, establishing the Costa Rican Bureau of Social Security (CCSS). This legislation set the provisions for medical insurance that through the gradual expansion of the CCSS would eventually become a universal health insurance system. Costa Rica wrote a new constitution in 1949. The most significant component of the Constitution was the abolishment of a national army. This opened funding and allowed more attention to go toward social programs, such as education and health. Gradual health sector improvement ensued until 1973, when the health sector was given a dramatic boost. The General Health Law of 1973 placed all health treatment services, including all health care areas and hospitals, under the control of the national social security program. In the next decade public health care coverage extended to reach 78% of the population in 1982. By this point, all those employed, regardless of their socioeconomic status, received health care.[17] The Ministry of Health (MOH), which

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[7] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 5.

[8] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 1.

[9] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 1.

[10] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.

[11] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.

[12] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 7.

[13] UNAIDS. "National Response Brief – Costa Rica." http://www.unaids.org/nationalresponse/result.asp

[14] UNAIDS. "National Response Brief – Costa Rica." http://www.unaids.org/nationalresponse/result.asp

[15] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 4.

[16] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 2.

[17] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.

was established in 1907[18], at this time was responsible for public health programs such as prevention and promotion, and provided primary care for the uninsured. The MOH and the CCSS, working together to provide national health care, continued to refine their roles. In the early 1990's the MOH turned over primary health care provision responsibilities to the CCSS.[19] The MOH has since been in charge of all public health programs, and the CCSS has been in charge of all health provision programs.

The public sector is the predominant health care sector in Costa Rica. It is composed of the following branches:

> "The Costa Rican Social Security Fund (CCSS), which provides health insurance, including comprehensive health care and financial and social benefits; the National Insurance Institute (INS), which covers occupational and automobile accidents; the Costa Rican Institute of Water Supply and Sewerage Systems (AyA), which regulates the supply of water for human consumption and wastewater disposal; and the Ministry of Health (MOH), which monitors the performance of essential public health functions and exercises the steering role in the sector."[20]

The CCSS provides universal health care insurance to employed Costa Ricans. Workers contribute 15% of their salaries to health insurance, broken down in this manor: 9.25% from the employers, 0.25% from the total national wages, and 5.5% from actual worker wages.[21] Universal coverage means that even those who are unemployed are able to obtain public funding for all health services, including prescription drugs. By law, the CCSS must cover 100% of the population, and it achieves this with the following strategy:

> "The CCSS is aware that only 80% of the population is insured either through the compulsory or voluntary system, or as pensioners or their dependents. Of the remaining 20%, 10% are insured through state subsidies, given that this population group is under the poverty line. The other 10% can request public services when necessary and pay for them directly."[22]

Not only is the insurance coverage universal, but also the access to comprehensive health care is nearly equal throughout the country:

> "A 1998 study showed that…access was practically the same in rural and urban areas (average distances to the nearest facility of 1.28 km and 1.10 km, respectively)."[23]

A large reason why the quality of coverage and access to care are so strong is that the CCSS employs a large number of mid-level health workers:

> "[There is] a relatively modest supply of doctors, which apparently serves the country's needs quite well because of extensive use of auxiliary nurses and health assistants; these personnel work in the rural health posts, health centers, and hospitals."[24]

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[18] IHCAI Foundation. "Costa Rican Health Care System Profile." http://www.ihcai.org/Health%20System%20of%20Costa%20Rica_Learn%20Spanish%20in%20tropics%20.htm.

[19] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 1.

[20] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 5.

[21] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.

[22] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 6.

[23] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 24.

[24] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.

Mid-level health workers with little training are very effective at extending access to rural areas. The relatively small amount of training necessary makes it easier for people from villages to become medically certified and contribute to the health care provision in their villages. The usage of mid-level health workers also reduces the overall cost of the health care system because the government doesn't have to pay for expensive medical educations, and it doesn't have to pay high doctors' salaries. South Africa is looking to use more mid-level health workers for just this reason.

The CCSS has a very innovative way of organizing its health care professionals. It provides five comprehensive care programs for children, adolescents, women, adults, and the elderly.[25] It operates through 93 health areas and 783 Basic Comprehensive Health Care Teams (EBAIS).[26] Each EBAIS is composed of a physician, a nurse, and one or more primary care technical assistants (ATAP's). Currently each EBAIS serves an average of 3,500 people.[27] Teamwork is an overarching theme in the health care system. The branches of the centralized public health sector must work together, the states must cooperate with national mandates, and the health care providers work in teams. Working in teams allows each EBAIS to develop comraderie and refine its skills as a unit to provide better health care than if the members were working in inconsistent groups. These teams serve set groups of people. In the Costa Rican system, a person is assigned to providers and a medical center based on place of residence.[28] Lack of choice may be perceived as a problem, but consistency gives each patient the best care he can receive in a centralized publicly funded system. Consistency also nurtures Costa Rica's highly developed information collection system. There is a very extensive amount of information available in the public health sector. However, the private sector lacks an efficient information collection system. This is a significant problem because of the increasing importance of the private sector in health care.[29]

Thirty percent of the population used the private sector in 2001, and 24% of doctors worked at least partly in the private sector.[30] The CCSS does not cover the costs of private sector usage. Mixed Medicine, in which a patient will pay for a private consultation with the physician of his choice, and the CCSS will pay for the diagnostic services and drugs, is playing an increasing role.[31] Another new trend is the usage of Corporate Medical Officers. In this type of program a company will hire a private physician to care for its workers and their families, and the CCSS pays for diagnostic and drug services.[32] A more direct form of Public-Private Partnership (PPP) arose in 1998 when the CCSS began purchasing services from private providers called health

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[25] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 12.

[26] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 15.

[27] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 6.

[28] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 26.

[29] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 3.

[30] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 6.

[31] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 20.

[32] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 21.

cooperatives. "In 2001, four cooperatives and a foundation at the University of Costa Rica were already contracted, serving a total population of 400,000."[33] 11% of the population now gets coverage from PPP's.[34] Incorporating the private sector has alleviated some of the strain on the public system. The private sector does not threaten the public sector because people are happy with the public insurance they already pay for, the quality of public health care is very high, and publicly employed providers are well compensated.[35] A major problem that is arising with the incorporation of the private sector is the difficulty of regulating it. It has been suggested that:

> "There are opportunities for the CCSS to use its purchasing power to require minimum performance as it contracts more with private providers."[36]

Strengthening the CCSS's central power will make it more effective. In a country where interests are do not deviate far from general consensus, centralizing power is the most effective way to guide social programs to achieve equity and public satisfaction and monitor outcomes. The CCSS has wielded its power throughout its existence to effect change. The CCSS uses its central purchasing power to maximize cost-effectiveness of drug purchases by making mass orders to international pharmaceutical companies for all the nation's pharmaceutical needs. Another example of how the CCSS has been able to affect a positive change is the recent implementation of management contracts.

In 2001, all health areas signed management contracts, which set outcome-based goals for performance to be evaluated at the end of each year.[37] This is a significant step toward giving health sector administration more of a business-like approach. Hospital and clinic directors are now getting managerial education.[38] This will hopefully increase efficiency in medical facilities. Management contracts are the primary new tool to guide the reallocation of public funds on a performance-based system, where case mix, adjusted production, and quality outcomes will determine hospital revenues.[39] This gives incentives to hospitals and providers to be more efficient and have better patient outcomes. The result is that finally, half of the accountability for health sector performance is now taken off of the CCSS and put onto the hospitals and clinics.[40] The evaluation of management contracts will be aided by a Diagnostic Related Groups (DRG) system, which is set up in Costa Rica but has not yet been used.[41] The DRG system is a way of monitoring the services rendered by each hospital or clinic monthly. It is a helpful guide, but it only gives quantitative

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[33] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 6.

[34] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.

[35] Bossert, Thomas, PhD. "Phone Interview – December 5, 2002." *Harvard School of Public Health.*

[36] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.

[37] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 2.

[38] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 21.

[39] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 5.

[40] Bossert, Thomas, PhD. "Phone Interview – December 5, 2002." *Harvard School of Public Health.*

[41] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 5.

measures. Therefore qualitative evaluation will have to be made separately when evaluating each hospital's annual performance. There will need to be a large amount of new support for the CCSS to successfully monitor this program and link pay to performance.[42]

In parallel, the MOH has recently developed a regulation program for the accreditation of hospitals based on quality assurance. The program is currently a pilot project, which requires all maternity hospitals to adhere to standards set by the MOH in order to earn accreditation.[43] However, "The ministry's ability to enforce sector regulation is weak,"[44] and will need support to make this program effective on a national scale.

The Ministry of Health has recently maintained a low profile. With the transfer of many of its programs to the CCSS in the 1990's, the MOH lost power. However, throughout the history of the Costa Rican health care system, the Ministry of Health's public health programs have been crucial to the success of the system. Milton Roemer praises the MOH's prevention programs:

> "The benefits of prevention were dramatically demonstrated. Their strength and effectiveness probably contributed to the harmonious relationships that the MOH developed later with the social security program."[45]

Indeed, the MOH's prevention and promotion programs have contributed greatly to Costa Rica's overall health outcomes. The following two departments give examples of what the MOH contributes:

> "Sanitary controls for and registration of drugs, food, and hazardous toxic substances are the responsibility of the Department of Drugs and Narcotics Controls and Registries of the MOH. Health regulation and surveillance, which includes the monitoring of air and soil quality, housing, chemical safety, and hazardous waste are the responsibility of the Environmental Sanitation Division of the MOH."[46]

There are several other programs that contribute to Costa Rica's health sector success. By 1995 the National Institute of Aqueducts and Sewers (AyA), had provided potable drinking water to 99.6% of the population, and had given 95.7% of the population a sewerage system. Electricity was available to 93% of the population at that time.[47] The Costa Rican Demographic Association does extensive work in sex education and family planning.[48] Roemer states, "Health-related research, to produce new knowledge in fields of special importance, is exceptionally well-developed in Costa Rica."[49]

The specialization of duties created by dividing the MOH and the CCSS and their collaboration has lead to a very successful health care system. Milton Roemer says, "Accord-

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[42] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 2.

[43] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 13

[44] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 3.

[45] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.

[46] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 13.

[47] Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm. Pg. 3.

[48] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.

[49] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.

ing to conventional measurements of health status, the results [of the Costa Rican health care system] have been phenomenal."[50] However, nothing makes a more decisive statement about the success of a health care system than the satisfaction levels of its users. A 2000 SUGESS survey found that 88% of health system users reported receiving proper medical treatment and 81% said the physicians educated them properly.[51] And a national survey in 2000 showed that over 70% of health system users were satisfied with their care.[52]

Reform

The Costa Rican health care system has matured through several waves of challenge and reform. Despite its impressive health outcomes, Costa Rica is now in a period of reform intended to refine its successful programs, and improve efficiency by building off of trends that have been developing for years. A period of reform starting in 1994 was successful, and now the World Bank will provide an extra surge to finish implementing positive reforms.

The reform period from 1994-2001 was funded by the Inter-American Development Bank (USD$4.3 million), and the World Bank (USD$22 million). Technical support was also given by the Pan-American Health Organization/World Health Organization.[53] This reform had a four part agenda:

> "A steering role for the Ministry of Health and its strengthening; institutional strengthening of the CCSS; a new system for the reallocation of financial resources; and adaptation of the health care model."[54]

The new World Bank reform project is entitled, "Costa Rica – Second Health Sector Strengthening and Modernization Project." This project will allocate nearly USD$33 million to: "Improve health system performance and financial sustainability by supporting the ongoing policy changes in the health sector in Costa Rica."[55] The Costa Rican government's reform priorities are to: "Develop high levels of regulatory capacity and to implement the most important regulations during the next five years."[56]

Many of the problems with the health care system can be better addressed by first strengthening the centralized power of the MOH and the CCSS. PAHO states:

> "Steering role functions [in the MOH] need to be further strengthened, and it is necessary to improve the performance of certain essential public health functions, the management of services [by the CCSS], the quality of care, and equity in the allocation of resources."[57]

Once the MOH and the CCSS have been strengthened, then the CCSS will be better enabled to fulfill its responsibility of facilitat-

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[50] Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991. Pg. 420

[51] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg.27.

[52] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 17.

[53] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.

[54] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.

[55] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 6.

[56] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 6.

[57] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 2.

ing the reform projects. A major objective is to improve the financial state of the health care system by enacting efficiencies and reallocating funds.

