Right to Health in India: Contemporary Issues and Concerns

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Introduction

A lot of things have changed in the field of health since India became independent. Much of the time the only health indicator which seems to be of concern seems to be the country’s population. This is the only number displayed on the boards of important national institutions like the offices of Ministry of Health and Family Welfare office, and the All India Institute of Medical Sciences in New Delhi. And most people see the very high increase of our population from about 30 crore at the time of independence to over 120 crore now as ‘bad news’. But many other numbers have changed as well, and we seldom give them much thought. The average life expectancy of an Indian was a little over 32 years in 1947 and has now doubled to over 65 years for both women and men. The death rate, which was as high as 27 people for every thousand persons has come down to less than 9, and where every third child out of twenty born died before the age of one year, now it is less than 1 child. Over these years we have many more doctors, nurses and hospitals, and the healthcare system is able to save many more lives with the new technologies that are now available. Our country has emerged as a major source of production of medicines and is probably the cheapest in the world. Our healthcare systems are so good now, that people not only from our

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neighbouring and poorer countries, but also those from the western affluent countries, come to India for health care. These are among the 'good news'.

Some readers may by now start feeling a little uncomfortable that this is not the complete picture and I will not be surprised. Their experience of the health related situation could be very different. They may have experienced how expensive the private medical care system is. Others may have had to pay bribes in so-called free public hospitals. Many may have seen that there are no doctors available in rural health centres. Others may feel that it is not 'right' that the poor are unable to get health care services from Indian hospitals while the rich from foreign countries are freely able to get care because they can pay. In their experiences with the health care system, many may have felt helpless as they didn't know why they were given the treatment they were given, because the busy doctors never explained, others may have felt 'pushed' to accepting a treatment they didn't want because the doctor never asked them what they wanted. Moving away from personal experiences we sometimes read or hear about dogs in the labour room, of ambulances which arrive after the patient died, of the government doctors who keep the poor women in the labour waiting all day long because they are busy with patients in their private chamber and a host of other incidents which appear to be 'wrong'.

On closer examination most healthcare related circumstances do not seem the same for all people. First there seems to a difference in the health system's approach to different people, for example nurses as well as doctors are often dismissive towards the not so well dressed while being pleasant towards the well turned out and English speaking patient in the same hospital. Second there is also the difference in survival rates, for example, children born in the villages of Uttar Pradesh survive much less than those born in the condominiums of Noida not far away. To some these differences may seem 'natural and normal' to others they may feel 'unfair'. The concept of 'fairness', and the quest for 'equality' among human beings, underpins our understanding of 'human rights'. It influences the way we see and respond to the world around us, including in the domain of health. This article will trace the evolution of the 'right
to health', how this right is articulated and implemented both globally and in India and conclude with a review of its contemporary status in India.

**Evolution of the Modern Human Right to Health**

The modern idea of ‘human rights’ was concretised soon after the Second World War. To many among the victorious Allied forces, Hitler’s treatment of the Jews was not only wrong but also unacceptable. Many of the atrocities unearthed during the Nuremberg trials were ‘scientific experiments’ conducted by Nazi doctors. Today these are considered torture. This difference in our understanding of how we can or should treat any fellow human being, and especially how a country treats its citizens is the basis of ‘human rights’. Human rights have been identified and then elaborated through a series of covenants and treaties within the United Nations system. Soon after the Nuremberg trials followed the Universal Declaration of Human Rights (UDHR) – a declaration of how individuals in the world should be treated. On the 10th of December 1948 the United Nations accepted the UDHR which begins with declaration that ‘all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.’ The UDHR also affirms that the concept and respect of human rights is the basis for freedom, justice and peace in the world. The right to health is included as Article 25 of the UDHR, and declares that “(E)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.” The second part of this Article makes reference to the care needs of mothers and children.

A few months earlier on the 7th of April 1948 the Constitution of the World Health Assembly was adopted, and this included ‘(T)he 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’ as one of its core
principles. While the need for including right to health within the overall framework of human rights was felt from the beginning of the articulation of rights, an understanding of the ways in which this could be practically done has emerged much later.