We have already reviewed the reform mechanisms for reallocating funds; namely, using management contracts to create performance-based allocation of funds. Another movement to save money is to reduce the amount of inpatient care by transferring more patients to ambulatory care. Inpatient care is far more expensive than ambulatory care. But ambulatory care requires higher quality health service initially, and better mechanisms for providing home care. The World Bank makes this statement about increasing ambulatory care:

> "In 1999, fewer than 5 percent of all hospital discharges were resolved in an ambulatory setting. With minor investments in training, equipment and infrastructure (remodeling), the CCSS could increase ambulatory interventions to nearly 20 percent of all discharges. Benefits would include cost savings of more than USD$12 million per year, improved quality, and greater patient satisfaction."[58]

Another area where financial improvements can be made is in purchasing pharmaceuticals. "Pharmaceuticals represent 12% of CCSS health expenditure (nearly 1% of the GDP)."[59] There needs to be improved monitoring of drug usage through improved communication between health centers and the central purchasing power of the CCSS, so that the correct amounts and types of drugs are purchased.

The need for better communication calls for an improvement in health care information systems. For reasons referred to above:

> "Implementation of an integrated [information] management system for health care providers, hospitals and health areas is a continuing obstacle to improved efficiency."[60]

Better access to information will be needed to monitor health outcomes, which is especially important to the new performance-based funding allocation system. The natural counterpart to improving communication is improving technology. In the past ten years technology has made astronomical advances. However:

> "The CCSS has not built a new hospital in the past 30 years, and during the 1990's investment [in hospital infrastructure] was reduced to less than 3 percent of total expenditure."[61]

More money will clearly have to be invested into hospitals and technology if Costa Rica is to achieve the high potential for health care that its excellent system has set it up for. While Costa Rica has impressive outcomes for its region and its economy, it still lags behind the best systems in the world in terms of performance. But it may work its way up in the pattern of gradual improvement that it has traditionally followed.

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[58] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.

[59] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.

[60] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.

[61] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.

A major problem with health care access is that there are long waiting lines for specialty care such as orthopedics, surgery, and gynecology. PAHO reports:

> "[At the start of 2001 the waiting list for surgical hospitalization numbered nearly 14,000 patients][62] …75% of hospitals have one or more specialties with…waiting lists longer than three months."[63]

Another area where access can be improved is in rural areas. Although Costa Rica does an excellent job of extending services to all, there is still room for improvement toward equity.[64] As the demographics change, approaches toward equity will have to follow suit. There is an increasing elderly population, which will benefit from establishing better home care and hospice care mechanisms.[65] Likewise, the leading causes of death have changed in Costa Rica, and the MOH needs to adjust its prevention and promotion programs to address non-communicable diseases and healthy lifestyles.[66]

Medical education also needs to adjust to the changes of the times. In particular the medical education curriculum needs to better address the most advanced technologies, pharmaceutical advances, and the new primary health care model. At the same time, continuing medical education needs to be enforced and the same topics need to be taught to keep the current physicians up to date.[67]

These reforms are being made to Costa Rica's strong comprehensive health care system to help it achieve its potential for reaching and sustaining goals of universality, quality, and affordability.

Implications

One of the World Bank's statements of purpose for funding the second health sector reform in Costa Rica is:

> "Provision of assistance to expand knowledge of international experiences in similar topics, emphasizing and facilitating the dissemination of the Costa Rican experience to other countries."[68]

Costa Rica's health care system will serve as an example to other countries. There are very few countries that match Costa Rica's profile of small size, small population, social and political solidarity, and gradually growing middle-wealth economy. But it was not these factors that led to Costa Rica's excellent health care system. It was how Costa Rica used these factors that has aligned it for success. When one looks at Costa Rica in the Latin American context, the nation's achievements become very impressive. The factors listed above did not come with the land, but were arrived at through social development. It becomes apparent that steadfast commitment to social reform with priorities on education and health may lead a nation to social success.

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[62] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 6.

[63] "Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002. Pg. 26.

[64] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.

[65] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.

[66] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 5.

[67] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 4.

[68] "Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/. Pg. 7.

Costa Rica can be looked at as a pilot project for Latin America. This is analogous to looking at the health care system in one state of India as compared to the entire nation. When segmented down to a manageable region, a centralized health care system works best if one agrees with the Costa Rican model. Centralization allows for decisive management, and power to effect the changes necessary to building a successful health care system. However, when dealing with a larger region, the South African and Canadian systems point to centralization within states, and a decentralized national approach under the control of a central authority.

There are several components of the Costa Rican health care system, which should be of special notice to India. Primarily, management contracts are an excellent way to share accountability, promote the monitoring of information and health outcomes, promote improved quality of care through incentives, and reduce costs by leading to more efficiency. Mid-level health workers are very valuable for extending care to underserved regions and for reducing overall medical costs. Costa Rica's use of Public-Private Partnerships may carry some lessons about how to better incorporate India's 80% private sector into a national health care system. And Costa Rica's ability to harness and utilize external aid could be a good example to India, which will rely heavily on external funding to alleviate its problems with HIV/AIDS, and to build its national health care system.

Works Cited

Bossert, Thomas, PhD. "Phone Interview – December 5, 2002." *Harvard School of Public Health*.

Clark, Mary A. "Health Sector Reform in Costa Rica: Reinforcing a Public System." Tulane University. Nov. 1, 2002.

"Costa Rica – Second Health Sector Strengthening and Modernization Project." World Bank. 2001. http://www-wds.worldbank.org/

IHCAI Foundation. "Costa Rican Health Care System Profile." http://www.ihcai.org/Health%20System%20of%20Costa%20Rica_Learn%20Spanish%20in%20tropics%20.htm

Infoplease Atlas. "Map of Costa Rica." http://www.infoplease.com/atlas/country/costarica.html

Pan American Health Organization – Country Profile: Costa Rica. http://www.paho.org/English/SHA/prflCOR.htm

Politicas Nacionales De Salud. "Procedimiento Para Incluir o Modificar Politicas Nacionales De Salud." http://www.netsalud.sa.cr/ms/ministe/politicas/proce3.htm

"Profile of the Health Services System of Costa Rica." PAHO. May 27, 2002.

Roemer, Milton. National Health Systems of the World – Volume I. Oxford University Press. New York, NY: 1991.

UNAIDS. "National Response Brief – Costa Rica." http://www.unaids.org/nationalresponse/result.asp

Annexure 6

South African Health Care
A System in Transition

Greg Connolly, **Global Health Council**

Since the overthrow of Apartheid in 1994, the health care system in South Africa has been under an ongoing revolution to erase inequities in service and access, and to fund a higher level of health care. Their approach is to decentralize the health care system into a District Health System, and to assure that a standard Primary Health Care package is available to all. This system in transition has made commendable achievements, but there are still plenty of improvements to be made before South Africa attains the system it has envisioned. The most formidable adversary to their health care reform is the HIV/AIDS epidemic. The successes and shortcomings of this middle-income developing country's approach to improving health care provide valuable lessons to other countries that face similar challenges to improving their health care systems.

The South African Health Care System

South Africa, a middle income nation with a GDP per capita of USD $7,555, and a population of 43,791,000, is a nation in transition.[1] After four decades of minority apartheid rule, a democratic government was established in 1994.[2] This radical change in identity has called for a great deal of policy adjustment. This change, coupled with the emergence of the HIV/AIDS epidemic has cornered South Africa into a national crisis; a crisis that is centered on health care. The keystone of any government is tending to the well being of its people. The well being of South Africans is teetering on the edge, and the people are depending on the government to respond by putting the majority of its efforts into improving national health.

Currently, the total health expenditure per capita in South Africa is USD$530.00, and the total health expenditure as a percentage of the GDP is 8.8%. These expenditures stand beside marginal quality health indicators such as the life expectancy at birth of 47.7 years for men, and 50.3 years for women. Child mortality rates are 103 deaths per 1000 births for males, and 90 deaths per 1000 births for females.[3] Unfortunately, these figures are worsening in a landslide caused by HIV/AIDS. But the government's formidable approach to reforming health care, by starting anew with a vision of health care equity, is on the right track.

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[1] "WHO Country Profile: South Africa." http://www.who.int/country/zaf/en

[2] McIntyre, D. and Gilson, L. "Putting Equity in Health Back onto the Social Policy Agenda: Experience from South Africa." Soc Sci Med 2002 Jun; 54(11): 1637-56.

[3] "WHO Country Profile: South Africa." http://www.who.int/country/zaf/en

South Africa's vision for health care is a decentralized system that offers an equally accessible and free basic package of primary health care to all of its citizens.[4] These goals are presented in the National Health Bill of 2001, which establishes the structure for the implementation of a national health care system based on Primary Health Care (PHC), and operated by District Health Systems (DHS). For a description of the government-funded services covered by the Primary Health Care package in South Africa, visit this website (http://www.doh.gov.za/docs/reports-f.html). The national Department of Health, headed by Minister Mantombazana Edmie Tshabalala-Msimang, oversees the system of nine provincial health departments. Municipal boundaries for local governments were demarcated in 2000. Each provincial health department has its own ministers and leaders. However, the youth of this decentralized system is resulting in predictable management issues.

The impetus behind creating a decentralized health care delivery system was that provincial governments would have the ability to customize the health systems to their unique cultural groups, while the national department of health would balance out inequities to assure that all districts conform to the national health policy. In such a culturally diverse nation, the state would be mistaken to mandate a one-size-fits-all national health care policy. Meanwhile, the districts are presumably small enough, and carry enough social solidarity that the District Health Systems are centralized into one department. Eric Buch of the School of Public Health of the University of Pretoria praises the model of decentralization:

> "Establishment of a District Health System with provinces and local authorities starting to pool their resources and integrate care, [offers] a more comprehensive service under one roof. This not only improves economies of scale and efficiency, but means that parents do not have to go to two or more venues and face duplicate queues and examinations to get care for themselves and their families."[5]

He also explains that in order to meet the goals for elevating clinics to fully functional levels, all clinics must have infrastructural services, such as electricity, refrigeration, potable water, sanitation, and roads by 2004.[6] Not only are clinics to be improved, but more clinics are to be built. The goal is to provide equal accessibility to health care for all South Africans. This primary objective of the South African health care system is to ensure that all South Sfrican citizens are able to realize their fundamental rights to health care as

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[4] Sait, Lynette. "Health Legislation: South African Health Review 2001." http://www.hst.org.za/sahr/2001/chapter1.htm

[5] Buch, Eric. "SAHR 2000: The Health Sector Strategic Framework: A Review." *The Health Systems Trust.* http://www.healthlink.org.za/sahr/2000/chapter2.htm.

[6] Buch, Eric. "SAHR 2000: The Health Sector Strategic Framework: A Review." *The Health Systems Trust.* http://www.healthlink.org.za/sahr/2000/chapter2.htm.

enshrined in Section 27 of the Constitution. However, Dr. David McCoy, the Director of Research at the Health Systems Trust in South Africa, explains why the South African system is not yet a "universal" health care system:

> "In order to define the nature of people's rights to health care, the national DoH has defined 'package of Primary Health Care' that is expected to be available through the public sector. It lists the scope of services to be provided in clinics and district hospitals. In addition, we have a variety of clinical policies that define national policy on standards of treatment and care in the country. For example, we have official national HIV treatment guidelines. However, while everyone essentially has unimpeded access to PHC, in practice, many people have physical and financial barriers to getting to health facilities, and when they do attend a health facility, there is a significant gap between what is set out in the policies with what is actually being delivered."[7]

The definition of "universal" health care that is generally subscribed to is a system in which the government covers the costs and administration of the entire health sector, such as in the Canadian Health Care system. But this kind of system is highly unlikely to be instituted in South Africa. The obstacles are that the health system is already saturated with issues demanding attention, there is an entrenched private health sector, HIV/AIDS is churning up any continuity in health system development, it is not an upper wealth nation, and there is not enough social solidarity.

Dr. McCoy explains the funding mechanisms of the South African health system:

> "We don't have a dedicated health insurance system. The public sector is mainly funded from the general tax base and to a much lesser degree from user fees. There are proposals for social health insurance for the poor but employed, [leaving the poor and unemployed unattended], which may segment the health care system between the unemployed and the employed, as happens in South America. While this offers opportunities for more people to access the private sector, it could entrench a weak health care system for the poor who are excluded from social health insurance. Outside of the public sector, is a large private health care sector which outstrips public health expenditure."[8]

In the private sector, prepaid health plans accounted for 76.6% of the private expenditure on health in 2000.[9] Medical Schemes are the dominant third-party intermediary with 73% of the private expen-

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[7] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 25, 2002."

[8] Dr. David McCoy. Director of Research for the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

[9] "WHO Country Profile: South Africa." http://www.who.int/country/zaf/en

diture.[10] And out-of-pocket expenditure on health as a percentage of the total expenditure on health in 2000 was 12.6%.[11] Antoinette Ntuli of the Health Systems Trust proclaims: "The greatest health sector inequity continues to be the imbalance of resources available to the public and private sectors."[12] Such inequities are inherent in a young system that is developing rapidly on a macro scale. Eric Buch explains the development pattern in South Africa:

"In other middle income countries the issues are more around constant improvement off the baseline. In South Africa they are around providing services for all that were previously available to a few."[13]

This approach has been necessary given South Africa's impending health crisis, yet it has left much room for improvement. The mission statement of the Department of Health's "1999-2004 Health Sector Strategic Framework" is:

"While the first five years focussed on increasing access to health care, especially for those who did not have access, … the next five years will focus on accelerating quality health service delivery."[14]

This optimistic outlook passes over the need to improve on areas missed in the initial surge of health sector reform. It inappropriately implies that an end has been reached for achieving equal access to health care. Let us now look at the issues that have challenged health sector reform, address suggested improvements, and present the direction in which South Africa is moving toward achieving its envisioned socialized health care system.

Challenges to the South African Health Care System

If the vitality of the health care services were related to water supply, then the health care system would be the dam, and the reservoir would be the resources that power the system. In South Africa, the reservoir is running dry. There is inadequate funding, poor access to information, a outward migration of medical professionals, and insufficient leadership to sustain the system.

The most basic resource that the health care system relies on is funding. In light of the HIV/AIDS crisis, it is promising that the government spends 11.2% of its budget on public health.[15] However, this will need to increase. In the medical sector, it appears that even if all efficiency measures are achieved, current public sector fund-

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[10] Goudge, Jane, et Al. "Private Sector Funding: South African Health Review 2001." http://www.hst.org.za/sahr/2001/chapter4.htm

[11] "WHO Country Profile: South Africa." http://www.who.int/country/zaf/en

[12] Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

[13] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[14] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[15] "WHO Country Profile: South Africa." http://www.who.int/country/zaf/en

ing will not satisfy the costs of providing the care desired.[16] Eric Buch suggests:

> "There are two places that significant additional funds could come from. The first is a budget that grows significantly in real terms, and the second through raising more funds from users."[17]

These are not dynamic solutions. But perhaps what is most needed is more resources from the conduits built into the system. However, the funding mechanisms built into the system are also problematic. Antoinette Ntuli outlines the funding paradox:

> "Current mechanisms for funding local government health services are problematic. From the provincial perspective they do not allow for adequate monitoring, while local governments are concerned about the cash flow problems resulting from payments that are paid quarterly in arrears."[18]

In parallel, the private sector is also experiencing funding problems. Eric Buch reports:

> "The private sector model of guaranteed fee-for-service payment to providers through for-profit medical administration companies, together with other factors, kept private health inflation well above that prevailing in the economy."[19]

The above passage may imply that excessive expenditures are the results of overproviding by health care professionals, however Buch clarifies that this is not the primary cause of expense:

> "Excessive expenditure on health care is not only driven by the lack of constraints on members due to third party payer insurance, but more importantly due to an asymmetry of information between provider and patient on what interventions are required and suitable."[20]

Effective information dissemination is crucial to operating an efficient health care system. In South Africa, information is in short supply. Ninety-seven percent of provincial expenditures on health information goes to hospitals, with the districts getting only three percent.[21] In order for inequities of access to be neutralized, this ratio must be reduced so that rural clinics are given, and return enough information to enable them to deliver care of acceptable quality. When asked if South Africa is do-

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[16] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[17] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[18] Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

[19] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[20] Buch, Eric. "SAHR 2000: The Health Sector Strategic Framework: A Review." *The Health Systems Trust.* http://www.healthlink.org.za/sahr/2000/chapter2.htm.

[21] Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

ing a good job of information dissemination, Dr. David McCoy responded:

> "I guess it's all relative. The Department of Health does take the need to disseminate information seriously. The Health Systems Trust is one of the main sources of information [in South Africa] to health care workers, and they are partially funded by the DoH. "[22]

The other side of information dissemination is information gathering. Dr. McCoy elaborates on this theme:

> "Research is very important, but it can also be very distracting. What is important is relevant research and research that targets policy makers and managers as the consumers (not academic journal editors). South Africa also needs to invest time in face-to-face communication of research findings, and not rely on passive paper-based dissemination. The bureaucracy is reasonably receptive to constructive criticism, but this culture needs to be carefully nurtured and protected."[23]

One way any government bureaucracy can be culturally sensitive and open to civil input is to empower nongovernmental organizations (NGO's) to perform some of the work on the ground. Eric Buch makes a case for NGO support in this passage:

> "It is generally agreed that NGO's working in, and with, communities and those focussing on a health problem e.g. cancer, tuberculosis, or a disability, have the ability to achieve results and mobilize energy and volunteerism in a manner that is difficult for formal health services to match. This energy seems to be dissipating in our society, with people waiting for government to do things for them. The Health Department needs to intervene to create an enabling environment for NGO's, facilitate the emergence of local NGO's and provide seed funding in hitherto unserved areas."[24]

NGO's tend to have an ability to feel the pulse of the people. They also tend to access areas that would normally be overlooked by government. One of the major challenges to the South African health care system is bringing health care to rural underserved populations. These people often forego health services that would be deemed necessary by health professionals because they don't have access to services, or because they lack the funds for services. There are also many traditional healers throughout South Africa, who should not be dismissed in the new health care system, but should be allowed their niche alongside modern health care services. NGO's are crucial to mediating sensitive issues like traditional healing, and helping to facilitate new measures in underserved areas.

Extending service to underserved areas is one of the most significant challenges to the health care system. Not only must new clinics be built, and basic utilities and resources provided, but also there need to be

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[22] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

[23] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

health professionals to work in underserved areas. Doctors will need to commit to working regularly in clinics. Moreover, supporting health services staff such as nurses and assistants will need to be enticed into working in underserved areas, and will require specific training for working in these new environments. This will be a costly and demanding measure. Eric Buch offers one suggestion for alleviating the financial burden and pressing demand for sending health professionals to work in underserved areas:

> "Large numbers of rehabilitation, pharmacy, environmental and other assistant categories (mid-level health workers), with one to two years of tertiary education, need to be rapidly but effectively trained and deployed…One conclusion drawn by the Human Resources planning process is that the current staffing model, based on professionals alone, is unaffordable, and that extensive use should be made of mid-level health workers."[25]

This advice, while sensible, may sound grating to many South African health analysts who are pressing for a more professional work force. Amid the rapid, but necessary changes to the health sector, the health work force is overburdened by changing values in the jobs, and unreasonable work loads.[26] Dr. Graham Bresick comments:

> "Urgent attention needs to be paid to the low morale, disillusionment, and high levels of stress and burnout among health service staff. We can't hope to build a reformed and improved health sector on a spent work force."[27]

Difficult working conditions, few incentives, and low morale are causing health professionals to leave their jobs or seek work in other countries. South Africa has an enormous problem with the colloquially termed phenomenon of "Brain-Drain." Many health care professionals, who have received their training in South Africa, emigrate to countries with more inviting health care systems. South African Department of Health Minister Manto Tshabalala-Msimang states in her speech, "Health Department's Multi - Pronged Health Staffing Strategy":

> "We believe that if there is a major – and insidious – threat to our overall health effort, it is the continued outward migration of key health professionals, particularly professional nurses, with a consequent de-skilling of the professional base in both the public and private sector."[28]

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[24] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[25] Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

[26] Bresick, Graham. "Email to Greg Connolly – Dec. 13, 2002."

[27] Bresick, Graham. "Email to Greg Connolly – Dec. 13, 2002"

[28] Minister Manto Tshabalala-Msimang. "Health Department's Multi-Pronged Health Staffing Strategy." http://www.doh.gov.za/docs/pr/2002/pr1023.html

Antoinette Ntuli illustrates the magnitude of this threat with the following statistics:

> "In 2001 there were 19.8 medical practitioners per 100,000 population as compared with 21.9 in 2000. For professional nurses the ratio reduced from 120.3 in 2000 to 111.9 in 2001."[29]

The Department of Health has taken a few measures to combat this readily apparent threat. It developed a Code of Conduct for other Commonwealth Nations in their recruitment of South African professionals. It created a new "Community Service" program to encourage professionals to work in underserved areas. And it sent 254 students to Cuba to train to become physicians. These students have committed to return to South Africa to offer four years of service to underserved areas.[30]

Dr. David McCoy comments on these incentive programs:

> "This is a major priority of the health system and we have been talking about incentive schemes for the last six years. There has been a recent resurgence of interest in policy-making circles, but we await some positive outcomes. The only program that has been put in place is a compulsory community service program for medical graduates of one year, and a program to place Cuban doctors in rural areas. Both initiatives have been partially successful, but are insufficient to address the "brain drain" and the inadequate levels of staffing in the rural areas."[31]

It is not only the doctors and nurses who are strained by the needs of the health care systems; it is also the administrators. In the early stages of the new decentralized health care system, leadership was given to those who may not have had proper training, avenues of decision making were unclear, and the responsibilities of the leaders were too burdensome. Antoinette Ntuli elaborates on these problems:

> "Worryingly, many health services managers have a low sense of personal accomplishment. Huge demands, difficulties in prioritizing, inadequate management skills, lack of rewards for competence or sanctions for incompetence, and hierarchies that are too rigid all impact upon their ability to deliver quality health care. Other difficulties include inappropriate organograms, lack of financial delegation, unsatisfactory communication between provinces and districts and inconclusive appointments of staff, (especially to strategic positions) many of whom are in acting positions."[32]

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[29] Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

[30] Minister Manto Tshabalala-Msimang. "Health Department's Multi-Pronged Health Staffing Strategy." http://www.doh.gov.za/docs/pr/2002/pr1023.html

[31] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 25, 2002."

[32] Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

Dr. David McCoy echoes her concerns:

> "There are inadequate management skills amongst managers and policy makers who set the operational priorities for transforming the health care system in a rational sequence of steps. One cannot put the roof on before building the walls. This is technical work."[33]

Building a national health system is not easy, and South Africa has only had eight years in which to do it. The nation has certainly made a commendable effort at health care reform. The problems that arose are all problems that can be solved, and were virtually inherent in developing a new health care system. South Africa provides an example of a nation doing fairly well in transforming their health care system under pressure.

However, that pressure is immense and must be confronted. When asked if South Africa was doing a good job with its health care reform, David McCoy gave this response:

> "Is the glass half empty or half full? Relative to many developing countries we are doing okay. Given the history of the country and the relative inexperience of the government, we are also doing okay. However, relative to our health needs and the emergency that is AIDS, we are doing poorly. AIDS threatens to wipe out all gains made since 1994. We have to run fast to keep still."[34]

The HIV/AIDS Crisis

"South Africa has more HIV positive people than any other country in the world."[35] Two years ago the South African government reported that 4.7 million, which is one in nine, South Africans was HIV positive. Today that number is expected to be far higher. The South African government is starting to acknowledge its massive HIV/AIDS crisis. "This year the government almost tripled its anti-AIDS budget to USD$108 million, and plans to up to $194 million in the next financial year."[36] "Tony Leon, leader of the main opposition Democratic Alliance said, 'South Africa's fight against AIDS has been massively hampered and harmed by government's dithering, denial and dissent from the orthodoxies associated with the disease." He also pointed out that women's life expectancy will fall from 54 to 38 in the next decade, and more than 2 million children will be orphaned by AIDS in this time.[37]

Not only are children being orphaned, but also:

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[33] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

[34] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

[35] Cohen, Mike. "World AIDS Day rallies focus on global awareness." *Associated Press*. The Burlington Free Press. December 2, 2002.

[36] Cohen, Mike. "World AIDS Day rallies focus on global awareness." *Associated Press*. The Burlington Free Press. December 2, 2002.

[37] Cohen, Mike. "World AIDS Day rallies focus on global awareness." *Associated Press*. The Burlington Free Press. December 2, 2002.

> "Each year, more than 600,000 infants [worldwide] become infected with HIV, mainly through mother-to-child transmission. WHO and the UNAIDS Secretariat recommend that the prevention of mother-to-child transmission of HIV, including antiretroviral regimens such as nevirapine, should be included in the minimum standard package of care for HIV-positive women and their children."[38]

The article by WHO and UNAIDS also explains: "The simplest regimen [of PMTCT drug therapy] requires a single dose of nevirapine to the mother at delivery and a single dose to the newborn within 72 hours of birth."[39]

Yet despite the World Health Organization and UNAIDS endorsements of nevirapine therapy, the South African government was reluctant to distribute the drug to health providers. Instead the Department of Health set up an eighteen-site test of the effectiveness and risks of Intrapartum Nevirapine treatment, because as Minister Manto Tshabalala-Msimang explained:

> "The public sector cannot afford to provide the drugs, while nevirapine did not guarantee the virus could not be passed from mother to child."[40]

This is a clear example of the Department of Health's reluctance to give HIV/AIDS the attention it has warranted. It is this kind of negligence that prompted Dr. Peter Berman of the Harvard School of Public Health to say; "South Africa could be an example of what to avoid in AIDS policy."[41]

Dr. David McCoy issued the following statement on what other countries can learn from South Africa's HIV/AIDS policy:

> "Political leadership is critical [to an effective HIV/AIDS policy]. Openness is critical, as is making the problem a national priority at the early stages of the epidemic.
>
> Ensuring that the basic primary health care infrastructure is capable of providing correct treatment of sexually transmitted infections (STI's), condoms, family planning, and TB control…in other words, getting the basics in place. This then provides a foundation for the implementation of more complex treatment programs.
>
> Human resource training is critical – especially of community lay workers who can act as agents of community mobilization. Prevention intervention is not just a health care system responsibility, but needs to be planned and implemented from a broad base of government and non-governmental institutions.