Human rights are often categorised as first and second generation rights, or as positive and negative rights. Health is seen as a second generation or positive right. What it means in real terms is that achievement of the right to health requires the state to take some deliberate actions/make provisions so that a person can enjoy these rights. These could be arrangements for hospitals, or for making safe drinking water available, or provide vaccines for children. The right to education also falls into this category. This is in contrast to the right to freedom of speech or of assembly where there the individual needs no state support to either speak or to make friends and associates. This category is often referred to as civil and political rights, while the rights related to health or education are referred to as economic, social and cultural rights. The UN has two separate Covenants the ICCPR\(^1\) and ICESCR\(^2\) which came into effect in 1966 and 1967 and together with the UDHR these three documents comprise the International Bill of Rights. This gives the three the status of International Law and all states/countries that sign onto these documents become duty bound to follow the letter and principle of these laws. Right to health is included as Article 12 of the ICESCR. The nature of the right to highest attainable standard of health was however not clearly explained till 2000 when the General Comment 14 was issued. This clarified that the right to health included

a) individual freedoms like the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation.

b) right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

\(^1\) ICCPR stands for International Covenant on Civil Political Rights  
\(^2\) ICESCR stands for International Covenant on Economic Social and Cultural Rights
The system of health protection included a range of appropriate services which were to be available, accessible, (culturally) acceptable and of high quality. Non discrimination and equal treatment is fundamental to the exercise of this right. The acceptance of this right by a country calls for it to adopt laws, policies and plans to meet the health needs of its citizens. The right to health is often confused with the right to healthcare, which is a limited concept and is restricted to services which are directly related to health, i.e. primarily curative and preventive health services. With the right to health all underlying determinants of health including nutritious food, safe water, clean air, safe workplace environment and harmful traditions and practices are included within the ambit of this right. However the right to health was not made a mandatory obligation of governments because it was also realised that it would be difficult for poorer countries to make the same provisions as developed countries, and thus a principle of progressive realisation was included within the operational principles. But a concept of ‘core obligations’ were also introduced, to ensure that countries were obliged to provide a minimum set of provisions for its citizens. India is a signatory to the ICESCR.

Right to Health in India

At the same time that the UN was deliberating the UDHR, the Indian Constituent Assembly was deliberating the nature and remit of Constitutional or fundamental rights for the Indian citizens. Using principles similar to that of the first and second generation rights – two different sets of obligations were included within the Indian Constitution. The first included the ‘fundamental rights’ which were rights for which the state or governmental obligations were absolute and the second category were the ‘directive principles’ which were to be progressively realised. The constitutional provision for right to health is not very explicit and is included within Articles 42 and 47. Article 42 makes “(P)rovision 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 makes it the “(D)uty 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”. However since these are part of the directive principles, these are neither mandatory nor can they be basis for bringing a lapse to the notice of the court.

However the Supreme Court of India, through its progressive interpretation of the Constitution has effectively included the right to health as an integral part of the right to life (Article 21) which is a fundamental right. Through a number of cases like the Bandhua Mukti Morcha vs Union of India, Consumer Education and Resource Centre Vs Union of India, State of Punjab and Others v. Mohinder Singh, Parmanand Katara Vs Union of India, Paschim Baga Khet Mazdoor Samiti Vs State of West Bengal and others, the Supreme Court has held that various conditions which make up the right to health like

- all the necessities of life such as adequate nutrition, clothing.
- clean drinking water and sanitation facilities.
- humane working conditions and health services.
- medical care professional obligation of doctors, both public and private to extend his services with due expertise for protecting life.
- to provide timely medical treatment to a person as legal and mandatory obligations of the state.

Constitutional Right to Health: A global review

While International human rights law mandates right to health as an integral part of human rights, at the country level, constitutions have a natural and much greater legitimacy. A review of constitutional provisions

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3 This paragraph draws from Legal Position on Right to Health Care Part II available at http://www.cehar.org/rthc/paper3.htm
(Kinney and Clarke 2004) around right to health found that 67.5 percent of the 159 country constitutions reviewed had some provisions around the right to health.

The study found that many of the countries which had their constitutions framed after the second world war had the right to health included within it, while some countries which had older constitutions, like Netherlands, Belgium, Canada had revisions in the 1980 – 90 period incorporating health related provisions. Interestingly some poor countries, like Haiti, had an elaborate articulation of the right to health, while many countries with substantial financial and programmatic attention to health care did not have any constitutional mandate. The second group includes rich European countries like Germany, Norway, France and Denmark.