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[38] "WHO and UNAIDS continue to support use of nevirapine for prevention of mother-to-child HIV transmission." http://www.who.int/mediacentre/statements/unaids/en/print.html

[39] "WHO and UNAIDS continue to support use of nevirapine for prevention of mother-to-child HIV transmission." http://www.who.int/mediacentre/statements/unaids/en/print.html

[40] Sait, Lynette. "Health Legislation: South African Health Review 2001." http://www.hst.org.za/sahr/2001/chapter1.htm

[41] Berman, Peter and Bossert, Tom. "Interview with the Global Health Council." *Harvard School of Public Health.*

Understanding local culture and beliefs is very important. Social science research must be employed from the beginning to inform prevention interventions in particular. The western model of individual-based counseling is inappropriate and has been a millstone around our neck."[42]

These words of advice are poignant especially to countries that are now just starting to be infiltrated by HIV/AIDS. India, China and other countries in Asia, where the virus is spreading most rapidly should learn from South Africa's shortcomings in HIV/AIDS policy.

Implications

The South African health care system has many implications for developing countries. The model of social equity in health care that South Africa envisions is appropriate to the needs of its people, and can be achieved given the nation's wealth, infrastructure, and relative social solidarity. Decentralization beneath a governing body seems to be the most effective design in a socialized health care system. Public provision of primary health care services without interfering with privatized secondary and tertiary health care services achieves a balance of government control while allowing for the private market to drive progress. South Africa's approach to reform was on the macro scale. This may not be possible for more diverse and impoverished nations, and as seen here, can leave holes, which require repairing. Perhaps a more thorough approach to health care reform would be to start small in a pilot program format, and through the work of both government and non-governmental organizations, build up to a national system while attending to the complications that arrive along the way. Most significantly, developing countries should learn from South Africa's HIV/AIDS policy. As South Africa is learning, while it is important to develop a strong national health care system, the effort may be futile if the country doesn't also address the HIV/AIDS pandemic.

Works Cited

Barron, Peter, and Asia, Bennett. "The District Health System: South African Health Review 2001 – Chapter 2." http://www.hst.org.za/sahr/2001/chapter2.htm.

Berman, Peter and Bossert, Tom. "Interview with the Global Health Council." *Harvard School of Public Health.*

Bresick, Graham. "Email to Greg Connolly – Dec. 13, 2002."

Buch, Eric. "The Health Sector Strategic Framework: A Review: South African Health Review 2000 – Chapter 2." Http://www.healthlink.org.za/sahr/2000/chapter2.htm

Cohen, Mike. "World AIDS Day rallies focus on global awareness." *Associated Press*. The Burlington Free Press. December 2, 2002.

[42] McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 25, 2002."

Goudge, Jane, et Al. "Private Sector Funding: South African Health Review 2001." http://www.hst.org.za/sahr/2001/chapter4.htm

Mbatsha, Sandi, and McIntyre, Di. "Financing Local Government Health Services: South African Health Review 2001 – Chapter 3." http://www.hst.org.za/sahr/2001/chapter3.htm.

McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 25, 2002."

McCoy, Dr. David. Director of Research at the Health Systems Trust. "Email to Greg Connolly – Nov. 29, 2002."

McIntyre, D. and Gilson, L. "Putting Equity in Health Back onto the Social Policy Agenda: Experience from South Africa." Soc Sci Med 2002 Jun; 54(11): 1637-56.

Minister Manto Tshabalala-Msimang. "Health Department's Multi-Pronged Health Staffing Strategy." http://www.doh.gov.za/docs/pr/2002/pr1023.html

Ntuli, Antoinette. "Listening to Voices: Preface to the South African Health Report 2001." http://www.hst.org.za/sahr/2001/preface.htm

Pillay, Yogan. "Voices of Health Policy Makers and Public Health Managers: South African Health Review 2001 – Chapter 16." http://www.hst.org.za/sahr/2001/chapter16.htm.

Sait, Lynette. "Health Legislation: South African Health Review 2001." http://www.hst.org.za/sahr/2001/chapter1.htm

"South African Health Reviews 1995-2001." The Health Systems Trust. http://www.hst.org.

"South African Minister of Health Profile." http://www.doh.gov.za/ministry/minister.html

"WHO and UNAIDS continue to support use of nevirapine for prevention of mother-to-child HIV transmission." http://www.who.int/mediacentre/statements/unaids/en/print.html

"WHO Country Profile: South Africa." http://www.who.int/country/zaf/en

Annexure 7

Operationalizing Right to Healthcare in India

Ravi Duggal, **CEHAT**

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

– Henry Sigerist

More than half a century's experience of waiting for the policy route to assure respect, protection and fulfillment for healthcare is now behind us. The Bhore Committee recommendations which had the potential for this assurance were assigned to the back-burner due to the failure of the state machinery to commit a mere 2% of the Gross Domestic Product at that point of time for implementation of the Bhore Plan (Bhore, 1946). The experience over the nine plan periods since then in implementing health plans and programs has been that each plan and/or health committee contributed to the dilution of the comprehensive and universal access approach by developing selective schemes or programs, and soon enough the Bhore plan was archived and forgotten about. So our historical experience tells us that we should abandon the policy approach and adopt the human rights route to assuring universal access to all people for healthcare. The State is today talking of health sector reform and hence it is the right time to switch gears and move in the direction of right to health and healthcare.

The right to healthcare is primarily a claim to an entitlement, a positive right, not a protective fence.[1] As entitlements rights are contrasted with privileges, group ideals, societal obligations, or acts of charity, and once legislated they become claims justified by the laws of the state. (Chapman, 1993) The emphasis thus needs to shift from 'respect' and 'protect' to focus more on 'fulfill'. For the right to be effective optimal resources that are needed to fulfill the core obligations have to be made available and utilized effectively.

Further, using a human rights approach also implies that the entitlement is universal. This means there is no exclusion from the provisions made to assure healthcare on any grounds whether purchasing power, employment status, residence, religion, caste, gender, disability, and any other basis of discrimination.[2] But this does not discount the special

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[1] In the 18th century rights were interpreted as fences or protection for the individual from the unfettered authoritarian governments that were considered the greatest threat to human welfare. Today democratic governments do not pose the same kind of problems and there are many new kinds of threats to the right to life and well being. (Chapman, 1993) Hence in today's environment reliance on mechanisms that provide for collective rights is a more appropriate and workable option. Social democrats all over Europe, in Canada, Australia have adequately demonstrated this in the domain of healthcare.

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

needs of disadvantaged and vulnerable groups who may need special entitlements through affirmative action to rectify historical or other inequities suffered by them.

Thus establishing universal healthcare through the human rights route is the best way to fulfill the obligations mandated by international law and domestic constitutional provisions. International law, specifically ICESCR, the Alma Ata Declaration, among others, provide the basis for the core content of right to health and healthcare. But country situations are very different and hence there should not be a global core content, it needs to be country specific.[3] In India's case a certain trajectory has been followed through the policy route and we have an existing baggage, which we need to sort out and fit into the new strategy.

Specific features of this historical baggage are:

- a very large and unregulated private health sector with an attitude that the existing policy is the best one as it gives space for maximizing their interests, a complete absence of professional ethics and absolute disinterest in organizing around issues of self-regulation, improvement of quality and accountability, and need for an organised health care system
- a declining public health care system which provides selective care through a multiplicity of schemes and programs, and discriminates on the basis of residence (rural-urban) in providing for entitlements for healthcare
- existing inequities in access to healthcare based on employment status and purchasing power
- inadequate development of various preconditions of health like water supply and sanitation, environmental health and hygiene and access to food[4]
- very large numbers of unqualified and untrained practitioners
- declining investments and expenditure in public health
- adequate resource availability when we account for out-of-pocket expenses
- humanpower and infrastructure reasonably adequate, though inequitably distributed
- wasteful expenditures due to lack of regulation and standard protocols for treatment

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

Framework for Right to Healthcare

The quote used as the Preamble is very relevant to the notion of right to healthcare. Sigerist said this long ago and since then most of Europe and many other countries have made this a reality. And today when such demands are raised in third world countries, India being one of them, it is said that this is no longer possible - the welfare state must wither away and make way for global capital! Europe is also facing pressures to retract the socialist

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

[4] Efforts to prevent hunger have been there through the Integrated Child Development Services program and mid-day meals. Analysis of data on malnutrition clearly indicates that where enrollment under ICDS is optimal malnutrition amongst children is absent, but where it is deficient one sees malnutrition. Another issue is that we have overflowing food-stocks in godowns but yet each year there are multiple occasions of mass starvation in various pockets of the country.

measures, which working class struggles had gained since 19th century. So we are in a hostile era of global capital which wants to make profit out of anything it can lay its hands on. But we are also in an era when social and economic rights, apart from the civil and political rights, are increasingly on the international agenda and an important cause for advocacy.

Thus health and health care is now being viewed very much within the rights perspective and this is reflected in Article 12 "The right to the highest attainable standard of health" of the International Covenant on Economic, Social and Cultural Rights to which India has acceded. According to the General Comment 14 the Committee for Economic, Social and Cultural Rights states that the right to health requires *availability*, *accessibility*, *acceptability*, and *quality* with regard to both health care and underlying preconditions of health. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. This understanding is detailed below:

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

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

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

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

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

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-

care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

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

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

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

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

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

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

(a) To ensure the right of access to health facilities, goods and services on a non-dis-

criminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (prenatal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights. (Ibid)

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

Before we move on to suggest the framework it is important to review where India stands today vis-à-vis the core principles of availability, accessibility, acceptability and quality in terms of the State's obligation to respect, protect and fulfill.

In Table 1 we see that the availability of healthcare infrastructure, except perhaps availability of doctors and drugs - the two engines of growth of the private health sector, is grossly inadequate. The growth over the years of healthcare services, facilities, humanpower etc.. has been inadequate and the achievements not enough to make any substantive impact on the health of the people. The focus of public investment in the health sector has been on medical education and production of doctors for the private sector, support to the pharmaceutical industry through states own participation in production of bulk drugs at subsidized rates, curative care for urban population and family planning services. The poor health impact we see today has clear linkages with such a pattern of investment:

- the investment in medical education has helped create a mammoth private health sector, not only within India, but in many developed countries through export of over one-fourth of the doctors produced over the years. Even though since mid-eighties private medical colleges have been allowed, still 75-80% of the outturn is from public medical schools. This continued subsidy without any social return[5] is only adding to the burden of inequities and exploitation within the healthcare system in India.

- public sector participation in drug production was a laudable effort but soon it was realized that the focus was on capital goods, that is bulk drug production, and most supplies were directed to private formulation units at subsidized rates. It is true that the government did control drug prices, but post mid-seventies the leash on drug prices was gradually released and by the turn of the nineties controls disappeared. Ironically, at the same time the public pharmaceutical industry has also disappeared – the little of what remains produces a value of drugs lesser than their losses! And with this withering away of public drug production and price control, essential drugs availability has dropped drastically. Another irony in this story is that while today we export 45% of our drug production, we have to import a substantial amount of our essential drug requirements.[6]

- Most public sector hospitals are located in urban areas. In the eighties, post-Alma Ata and India ratifying the ICESCR, efforts were made towards increasing hospitals in rural areas through the Community Health Centres. This was again a good effort but these hospitals are understaffed by over 50% as far as doctors are concerned and hence become ineffective. Today urban areas do have adequate number of beds (including private) at a ratio of one bed per 300 persons but rural areas have 8 times less hospital beds as per required norms (assuming a norm of one bed per 500 persons). So there is gross discrimination based on residence in the way the hospital infrastructure has developed in the country, thereby depriving the rural population access to curative care services.[7] Further, the declining investment in the public health sector since mid-eighties, and the consequent expansion of the private health sector, has further increased inequity in access for people across the country. More recently a facility survey across the country by the Ministry of Health and Family Welfare clearly highlights the inadequacies of the public health infrastructure, especially in the rural areas.[8] This survey is a major indictment of the underdevelopment of the public healthcare system -

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

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

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

See footnote 8 on next page

even the District Hospitals, which are otherwise well endowed, have a major problem with adequacy of critical supplies needed to run the hospital. The rural health facilities across the board are ill provided. (MOHFW, 2001)

- Family planning services is another area of almost monopolistic public sector involvement. The investment in such services over the years has been very high, to the tune of over 15% of the total public health budget. But over and above this the use of the entire health infrastructure and other government machinery for fulfilling its goals must also be added to these resources expended. This program has also witnessed a lot of coercion[9] and grossly violated human rights. The hard line adopted by the public health system, especially in rural areas, for pushing population control has terribly discredited the public health system and affected adversely utilization of other health programs. The only silver lining within this program is that in the nineties immunisation of children and mothers saw a rapid growth, though as yet it is still quite distant from the universal coverage level.

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

- Piped water is available to only 25% of the rural population and 75% of urban population
- Half the urban population and three-fourths of the rural population does not purify/filter the water in any way
- Flush and pit toilets are available to only 19% of the rural population as against 81% of those in towns and cities
- Electricity for domestic use is accessible to 48% rural and 91% urban dwellers
- For cooking fuel 73% of villagers still use wood. LPG and biogas is accessed by 48% urban households but only 6% rural households
- As regards housing 41% village houses are *kachha* whereas only 9% of urban houses are so
- 21% of the population chews *paan masaala* and/or tobacco, 16% smoke and 10% consume alcohol

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

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

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

[9] It must be noted that coercion was not confined only to the Emergency period in the mid-seventies, but has been part and parcel of the program through a target approach wherein various government officials from the school teacher to the revenue officials were imposed targets for sterilization and IUCDs and were penalized for not fulfilling these targets in different ways, like cuts and/or delays in salaries, punishment postings etc.

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

Other concerns in access relate to the question of economic accessibility. It is astounding that large-scale poverty and predominance of private sector in healthcare have to co-exist. It is in a sense a contradiction and reflects the State's failure to respect, protect and fulfill its obligations by letting vast inequities in access to healthcare and vast disparities in health indicators, to continue to persist, and in many situations get worse. Data shows that out of pocket expenses account for over 4% of the GDP as against only 0.9 % of GDP expended by state agencies, and the poorer classes contribute a disproportionately higher amount of their incomes to access health care services both in the private sector and public sector. (Ellis, et.al, 2000; Duggal, 2000; Peters et.al. 2002). Further, the better off classes use public hospitals in much larger numbers with their hospitalization rate being six times higher than the poorest classes[10], and as a consequence consume an estimated over three times more of public hospital resources than the poor. (NSS-1996; Peters et.al. 2002)

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

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

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

Another stumbling block in meeting state obligations is information access. While data on public health services, with all its limitations, is available, data on the private sector is conspicuous by its absence. The private sector, for instance does not meet its obligations to supply data on notifiable, mostly communicable, diseases, which is mandated by law. This adversely affects the epidemiological database for those diseases and hence affects public health practice and monitoring drastically. Similarly the local authorities have miserably failed to register and record private health institutions and practitioners. This is an extremely important concern because all the data quoted about the private sector is an underestimate as occasional studies have shown.[11] The situation with regard to practitioners is equally bad. The medical councils of all systems of medicine are statutory bodies but their performance leaves much to be desired. The recording of their own members is not up to the mark, and worse still since they have been unable to regulate medical practice there are a large number of unqualified and untrained persons practicing medicine across the length and breadth of the country. Estimates of this unqualified group vary from 50% to 100% of the proportion of the qualified practitioners. (Duggal, 2000; Rhode et.al.1994) The profession itself is least concerned about the importance of such information and hence does not make any significant efforts to address this issue. This poverty of information is definitely a rights issue even within the current constitutional context as lack of such information could jeopardize right to life.

Finally there are issues pertaining to acceptability and quality. Here the Indian state fails totally. There is a clear rural-urban dichotomy in health policy and provision of

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

care; urban areas have been provided comprehensive healthcare services through public hospitals and dispensaries and now even a strengthened preventive input through health posts for those residing in slums. In contrast rural areas have largely been provided preventive and promotive healthcare alone. This violates the principle of non-discri-mination and equity and hence is a major ethical concern to be addressed.

Medical practice, especially private, suffers from a complete absence of ethics. The medical associations have as yet not paid heed to this issue at all and over the years malpractices within medical practice have gone from bad to worse. In this malpractice game the pharmaceutical industry is a major contributor as it induces doctors and hospitals to prescribe irrational and/or unnecessary drugs.[12] All this impacts drastically on quality of care. In clinical practice and hospital care in India there exist no standard protocols and hence monitoring quality becomes very difficult. For hospitals the Bureau of Indian Standards have developed guidelines, and often public hospitals do follow these guidelines. (BIS, 1989; Nandraj and Duggal, 1997) But in the case of private hospitals they are generally ignored. Recently efforts at developing accreditation systems has been started in Mumbai (Nandraj, et.al, 2000)[13], and on the basis of that the Central government is considering doing something at the national level on this front so that it can promote quality of care.

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

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

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

- Allocation of health budgets as block funding, that is on a per capita basis for each population unit of entitlement as per existing norms. This will create redistribution of current expenditures and reduce substantially inequities based on

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

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

residence.[14] Local governments should be given the autonomy to use these resources as per local needs but within a broadly defined policy framework of public health goals

- Strictly implementing the policy of compulsory public service by medical graduates from public medical schools, as also make public service of a limited duration mandatory before seeking admission for post-graduate education. This will increase human resources with the public health system substantially and will have a dramatic impact on the improvement of the credibility of public health services
- Essential drugs as per the WHO list should be brought back under price control (90% of them are off-patent) and/or volumes needed for domestic consumption must be compulsorily produced so that availability of such drugs is assured at affordable prices and within the public health system
- Local governments must adopt location policies for setting up of hospitals and clinics as per standard acceptable ratios, for instance one hospital bed per 500 population and one general practitioner per 1000 persons. To restrict unnecessary concentration of such resources in areas fiscal measures to discourage such concentration should be instituted.[15]
- The medical councils must be made accountable to assure that only licensed doctors are practicing what they are trained for.[16] Such monitoring is the core responsibility of the council by law which they are not fulfilling, and as a consequence failing to protect the patients who seek care from unqualified and untrained doctors. Further continuing medical education must be implemented strictly by the various medical councils and licenses should not be renewed (as per existing law) if the required hours and certification is not accomplished
- Integrate ESIS, CGHS and other such employee based health schemes with the general public health system so that discrimination based on employment status is removed and such integration will help more efficient use of resources. For instance, ESIS is a cash rich organization sitting on funds collected from employees (which are parked in debentures and shares of companies!), and their hospitals and

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

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

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

dispensaries are grossly under-utilised. The latter could be made open to the general public

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

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

The Core Content of Right to Healthcare

Audrey Chapman in discussing the minimum core contents summarises this debate, "Operatively, a basic and adequate standard of healthcare is the minimum level of care, the core entitlement, that should be guaranteed to all members of society: it is the floor below which no one will fall.[17] (Chapman, 1993). She further states that the basic package should be fairly generous so that it is widely acceptable by people, it should address special needs of special and vulnerable population groups like under privileged sections (SC and ST in India), women, physically and mentally challenged, elderly etc., it should be based on cost-conscious standards but judge to provide services should not be determined by budgetary constraints[18], and it should be accountable to the community as also demand the latter's participation and involvement in monitoring and supporting it. All this is very familiar terrain, with the Bhore Committee saying precisely the same things way back in 1946.

We would like to put forth the core content as under:

Primary care services[19] should include at least the following:

- General practitioner/family physician services for personal health care.
- First level referral hospital care and basic specialty services (general medicine, general surgery, obstetrics and gynaecology, paediatrics and orthopaedic), including dental and ophthalmic services.
- Immunisation services against all vaccine preventable diseases.
- Maternity and reproductive health services for safe pregnancy, safe abortion, delivery and postnatal care and safe contraception.

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[17] This implies that the health status of the people should be such that they can atleast work productively and participate actively in the social life of the community in which they live. It also means that essential healthcare sufficient to satisfy basic human needs will be accessible to all, in an acceptable and affordable way, and with their full involvement. (WHO, 1993)

[18] General Comment 3 of ICESCR reiterates this that the minimum core obligations by definition apply irrespective of the availability of resources or any other factors and difficulties. Hence it calls for international cooperation in helping developing countries who lack resources to fulfil obligations under international law.

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

- Pharmaceutical services - supply of only rational and essential drugs as per accepted standards.
- Epidemiological services including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures.
- Ambulance services.
- Health education.
- Rehabilitation services for the physically and mentally challenged and the elderly and other vulnerable groups
- Occupational health services with a clear liability on the employer
- Safe and assured drinking water and sanitation facilities, minimum standards in environmental health and protection from hunger to fulfill obligations of underlying preconditions of health[20]

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

Therefore it is essential to specify adequate minimum standards of health care facilities, which should be made available to all people irrespective of their social, geographical and financial position. There has been some amount of debate on standards of personnel requirements [doctor: population ratio, doctor: nurse ratio] and of facility levels [bed: population ratio, PHC: population ratio] but no global standards have as yet been formulated though some ratios are popularly used, like one bed per 500 population, one doctor per 1000 persons, 3 nurses per doctor, health expenditure to the tune of 5% of GDP etc.. Another way of viewing standards is to look at the levels of countries that already have universal systems in place. In such countries one finds that on an average per 1000 population there are 2 doctors, 5 nurses and as many as 10 hospital beds (OECD, 1990, WHO, 1961). The moot point here is that these ratios have remained more or less constant over the last 30 years indicating that some sort of an optimum level has been reached. In India with regard to hospital care the Bureau of Indian Standards (BIS) has worked out minimum requirements for personnel, equipment, space, amenities etc.. For doctors they have recommended a ratio of one per 3.3 beds and for nurses one per 2.7 beds for three shifts. (BIS 1989, and 1992). Again way back in 1946 the Bhore Committee had recommended reasonable levels (which at that time were about half that of the levels in developed countries) to be achieved for a national health service, which are as follows:

- one doctor per 1600 persons
- one nurse per 600 persons
- one health visitor per 5000 persons
- one midwife per 100 births
- one pharmacist per 3 doctors

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

- one dentist per 4000 persons
- one hospital bed per 175 persons
- one PHC per 10 to 20 thousand population depending on population density and geographical area covered
- 15% of total government expenditure to be committed to health care, which at that time was about 2% of GDP (Bhore, 1946)

The first response from the government and policy makers to the question of using the above norms in India is that they are excessive for a poor country and we do not have the resources to create such a level of health care provision. Such a reaction is invariably not a studied one and needs to be corrected. Let us construct a selected epidemiological profile of the country based on whatever proximate data is available through official statistics and research studies. We have obtained the following profile after reviewing available information:

- Daily morbidity = 2% to 3% of population, that is about 20-30 million patients to be handled everyday (7 - 10 billion per year)
- Hospitalisation Rate 20 per 1000 population per year with 12 days average stay per case, that is a requirement of 228 million bed-days (that is 20 million hospitalisations as per NSS -1987 survey, an underestimate because smaller studies give estimates of 50/1000/year or 50 million hospitalisations)
- Prevalence of Tuberculosis 11.4 per 1000 population or a caseload of over 11 million patients
- Prevalence of Leprosy 4.5 per 1000 population or a caseload of over 4 million patients
- Incidence of Malaria 2.6 per 1000 population yearly or 2.6 million new cases each year
- Diarrhoeal diseases (under 5) = 7.5% (2-week incidence) or 1.8 episodes/child/year or about 250 million cases annually
- ARI (under 5) = 18.4% (2-week incidence) or 3.5 episodes per child per year or nearly 500 million cases per year
- Cancers = 1.5 per 1000 population per year (incidence) or 1.5 million new cases every year
- Blindness =1.4% of population or 14 million blind persons
- Pregnancies = 21.4% of childbearing age-group women at any point of time or over 40 million pregnant women
- Deliveries/Births = 25 per 1000 population per year or about 68,500 births every day

(Estimated from CBHI, WHO, 1988, ICMR, 1990<a>, NICD, 1988, Gupta et.al.,1992, NSS,1987)

The above is a very select profile, which reflects what is expected out of a health care delivery system. Let us take handling of daily morbidity alone, that is, outpatient care. There are 30 million cases to be tackled every day. Assuming that all will seek care (this usually happens when health care is universally available, in fact the latter increases perception of morbidity) and that each GP can handle about 60 patients in a days work, we would need over 500,000 GPs equitably distributed across the country. This is only an average; the actual requirement will depend on spatial factors (density and distance). This means one GP per about 2500 population, this ratio being three times less favourable than what prevails presently in the developed capitalist and the socialist countries. Today we already have over 1,300,000 doctors of all systems (550,000 allopathic) and if we can integrate all the systems through a CME program and redistribute doctors as per standard

requirements we can provide GP services in the ratio of one GP per 700-1000 population.