In a separate review (Backman et al 2008) the health systems of 194 countries were reviewed to understand whether they included ‘right to health’ features. The features which were considered part of this approach include the following:

- Legal recognition and legal obligation – this includes both constitutional recommendation and case laws as in the case of India
- Standards and Quality – details about what the society can expect in term of health care and other provisions like safe drinking water, blood safety, essential medicines as well as availability of health workers and so on.
- Participation – provisions for the participation of all relevant stakeholders including disadvantaged groups, ordinary citizens / general population. Examples include the health conferences/ assemblies in Brazil, Peru and Thailand.
- Transparency – freely available information about health sector provisions and performance like quality, availability and pricing of essential medicines, private and public sector performance and so on.
• Equity, equality and non-discrimination - provisions to ensure outreach and inclusion to the most marginalised e.g. provisions for women, children, adolescents, marginalised population groups.
• Respect for cultural differences
• Referral systems
• Planning, monitoring and accountability
• Coordination systems and international coordination

The review found that a large majority of countries (121) did not include a constitutional provision. Most countries lacked a comprehensive health plan, and without disaggregated data attention to discrimination was difficult to monitor and accountability mechanisms were found to be weak in most countries. In conclusion the paper finds that the current state of information and data was inadequate to either find whether states were fulfilling their core obligations or whether there were any steps towards progressive realisation.

Right to health and the evolution of the Indian health system

The Indian health system is undergoing many changes both in operational and conceptual terms. Fundamentally India has a very mixed and complicated health system with a mixture of traditional and modern practices and belief systems. India has the distinction of both formal and informal traditional systems being used widely, and the formal traditional systems are now incorporated within public policy architecture through a separate Department of AYUSH (Ayurvedic, Unani, Siddha and Homoeopathy). There are separate medical colleges training health care providers in each of these different disciplines. Today many primary health centres across rural India provide modern medicine and traditional medicines concurrently, indicating a strong respect for local preferences, a key component of a right based approach. However local health traditions are not limited to the formal practitioners and include faith healers, herbal healers, bone setters and others and these systems still remain outside the ambit of policy discussions.
The broad outlines of India public health system was drawn up a little prior to independence by the Bhore committee (1946)\textsuperscript{4}. The PHC (Primary Health Centre) based template of the Bhore committee report, with the aim of universal coverage and population-based parameters remains in place even now. However more than 70 years later it has not been able to meet health rights of its citizens. In the 1960’s the health system became distracted by the compulsions of population control and progressively the Family Planning and Family Welfare component overwhelmed the health component of the programme, leading to the establishment of a new and better resourced Department of Family Welfare. The family planning programme with its population control focus with targets and incentives introduced a period of human rights violations being committed by the health sector. These included among others coercive sterilisations and gross negligence. Some aspects of those days continue through camps, target and incentive based sterilisation programmes in some states even today.

In the 1990’s and later it was realised that this obsession had neither yielded the anticipated results, and the overall public funding available to health care had become very little. While the trend in most countries was that public expenditure was the greatest component in health care expenditure, in India, it constituted only about 20 per cent\textsuperscript{5}. The private health care industry had started booming in the face of economic reforms starting from 1980’s and in 2000 it was found that health care cost had become the second largest cause of rural impoverishment and a large number of families became poor because of one episode of hospitalisation in the family. This pointed to a gross violation of the principles of economic accessibility, a core component of the right to health.

From the late 1990s onwards a series of changes, often conflicting, were introduced in the health system both at the national and state levels. According to constitutional provisions, health remains a state subject, while public health and family planning remain in the concurrent domain,

\textsuperscript{4} Health Survey and Development Committee was established in 1943 and was chaired by Sir Joseph Bhore.

\textsuperscript{5} Information available from National Health Accounts, India 2001-02
i.e. part of both central and state jurisdiction. In the changes subsequent to 2000 the area of agreement has been that the state investment in health has to increase from an abysmally low 0.9 per cent of GDP in 2000. However what is uncertain has been the route of providing services. Sometimes the privatisation has been seen as the route, while at other times the public sector has been seen as most important. At one point, public sector improvement was seen through a user-fees model, but now free service at the point of delivery is being seen as the alternative. At this time the consensus appears to be that the public sector has to be the main financer of health services, while the provisioning could be through different methods like public provisioning, contracting-in of providers, health insurance or other methods which include private sector engagement. The National Rural Health Mission (NRHM), the Rashtriya Swasthya Bima Yojana, a health insurance scheme for non-formal sector workers, various state level health insurance schemes for secondary and tertiary care like the Aarogyashri Scheme and others remain key platforms and mechanisms for delivering public services to the poor.

The concept of Universal Health Coverage has been recently discussed and deliberated through a specially constituted committee of the Planning Commission of India (High Level Expert Group or HLEG) and its report (HLEG 2011), which includes financial, managerial and regulatory guidelines remains the strongest articulation of a right to health approach in the country. However the report which was supposed to provide the basic architecture of the health chapter of the 12th Five Year Plan remains largely ignored in the 12th Plan document.