Organising the Universal Healthcare System[21]

The conversion of the existing system into an organised system to meet the requirements of universality and equity and the rights based approach will require certain hard decisions by policy-makers and planners. We first need to spell out the structural requirements or the outline of the model, which will need the support of legislation. More than the model suggested hereunder it is the expose of the idea that is important and needs to be debated for evolving a definitive model.

The most important lesson to learn from the existing model is how not to provide curative services. We have seen above that curative care is provided mostly by the private sector, uncontrolled and unregulated. The system operates more on the principles of irrationality than medical science. The pharmaceutical industry is in a large measure responsible for this irrationality in medical care. Twenty thousand drug companies and over 60,000 formulations characterise the over Rs. 260 billion drug industry in India.[22] The WHO recommends less than 300 drugs as essential for provision of any decent level of health care. If good health care at a reasonable cost has to be provided then a mechanism of assuring rationality must be built into the system. Family medical practice, which is adequately regulated, along with referral support, is the best and the most economic means for providing good health care. What follows is an illustration of a mechanism to operationalise the right to healthcare, it should not be seen as a well defined model but only as an example to facilitate a debate on creating a healthcare system based on a right to healthcare approach. This is based on learnings from experiences in other countries which have organized healthcare systems which provide near universal health care coverage to its citizens.

Family Practice

Each family medical practitioner (FMP) will on an average enroll 400 to 500 families; in highly dense areas this number may go upto 800 to 1000 families and in very sparse areas it may be as less as 100 to 200 families. For each family/person enrolled the FMP will get a fixed amount from the local health authority, irrespective of whether care was sought or no. He/she will examine patients, make diagnosis, give advise, prescribe drugs, provide contraceptive services, make referrals, make home-visits when necessary and give specific services within his/her framework of skills. Apart from the capitation amount, he/she will be paid separately for specific services (like minor surgeries, deliveries, home-visits, pathology tests etc..) he /she renders, and also for administrative costs and overheads. The FMP can have the choice of either being a salaried employee of the health services (in which case he/she gets a salary and other benefits) or an independent practitioner receiving a capitation fee and other service charges.

Epidemiological Services

The FMP will receive support and work in close collaboration with the epidemiological

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[21] The following discussion is an updated version based on work done by the author earlier at the Ministry of Health New Delhi as a fulltime WHO National Consultant in the Planning Division of the Ministry. An earlier version was published as "The Private Health Sector in India – Nature, Trends and a Critique" by VHAI, New Delhi, 2000

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

station (ES) of his/her area. The present PHC setup will be converted into an epidemiological station. This ES will have one doctor who has some training in public health (one FMP, preferably salaried, of the ES area can occupy this post) and a health team comprising of a public health nurse and health workers and supervisors will assist him. Each ES would cover a population between 10,000 to 50,000 in rural areas depending on density and distance factors and even upto 100,000 population in urban areas. On an average for every 2000 population there will be a health worker and for every four health workers there will be a supervisor. Epidemiological surveillance, monitoring, taking public health measures, laboratory services, and information management will be the main tasks of the ES. The health workers will form the survey team and also carry out tasks related to all the preventive and promotive programs (disease programs, MCH, immunisation etc..) They will work in close collaboration with the FMP and each health worker's family list will coincide with the concerned FMPs list. The health team, including FMPs, will also be responsible for maintaining a minimum information system, which will be necessary for planning, research, monitoring, and auditing. They will also facilitate health education. Ofcourse, there will be other supportive staff to facilitate the work of the health team.

First Level Referral

The FMP and ES will be backed by referral support from a basic hospital at the 50,000 population level. This hospital will provide basic specialist consultation and inpatient care purely on referral from the FMP or ES, except of course in case of emergencies. General medicine, general surgery, paediatrics, obstetrics and gynaecology, orthopaedics, ophthalmology, dental services, radiological and other basic diagnostic services and ambulance services should be available at this basic hospital. This hospital will have 50 beds, the above mentioned specialists, 6 general duty doctors and 18 nurses (for 3 shifts) and other requisite technical (pharmacists, radiographers, laboratory technicians etc..) and support (administrative, statistical etc..) staff, equipment, supplies etc. as per recommended standards. There should be two ambulances available at each such hospital. The hospital too will maintain a minimum information system and a standard set of records.

Pharmaceutical Services

Under the recommended health care system only the essential drugs required for basic care as mentioned in standard textbooks and/or the WHO essential drug list should be made available through pharmacies contracted by the local health authority. Where pharmacy stores are not available within a 2 km. radial distance from the health facility the FMP should have the assistance of a pharmacist with stocks of all required medicines. Drugs should be dispensed strictly against prescriptions only.

Rehabilitation and Occupational Health Services

Every health district must have a centre for rehabilitation services for the physically and mentally challenged and also services for treating occupational diseases, including occupational and physical therapy

Managing the Health Care System[23]

For every 3 to 5 units of 50,000 population, that is 150,000 to 250,000 population, a health

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

district will be constituted (Taluka or Block level). This will be under a local health authority that will comprise of a committee including political leaders, health bureaucracy, and representatives of consumer/social action groups, ordinary citizens and providers. The health authority will have its secretariat whose job will be to administer the health care system of its area under the supervision of the committee. It will monitor the general working of the system, disburse funds, generate local fund commitments, attend to grievances, provide licensing and registration services to doctors and other health workers, implement CME programs in collaboration with professional associations, assure that minimum standards of medical practice and hospital services are maintained, facilitate regulation and social audit etc... The health authority will be an autonomous body under the control of the State Health Department. The FMP appointments and their family lists will be the responsibility of the local health authority. The FMPs may either be employed on a salary or be contracted on a capitation fee basis to provide specified services to the persons on their list. Similarly, the first level hospitals, either state owned or contracted private hospitals, will function under the supervision of the local health authority with global budgets. The overall coordination, monitoring and canalisation of funds will be vested in a National Health Authority. The NHA will function in effect as a monopoly buyer of health services and a national regulation coordination agency. It will negotiate fee schedules with doctors' associations, determine standards and norms for medical practice and hospital care, and maintain and supervise an audit and monitoring system. It will also have the responsibility and authority to pool resources for the organized healthcare system using various mechanisms of tax revenues, social and national insurance funds, health cess etc..

Licensing, Registration and CME

The local health authority will have the power to issue licenses to open a medical practice or a hospital. Any doctor wanting to set up a medical practice or anybody wishing to set up a hospital, whether within the universal health care system or outside it will have to seek the permission of the health authority. The licenses will be issued as per norms that will be laid down for geographical distribution of doctors. The local health authority will also register the doctors on behalf of the medical council. Renewal of registration will be linked with continuing medical education (CME) programs which doctors will have to undertake periodically in order to update their medical knowledge and skills. It will be the responsibility of the local health authority, through a mandate form the medical councils, to assure that nobody without a license and a valid registration practices medicine and that minimum standards laid down are strictly maintained.

Financing the Health Care System

We again reemphasise that if a universal health care system has to assure equity in access and quality then there should be no direct payment by the patient to the provider for services availed. This means that the provider must be paid for by an indirect method so that he/she cannot take undue advantage of the vulnerability of the patient. An indirect monopoly payment mechanism has numerous advantages, the main being keeping costs down and facilitating regulation, control and audit of services.

Tax revenues will continue to remain a major source of finance for the universal health care system. In fact, efforts will be needed to push for a larger share of funds for health care

from the state exchequer. However, in addition alternative sources will have to be tapped to generate more resources. Employers and employees of the organised sector will be another major source (ESIS, CGHS and other such health schemes should be merged with general health services) for payroll deductions. The agricultural sector is the largest sector in terms of employment and population and at least one-fourth to one-third of this population has the means to contribute to a health scheme. Some mechanism, either linked to land revenue or land ownership, will have to be evolved to facilitate receiving their contributions. Similarly self-employed persons like professionals, traders, shopkeepers, etc. who can afford to contribute can pay out in a similar manner to the payment of profession tax in some states. Further, resources could be generated through other innovative methods - health cess collected by local governments as part of the municipal/house taxes, proportion of sales turnover and/or excise duties of health degrading products like alcohol, cigarettes, paan-masalas, guthkas etc.. should be earmarked for the health sector, voluntary collection through collection boxes at hospitals or health centres or through community collections by panchayats , municipalities etc... All these methods are used in different countries to enhance health sector finances. Many more methods appropriate to the local situation can be evolved for raising resources. The effort should be directed at assuring that at least 50% of the families are covered under some statutory contribution scheme. Since there will be no user-charges people will be willing to contribute as per their capacity to social security funding pools.

All these resources would be pooled under a single body, the national health authority, and payments to providers of services would also be made by this body. In order to do this standardized protocols of treatment and charges will have to be evolved and this itself will have a major impact on both quality of care as well as on efficient use of resources.

Projection of Resource Requirements

The projections we are making are for the fiscal year 2000-2001. The population base is one billion. There are over 1.3 million doctors (of which allopathic are 550,000, including over 180,000 specialists), 600,000 nurses, 950,000 hospital beds, 400,000 health workers and 25,000 PHCs with government and municipal health care spending at about Rs.250 billion (excluding water supply).

An Estimate of Providers and Facilities

What will be the requirements as per the suggested framework for a universal health care system?

- Family medical practitioners = 500,000
- Epidemiological stations = 35,000
- Health workers = 500,000
- Health supervisors = 125,000
- Public health nurses = 35,000
- Basic hospitals = 20,000
- Basic hospital beds = 1 million
- Basic hospital staff :
  - general duty doctor = 120,000
  - specialists = 100,000
  - dentists = 20,000
  - nurses = 360,000
- Other technical and non-technical support staff as per requirements (Please note that the basic hospital would address to about 75% of the inpatient and specialist care needs, the remaining will be catered to at the secondary/district level and teaching/ tertiary hospitals)

One can see from the above that except for the hospitals and hospital beds the other requirements are not very difficult to achieve. Train-

ing of nurses, dentists, public health nurses would need additional investments. We have more than an adequate number of doctors, even after assuming that 80% of the registered doctors are active (as per census estimates). What will be needed are crash CME programs to facilitate integration of systems and reorganisation of medical education to produce a single cadre of basic doctors. The PHC health workers will have to be reoriented to fit into the epidemiological framework. And construction of hospitals in underserved areas either by the government or by the private sector (but only under the universal system) will have to be undertaken on a rapid scale to meet the requirements of such an organised system.

An Estimate of the Cost

The costing worked out hereunder is based on known costs of public sector and NGO facilities. The FMP costs are projected on the basis of employed professional incomes. The actual figures are on the higher side to make the acceptance of the universal system attractive. Please note that the costs and payments are averages, the actual will vary a lot depending on numerous factors.

Projected Universal Health Care Costs 2000-2001

	Type of Costs	Rs in Millions	
➢	Capitation/salaries to FMPs (@ Rs.300 per family per year x 200 mi families) 50% of FMP services	60,000	
➢	Overheads 30% of FMP services	36,000	
➢	Fees for specific services 20% of FMP services	24,000	
➢	Total FMP Services	120,000	
➢	Pharmaceutical Services (10% of FMP services)	12,000	
	➢ **Total FMP Costs**		132,000
➢	**Epidemiological Stations** (@ Rs.3 mi per ES x 35,000)		105,000
➢	**Basic Hospitals** (@ Rs.10 mi per hospital x 20,000, including drugs, i.e.Rs.200,000 per bed)	200,000	
	➢ **Total Primary Care Cost**	437,000	
	➢ **Per capita = Rs. 437; 2.18% of GDP**		
➢	**Secondary and Teaching Hospitals,** including medical education and training of doctors/nurses/ paramedics (@ Rs.2.5 lakh per bed x 3 lakh beds)		75,000
	➢ **Total health services costs**	512,000	
➢	**Medical Research (2%)**		10,240
➢	**Audit/Info.Mgt/Social Res. (2%)**	10,240	
➢	**Administrative costs (2%)**		10,240
	➢ **TOTAL RECURRING COST**	542,720	
➢	**Add capital Costs (10% of recurring)**		54,272
	➢ **ALL HEALTH CARE COSTS**	596,992	
	➢ **Per Capita = Rs. 596.99; 2.98% of GDP**		

(Calculations done on population base of 1 billion and GDP of Rs. 20,000 billion; $1 = Rs.45, that is $13.24 billion)

Distribution of Costs

The above costs from the point of view of the public exchequer might seem excessive to commit to the health sector given current level of public health spending. But this is less than 3% of GDP at Rs.597 per capita annually, including capital costs. The public exchequer's share, that is from tax and related revenues, would be about Rs.400 billion or two-thirds of the cost. This is well within the current resources of the governments and local governments put together. The remaining would come from the other sources discussed earlier, mostly from employers and employees in the organised sector, and other innovative mechanisms of financing. As things progress the share of the state should stabilise at 50% and the balance half coming from other sources. Raising further resources will not be too difficult. Part of the organized sector today contributes to the ESIS 6.75% of the salary/wage bill. If the entire organized sector contributes even 5% of the employee compensation (2% by employee and 3% by employer) then that itself will raise close to Rs.250 billion. Infact the employer share could be higher at 5%. Further resources through other mechanisms suggested above will add substantially to this, which infact may actually reduce the burden on the state exchequer and increase contributory share from those who can afford to pay. Given below is a rough projection of the share of burden by different sources:

Projected Sharing of Health Care Costs

(2000-2001 Rs. in millions)

		Central Govt	State/Municp.	Organized Sector	Other Sources
1	Epidemiological services	70,000	25,000	7,000	3,000
2	FMP Services	65,000	45,000	5,000	
3	Drugs (FMP)	5,500	5,500	1,000	
4	Basic Hospital	100,000	85,000	15,000	
5	Secondary/Teaching Hospitals	20,000	30,000	20,000	5,000
6	Medical Research	8,000	1,000	1,000	240
7	Audit/ Info. Mgt./ Soc.Research	5,000	5,000	240	-
8	Administrative Costs	3,000	7,000	240	-
9	Capital Costs	25,000	25,000	4,000	272
	ALL COSTS	**136,000**	**263,500**	**167,980**	**29,512**
			Rs. 596,992 million		
	Percentages	**23**	**44**	**28**	**5**

Creating a consensus on the right to health care

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

The initiative to bring healthcare on the political agenda will have to be a multi-pronged one and fought on different levels. The

idea here is not to develop a plan of action but to indicate the various steps and involvements which will be needed to build a consensus and struggle for right to healthcare. We make the following suggestions:

- Policy level advocacy for creation of an organized system for universal healthcare
- Research to develop the detailed framework of the organized system
- Lobbying with the medical profession to build support for universal healthcare and regulation of medical practice
- Filing a public interest litigation on right to healthcare to create a basis for constitutional amendment
- Lobbying with parliamentarians to demand justiciability of directive principles
- Holding national and regional consultations on right to healthcare with involvement of a wide array of civil society groups
- Running campaigns on right to healthcare with networks of peoples organizations at the national and regional level
- Bringing right to healthcare on the agenda of political parties to incorporate it in their manifestoes
- Pressurizing international bodies like WHO, Committee of ESCR, UNCHR, as well as national bodies like NHRC, NCW to do effective monitoring of India's state obligations and demand accountability
- Preparing and circulating widely shadow reports on right to healthcare to create international pressure

The above is not an exhaustive list. The basic idea is that there should be widespread dialogue, awareness raising, research, documentation and legal/constitutional discourse.

To conclude, it is evident that the neglect of the public health system is an issue larger than government policy making. The latter is the function of the overall political economy. Under capitalism only a well-developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy (which directly benefit capital accumulation) is more urgent (from the business perspective) than the social sectors, hence the latter get only a residual attention by the state. The policy route to comprehensive and universal healthcare has failed miserably. It is now time to change gears towards a rights-based approach. The opportunity exists in the form of constitutional provisions and discourse, international laws to which India is a party, and the potential of mobilizing civil society and creating a socio-political consensus on right to healthcare. There are a lot of small efforts towards this end all over the country. Synergies have to be created for these efforts to multiply so that people of India can enjoy right to healthcare.

Table 1: HEALTHCARE DEVELOPMENT IN INDIA 1951-2000

			1951	1961	1971	1981	1991	1995	1996	1997	1998	2000
1	Hospitals	Total	2694	3054	3862	6805	11174	15097	15170	15188		17,000
	% Rural	39	34	32	27		31	34	34			
		% Private				43	57	68	68	68		
2	Hospital & dispensary beds	Total	117000	229634	348655	504538	806409	849431	892738	896767		1,000000
		% Rural	23	22	21	17		20	23	23		
		%Private				28	32	36	37	37		
3	Dispensaries		6600	9406	12180	16745	27431	28225	25653	25670		
		% Rural	79	80	78	69		43	41	40		
		% Private				13	60	61	57	56		
4	PHCs		725	2695	5131	5568	22243	21693	21917	22446	23179	24,000
5	Sub-centres				27929	51192	131098	131900	134931	136379	137006	140,000
6	Doctors	Allopaths	60840	83070	153000	266140	395600	459670	475780	492634	503947	550,000
		All Systems	156000	184606	450000	665340	920000			1080173	1133470	1,250000
7	Nurses		16550	35584	80620	150399	311235	562966	565700	607376		700,000
8	Medical colleges	Allopathy	30	60	98	111	128		165	165	165	170
9	Out turn	Grads	1600	3400	10400	12170	13934	*	*	*	*	20,000
	P. Grads			397	1396	3833	3139			3656		5,000
10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3	38.4	79.4	91.3	104.9	120.7	165.0
11	Health outcomes	IMR/000	134	146	138	110	80	74/69	72	71	72	70
		CBR/000	41.7	41.2	37.2	33.9	29.5	29	27	27	27	26
		CDR/000	22.8	19	15	12.5	9.8	10	9	8.9	9	8.7
	Life Expectancy	years	32.08	41.22	45.55	54.4	59.4	62	62.4	63.5	64	65
	Births attended by trained practitioners	Percent				18.5	21.9		28.5		42.3	
12	Health Expenditure	Public	0.22	1.08	3.35	12.86	50.78	82.17	101.65	113.13	126.27	178.00
	Rs. Billion	Private@	1.05	3.04	8.15	43.82	173.6	233.4		399.84		
		CSO		2.05	6.18	29.70	0	7	329.00	373.00	459.00	833.00
		estimate pvt.					82.61	279.00				
	Health Expenditure as percent of GDP	Public	0.25	0.71	0.84	1.05	0.92	0.95	0.91	0.88	0.81	0.87
		Private		1.34	1.56	2.43	1.73	3.25	2.95	2.94	2.98	4.07
		CSO										
	Health Expenditure as % to Govt.	Public	2.69	5.13	3.84	3.29	2.88	2.13	2.98	2.94	2.7	2.9
	Total											

Data from - 1951:NSS 1st Round 1949-50; 1961: SC Seals All India District Surveys,1958; 1971: NSS 28th Round 1973-74; 1981: NSS 42nd Round 1987; 1991 and 1995: NCAER – 1990; 1995: NSS 52nd Round 1995-96; 1997: CEHAT 1996-97

*Data available is grossly under-reported, hence not included

Notes: The data on hospitals, dispensaries and beds are underestimates, especially for the private sector because of under-reporting. Rounded figures for year 2000 are rough estimates.

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

Annexure 8

Building a Right to Health Campaign

- By Dr. T. Sundararaman

Right to Health is universally accepted as a basic and inalienable human right. This consensus cuts across the political spectrum. Even in a state governed by undiluted neo-liberalism, though state provision of health care is opposed, state financing of health care in such a way that even the poor have some basic access to health care is conceded as a principle that should govern health policy. This of course does not mean that all sections are equally serious about implementation of such a policy. Political practice has a set of priorities very different from political theories. Where a democratic awareness is low there is less likelihood of converting a stated opinion into a legal framework. Where a democratic awareness is high health care services benefit early and more extensively than other sectors. Thus in the OECD countries – excluding the US, close to 90% of all health expenditure is borne by the state.

In the third world context exemplified by India, though accepted as a principle this right is far from reached. However in public consciousness the network of government health centers – dysfunctional and non-functional though they may be – is representative of this commitment to provide health for all and in a situation of low awareness their mere existence is even seen as an acquittal of that commitment. Its non-use or poor functioning is attributed to poor people's awareness, poor employee motivation, poor administration – but seldom is it seen as a political failure for which political leaderships must be held accountable. Other token gestures like huge, well publicized health camps and photograph-centered health programmes also play a major role in gaining political good will though they contribute negligibly in terms of health outcomes.

There are many reasons for this and the basic reasons are well known. Nothing is gained from contesting who can articulate it louder, better, sharper, clearer, more radically, with more data, with more sohphiscation etc. The point is how to change the existing situation. How to make-

- the right to health into a judiciable right
- denial of the right to health morally reprehensible
- How to make the right to health politically critical -punishable by an aware electorate.

For building an effective campaign for right to health the central task must necessarily be the task of mobilizing those who are personally facing the brunt of the anti-people policies- the millions of the poor who have reducing access to public health services, the millions who suffer from bad, unregulated private sector care, those who die of starvation, those who suffer from a lack of basic working and living conditions. Any movement that is not based on the mobilization of this section is seriously limited. Moreover it is inconsistent within itself. (If a key slogan is peoples health in peoples hands – but then it has to be placed in there by people themselves). Since the majority are suffering one expects this section to be the most steadfast and militant in the fight for change.

However most organizations and networks currently focusing on right to health come from solid middle class backgrounds and the organizations themselves are not "owned" by

any of these large sections of the working people. It is obviously the mass organizations of the working people, organized and led by their own leaders who can best take forward this struggle. The health networks and NGOs can at best be of assistance to them and interact with them on this.

In practice the organizations of working people representing the sections mostly affected by the current health policies have not taken up health issues in a major way. Nor except in a few instances coalition built up in an effective campaign. One reason for this situation is that most of the traditional organizations of the working people respond to the problems as perceived by their membership. Since the dominant perception of health remains drugs, doctors and diseases, most of these organizations can seldom go beyond the limitations of these perceptions.

Of course even within this perception certain demands like increase in budgetary allocations and expansion of state provided services and increase in wages and service conditions of employees form a ground for action – but they are not adequate to form a movement. By failing to account for problems like inadequate utilization of existing services, by unquestioningly accepting the current package of services and by failing to address questions like corruption, these movements fail to find credibility and to pose alternatives. Today in a curious twist of events the very points articulated by traditional left can be voiced by the international agencies for completely opposite goals. Thus the poor public sector performance becomes a justification for privatization and for farming out health care and health institutions to NGOs. The increase in budgetary allocation for health is resoundingly made by the Bank, as other areas of public investment are less permissible in a neo liberal framework.

Even if sections of the leadership of such mass organizations are convinced of this need to build an alternative consciousness of health, they still have the problem of how to be able to take their membership along given its existing perception, or even how to build a movement in these terms. It is one thing to convert a felt need into an agitation. It is even possible to give voice to demands that are perceived but for many reasons not hitherto been articulated. But the lot of health movements is very often to question existing popular demands – not articulate them. And this can be problematic for politics as it is currently constituted. Thus for example opening new medical colleges is seldom questioned especially if it is in the private sector. Many villages when asked would want a health center or hospital in their village though another one nearby would be languishing.

Another level of mobilizing against neo-imperialism and its anti people policies is in the arena of " public opinion". Does public opinion reflect the views of the majority of the people? It is perhaps more reflective of the newspaper reportings of more articulate sections, much of it being the organized workers and the middle class. Nevertheless this public opinion does actively shape politics and is a most important arena for intervention. The Jan Swasthya Abhiyan has been relatively more successful in this task. The entire mobilization for PHA, the books we published and sold, the media events widely reported in the regional papers, the meetings held with editors of newspapers all contribute to keeping health issues in the public eye and in shaping a critical understanding of health policies by the public. However the current ruling political parties, knowing the limited mass support we enjoy can safely ignore us and our views or at the most weather the minor disturbances we

create. This indeed is the way they responded to the People's Health Assembly (PHA), to our critique of health policy, to our views on drug policy and would now do so to our right to health campaign.

Also we need to note that the majority from the poorer section subscribe to the dominant perspectives of health and health policy and they have in the main an "apolitical" and techno-centric view of health issues including an uncritical understanding of the authority of health professionals and health institutions like WHO. Though our oppositional perspectives are welcomed by a small politically conscious section, we are often limited to talking within this "converted" section and unable to make inroads into the larger apolitical majority. The majority of such "public opinion" today sees privatizations as good care given a failing public health system. By quoting figures showing the higher utilization of public services by the middle class a case is made that since anyway the poor do not access public health care facilities the exclusion of the poor is not a valid argument against privatization!! This is very similar to the arguments used for dismantling the Public Distribution System.

For mobilization within this section, two apparently contradictory approaches are useful. One is the articulation of comprehensive radical critiques, (if possible with alternatives) for marking out the correct political position. Even if people do not immediately accept such a radical critique however convincingly portrayed, we can hope that eventually as ruling class policies fail they will stand exposed and the correctness of the radical position will become more self-evident.

Another approach is to engage in lobbying and advocacy for policy changes or even administrative measures that cause an improvement here or there, without necessarily even seeking for major, leave alone radical changes. Many who take this approach do not share any overall critique of capitalism. They believe that administrators and policy makers have no inherent bias and can be convinced by argument and example. To some such minor reforms are all that is possible or even desirable. However once they engage in such action they come to increasingly see the obstacles in the way of change and come to have a better grasp of the issues involved. They thus rediscover for themselves the under-standing that many founders of the health movement had come to almost half a century ago.