Implementing a right to health informed programme in India: contemporary concerns and recommendations

As India’s development story is being hailed across the world there are many questions being raised about the differential nature of growth

6 A health insurance scheme for the poor from the Ministry of Labour and Employment which provides benefits up to Rs 30,000 for hospitalization. For additional details see www.rsb.gov.in

7 A health insurance scheme for tertiary care for the poor run by the state government in Andhra Pradesh. Similar schemes are also run by Karnataka and Tamil Nadu.
experienced by different sections of the population. Many authorities have raised concerns about an increasing gap between the rich and the poor. Against such a backdrop, the discussion about rights becomes specially relevant because rights lay down the minimum conditions for all. This section discusses the current status of right to health in the country reviewing the contemporary health scenario using the framework of state obligations ie. respect, protect and fulfil.

**Health financing, health expenditure and out-of-pocket expenses**

Health care is expensive and economic barriers are one of the greatest barriers to fulfilling the right to health. Low investment has meant low staff salaries, large vacancies, lack of maintenance and upgradation of facilities and so on. In order to improve the situation the National Rural Health Mission introduced a mechanism through which the national and state governments progressively increased their annual health outlays. The 12th Five Year Plan has also accepted this in principle projecting an overall increase to 1.87% compared to the HLEG reports call for an increase to 2.5% of GDP. The main challenge is to reduce out of pocket expenditure at the point of care through free medicines and free care for a range of health conditions up to the secondary and tertiary level. The expansion of insurance programmes like the RSBY (currently funded through the Ministry of Labour and Employment) is often seen as an answer but some recent reviews (Narayana 2010, Nandi et al. 2012) have raised questions. Provision of free medicines has started to emerge as a possible policy solution with Rajasthan taking the lead.\(^8\) This provision has the potential to reduce out-of-pocket expenditures significantly, and can thus be an important indicator for tracking fulfilment of the right to health.

**Standards and Regulation**

Legal protection through recourse to courts of law are a necessary but very inadequate protection for health related rights. Health rights violations

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8 Rajasthan launched its free medicine scheme on October 2, 2011. For a report see *The Hindu*, October 3, 2011
Rajasthan launches free medicine scheme http://www.thehindu.com/todays-paper/tp-national/rajasthan-launches-free-medicine-scheme/article2507562.ece
affect the poorest the most, and they are also the most ill-equipped to approach courts and pursue litigation. The articulation of standards and setting in place of regulatory compliance procedures are a much better way to ensure the protection of the right to health. Unfortunately the regulatory framework related to health is very weak, and despite some rhetoric little has been done to strengthen this aspect even though the country is served by a vast private sector. To understand the implications of this weak regulatory framework around health we can consider the following example. We have regulatory mechanisms which are supposed to inform the process of manufacture and distribution of medicines. But many of these procedures are not complied with either by manufacturers or by those who sell medicines. There is little inspection or oversight, and we have frequent reports of counterfeit or fake medicines which in some cases lead to death of the patient. On the other hand almost all medicines are available over the counter without any prescriptions, leading to inappropriate use of medicines. India aspires to be a 'developed' country, but in all developed countries ‘over the counter’ medicines and ‘prescription’ medicines are strictly segregated.

Some, but not all states have laws related setting up clinics, nursing homes and other health establishments. Where there are laws these are violated, and the violators include prominent doctors, against whom no one dare complain. A pertinent example of regulation is the PCPNDT Act which regulates the use of technology for detection of the sex of a foetus. The law was passed in 1994, but before the Supreme Court took up a PIL in 2000, no state had set up the relevant regulatory mechanisms. It took more than 10 years after the law was enacted for the first conviction, and all the while the sex ratio among the new born continued to decline.

The overall regulation of medical practice is through the Medical Council of India, but the corrupt nature of the regulatory body was revealed recently when the Director was caught red handed accepting a bribe to grant permission to a private medical college. The Clinical

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9 The first conviction under PNDT Act took place in Haryana in 2005
10 MCI Director Ketan Desai was caught taking a bribe by the CBI on April 22, 2010
Establishment Act (2010) was recently passed making it mandatory for all clinics, nursing homes, laboratories etc. to be registered. Some states have started adopting this law and it is hoped that it will lead to some measure of regulation.