And this process of rediscovering for themselves is important. Many, many of the people who are active in health advocacy and even in radical opposition today have come through just such a process. Many professionals in my institution who got into drug policy issues purely as an issue of professional clinical pharmacology or because they were put on some official committee or other where they felt the need to contribute, have oven ten years developed a much better view of politics of health. Whereas those who did not get into any activity have remained unmoved and reactionary as ever. As new generations are spawned out of our educational system, exposed to no ideological influence but the mainstream media, any move that involves them in any type of collective work, that too with a commitment to the poor is a step forward. It is the passiveness and self-centeredness of the majority that is more dangerous. In the course of the PHA and follow up, we have been witness to even orgainisations moving into more comprehensive understandings than what they started out with. And many of them may be willing to share an oppositional – agitational platform today which they would have been unwilling to do just three years back.

The scope of even this movement for the shaping of public opinion is currently too feeble and often reduced to token gestures – a conference resolution, a press release etc. To generate a public debate on many of these issues much more active work needs to go in. The judicial route and Public Interest Litigations (PIL) is one way to catch the media attention and put pressure on the administration and political sphere. Media events like conferences or sit-ins or limited agitational action also helps fuel the debate. Some of the concessions won through legal action, through administrative action forced by such public pressure can be used to strengthen mass action and the larger political consciousness that in turn leads to political change. Indeed mass action cannot be encouraged and sustained without short term gains.

Which leaves us with the core question of how does one build a larger public campaign for the 'right to health' – campaign in which the millions of the affected join in and lead ? This was indeed the promise of the PHA and why the PHA drew such a tremendous response and we need to reflect whether we have lived up to the expectations and implicit commitments of such a mobilization? Indeed if we look at post PHA action directions – we would find that as a coalition – in all dimensions except one we made some progress – however modest. The exception was in our slogan " a health worker in every village".

" A health worker in every village" is not possible for any one organization but potentially with all the partners growing it is possible for the Jan Swasthya Abhiyan – especially if it is enriched by more networks involved in the Asian social forum process. But these partners have to be ready to wed themselves into a programme of coordinated grass roots action with geographical distribution of work – with blocks or even smaller cluster of units as the unit of distribution. "A health worker in every village" is not possible if we restrict it to one definition of the health worker – shall we say the Jamkhed or David Werner model, but is certainly possible if we understand it to involve a multiplicity of models and local goals and activity sets for the health worker. Largely the set of activities that shall define this health worker are-

1. Increased health education and health awareness work
2. Improved utilization and pressure to increase health care services.
3. Collective action by people to safeguard and improve their health which may include curative care services provided by the health worker.
4. Organization of women and coordination with women's empowerment activities
5. Intervention in and strengthening of the elected local body's capabilities and role in health care. Arguably these health workers are better named as local health activists.

" A health worker in every village" is not possible if this network has some persons doing the work and others holding the net. Experience shows that through an almost inevitable process those merely holding the net often take leadership roles promptly denying and distancing themselves for local action for immediate demands especially if it involves service provision or linkages with government as politically incorrect. But then working out an alternate, non-heirarchial system of coordination becomes a challenge.

"A health worker in every village" is not possible if it is understood only as recruiting training and deploying one indivdual in every village. The health worker must be understood

as an idiom for and an organizer of collective local action on behalf of weaker sections of the village using the space created by the broader consensus on right to health and the lesser resistance this would generate. If participatory local action is organized and if it is led by participatory NGOs and peoples movements coordinated in a participatory matter then one leads to major expansion of democratic and secular space within civil society - which is one of the most urgent needs of the day. Such programmes can link up with local programmes in education, agriculture, credit cooperatives and so on – but it just appears that at the moment health is an easier and better initiator for a nationwide movement.

There are many who worry about large networking – seeing in it empire building. Such concerns are well taken but if they become the deciding concern then we need to remember that globally and nationally the most reactionary sort of empires are in the making and working in a few villages would soon become altogether impossible if they succeed. Everyone needs to be working in a few villages but together we – a much larger we than we have today – must be working in every village if the forces of darkness are to be resisted.

This slogan does not exclude campaigns like right to food or right to essential drugs or civic rights – it is an idiom of grassroots level combination of forces. I suspect that with the success of the ASF, more such ASF platforms at the national level will give diminishing returns with each repetition unless there is a coming together at field level work and with a health worker at every village all these would take on much greater meaning – especially if there are mechanism to get their feedback and priorities for launching such campaigns.

"A health worker in every village" as a campaign requires to be built around immediate measures to alleviate the pain and suffering of people. Whatever local collective action can be generated and whatever local administrative action can be pressured boosts the move forward. However for more tangible gains – side by side with local action we need to work at reform of the public health system – so that is can deliver. The public health systems' failure to deliver has many facets and should not be reduced to one or two – (budget, lack of accountability etc.) There must be pressure for health sector reform at our terms. This requires the JSA to urgently take stock of all exisiting health sector reform plans and simultaneously pose our own alternative health sector reform plan– an immediate two year budgeted plan not requiring a change of systems. Such an implementable plan must show what can be done to improve services and respond to the pressures created by health workers. Such a plan would also counter the ideological use of the public system's failure to bolster the plans for privatization and further marginalisation of the poor.

The development of such alternate health sector reform plans (as different from revolutionary alternatives) again requires entirely new linkages – national and global – with professionals and academicians –all working in the context of " a health worker in every village". The alternate health sector reform plans should be a systems approach to the problems, that leads towards decentralized health planning and implementation, incorporates issues of heath financing and legal entitlements and is consistent with a move towards a radical health policy though in itself it is not a radical alternative – only a ground for optimism about the future.

Arguably the greatest immediate need for the movement for right to healthcare is optimism about the possibilities of generating changes in our lifetimes.

Annexure 9

International Covenant on Economic, Social and Cultural Rights (ICESR)

Unofficial Summary

Article 1

All peoples have the right of self-determination, including the right to determine their political status and freely pursue their economic, social and cultural development.

Article 2

Each State Party undertakes to take steps to the maximum of its available resources to achieve progressively the full realization of the rights in this treaty. Everyone is entitled to the same rights without discrimination of any kind.

Article 3

The States undertake to ensure the equal right of men and women to the enjoyment of all rights in this treaty.

Article 4

Limitations may be placed on these rights only if compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.

Article 5

No person, group or government has the right to destroy any of these rights.

Article 6

No person, group or government has the right to destroy any of these rights.

Article 7

Everyone has the right to just conditions of work; fair wages ensuring a decent living for himself and his family; equal pay for equal work; safe and healthy working conditions; equal opportunity for everyone to be promoted; rest and leisure.

Article 8

Everyone has the right to form and join trade unions, the right to strike.

Article 9

Everyone has the right to social security, including social insurance.

Article 10

Protection and assistance should be accorded to the family. Marriage must be entered into with the free consent of both spouses. Special protection should be provided to mothers. Special measures should be taken on behalf of children, without discrimination. Children and youth should be protected from economic exploitation. Their employment in dangerous or harmful work should be prohibited. There should be age limits below which child labor should be prohibited.

Article 11

Everyone has the right to an adequate standard of living for himself and his family, including adequate food, clothing and housing. Everyone has the right to be free from hunger.

Article 12

Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health.

Article 13

Everyone has the right to education. Primary education should be compulsory and free to all.

Article 14

Those States where compulsory, free primary education is not available to all should work out a plan to provide such education.

Article 15

Everyone has the right to take part in cultural life; enjoy the benefits of scientific progress.

References

Abel-Smith,Brian, 1977 : Minimum Adequate Levels of Personal Health Care, in Issues in Health Care Policy, ed.John Mckinlay, A Milbank Reader 3, New York

Andreassen, B, Smith, A and Stokke, H, 1992: Compliance with economic and Social Rights: Realistic Evaluations and Monitoring in the Light of Immediate Obligations in A Eide and B Hagtvet (eds) Human Rights in Perspective: A global Assessment, Blackwell, Oxford

Bhore, Joseph, 1946 : Report of the Health Survey and Development Committee, Volume I to IV, Govt. of India, Delhi

BIS, 1989 : Basic Requirements for Hospital Planning CIS:12433 (Part 1)-19883, Bureau of Indian Standards, New Delhi

BIS, 1992 : Basic Requirements for a 100 Bedded Hospital, A Draft Report, BIS, New Delhi

CBHI, various years : Health Information of India, Central Bureau of Health Intelligence, MoHF&W, GOI, New Delhi

Chapman, Audrey, 1993: Exploring a Human Rights Approach to Healthcare Reform, American Association for the Advancement of Science, Washington DC

Duggal, Ravi, 2000: The Private Health Sector in India – Nature, Trends and a Critique, VHAI, New Delhi

Duggal, Ravi 2002: Resource Generation Without Planned Allocation, Economic and Political Weekly, Jan 5, 2002

Ellis, Randall, Alam, Moneer and Gupta, Indrani, 2000: Health Insurance in India – Prognosis and Prospectus, Economic and Political Weekly, Jan.22, 2000

General Comment 3…

General Comment 14…

Gupta, RB et.al.,1992 : Baseline Survey in Himachal Pradesh under IPP VI and VII, 3 Vols., Indian Institute of Health Management Research, Jaipur

ICESCR….

ICMR, 1990 <a>: A National Collaborative Study of High Risk Families - ICMR Task Force, New Delhi

MoCF, 2001: Annual report, Dept. of Chemicals and Petrochemicals, Ministry of Chemicals and Fertilizers, GOI, New Delhi

MoHFW, 2001: India Facility Survey Phase I, 1999, IIPS, Ministry of Health and Family Welfare, New Delhi

Nandraj, Sunil and Ravi Duggal, 1997 : Physical Standards in the Private Health Sector, Radical Journal of Health (New Series) II-2/3

NFHS-1998, 2000: National Family Health Survey –2: India, IIPS, Mumbai

NICD, 1988: Combined Surveys on ARI, Diarrhoea and EPI, National Inst. of Communicable Diseases, Delhi

NSS-1987 : Morbidity and Utilisation of Medical Services, 42nd Round, Report No. 384, National Sample Survey Organisation, New Delhi

NSS-1996 : Report No. 441, 52nd Round, NSSO, New Delhi, 2000

OECD, 1990 : Health Systems in Transition, Organisation for Economic Cooperation and Development, Paris

Phadke, Anant, 1998: Drug Supply and Use – Towards a rational policy in India, Sage, New Delhi

Rhode, John and Vishwanathan, H, 1994: The Rural Private Practitioner0, Health for the Millions, 2:1, 1994

Toebes, Brigit, 1998: The Right to Health as a Human Right in International Law, Intersentia – Hart, Antwerp

WHO, 1961 : Planning of Public Health Services, TRS 215, World Health Organisation, Geneva

WHO, 1988 : Country Profile - India, WHO - SEARO, New Delhi

WHO,1993: *Third Monitoring of Progress, Common Framework*, CFM3, Implementation of Strategies for Health for All by the Year 2000, WHO, Geneva,

Jan Swasthya Abhiyan (JSA) (translates from Hindi as People's Health Movement) has emerged from the People's Health Assembly Process in India. It is a coalition of 18 national networks, and more than 1,000 organizations from all over the country working in the field of health, science, women's issues and development. The inception of JSA took place during the National Health Assembly in Kolkata on the 30th of November and 1st of December 2000. The Abhiyan has taken up the campaign for the right to health care. It stands for 'Health For All, Now! Health Care For All, Now!'

CEHAT in Hindi is Health. **Centre For Enquiry Into Health And Allied Themes** is the research centre of Anusandhan Trust. It is involved in research, action, service and advocacy on health and allied themes. Socially relevant and rigorous academic health research and health action at CEHAT is for the well being of the disadvantaged masses, for strengthening people's health movements and for realising right to health care. CEHAT's work is focused on four broad themes, Health services and financing, Health legislation, ethics and patients' rights, Women's health and Investigation and treatment of psycho-social trauma. CEHAT is based in Mumbai (Mah), Pune (Mah) and Indore (M.P.), India.

The Global Health Council (GHC) is the world's largest membership alliance, based in the United States and dedicated to global health. The Council fulfills its mission to further the cause of improving health equity worldwide through Advocacy, Building alliances, and Communicating best practices and experiences. Every year in May, the Global Health Council host an Annual Conference on a particular global health issue. The Council believes that directing common efforts politically and practically will dramatically reduce disease and death in all countries.

The National Centre For Advocacy Studies (NCAS) is a membership based social change resource centre that aims at strengthening rights based and people centred advocacy, so as to empower people who are struggling for the creation of a just and humane society. NCAS began its work in 1992 and is located in Pune (Mah), India. The activities of NCAS include Imparting training for the leaders and activists of the voluntary organisations, Research and Documentation relevant for advocacy efforts and Networking with voluntary organisations working on common issues.

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