As our country is moving into a free market paradigm many service sectors have designated regulatory authorities being set up eg. Insurance Regulatory Authority of India (IRAI), Telecommunications Regulatory Authority of India (TRAI) (for the Insurance and Telecommunication sectors respectively) since the role of the government is now being seen as a regulator rather than a provider of services. However there is only a very nascent conversation on the issue of a health regulator authority. A draft National Health Bill had been proposed through the website of the Ministry of Health and Family Welfare which included reference to a similar authority. It is essential that the discussions around a National Health Authority which consolidates the regulatory standards and oversight mechanisms be reinitiated. It may be appropriate for the National Human Rights Commission to take a lead in this matter.

Monitoring Health Equity

Inclusive growth and focus on the most marginalised have emerged as important components of the policy rhetoric in India, and this is very desirable from a rights perspective, because it addresses discrimination. In the recent past, especially in the last five years, there has been an exceptional focus on maternal health. One indicator that has received a lot of attention has been the rate of Institutional Delivery, and many states have reported that the figures have increased two to three times or more in this period, and there has been a sense of achievement all across the health sector. However an equity-focussed analysis will reveal many gaps. NRHM included equity parameters in its design viz. focus on some states with poor indicators and flexible financial poor to ensure that the plans could be adapted to needs of specific districts were two such measures. However the NRHM also adopted a ‘uniform’ policy solution - institutional delivery, reinforcing it through incentives both for the
community health volunteer (ASHA) and the woman undergoing delivery (Janani Suraksha Yojana or JSY). Today a differential pattern is visible which indicates that the maternal health related indicators have done better in those states and in those districts where there were facilities for emergency obstetric care services like blood supply or the ability to conduct emergency caesarean section operations exist. The lack of poor quality of institutional delivery services have been pointed out in many reports and after seven years of NRHM there are many districts where the institutional delivery rates continue to be very low. The unfortunate part of the story is that in all districts across the country, services for women delivering at home, through training of traditional birth attendants has been discontinued... Thus many women who are poor, mostly dalit or tribal, and living in remote villages who have their delivery at home are denied health support and consequently their right to health remain unfulfilled and unprotected.

Availability of Essential Medicines

Medicines are an important component of the right to health and comprise about 70 per cent of outpatient care costs. Even though India has emerged as a global powerhouse in medicine production that the prices of drugs are very variable in India with different brands of the same drug priced differently by different producers. The ratio of the highest and the lowest price of the same drug is often enormous – ranging from twice to more than ten times. There is a list of essential medicines which come under pricing control but this list has been cut down on many occasions. The recent ‘Glivec’ case highlights the extent to which pharma companies will go to maintain their artificially high costs. The Supreme Court order is very salutary in this case, and highlights a country’s priority to support the right to health of its citizens.

The government of India had started an initiative called the Jan Aushadhi a few years ago to reduce the cost of essential medicines by

11 The Supreme Court of India dismissed an appeal by the Swiss drug maker Novartis to extend its patent for the updated form of an older drug imatinib (Glivec) in India in April 2013
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procuring these medicines in bulk and selling them through government supported outlets. Its implementation has not been very successful. The recent step taken by the Rajasthan government to make all medicines provided through the government hospitals free is a very welcome step. However two additional steps are necessary to make essential medicines available cheaply. The first is to ensure that all medicines under the WHO essential medicines list are only marketed under their generic or chemical name, and price of these medicines has to be controlled, or a ceiling fixed by the government.

Medical ethics and patient rights

A person who visits a doctor nowadays, either in a government or private hospital, often comes out with a prescription which has a long list of tests. Seldom does the doctor or any person associated with the clinic explain why these tests are necessary, or which are essential and which are optional. I recently came across a situation where the doctor had prescribed a series of expensive tests without conducting any physical examination. On asking why these tests were necessary, and whether some essential clinical tests had been performed I was told I would not understand. On mentioning that I too was a doctor, I was rudely told that I was not from the specialised discipline. This was not only a case of medical arrogance but unethical practice. The ancient Greek founder of medicine Hippocrates had realised that doctors have an enormous power of knowledge and skill to help a person, and conversely the ability to harm a person as well. He instituted the Hippocrates oath for doctors, which in its basic form is a pledge for doctors to knowingly do no harm to the patient, not to wilfully withhold knowledge or support, and to act in the best interest of the patient. In its current form medical ethics also calls upon doctors to explain what are the treatment options and the benefits and risks of different treatment options. The doctor needs to be constantly aware of the immense knowledge and power asymmetry between the doctor and patient and support the patient to take the best possible choice. Unfortunately medical ethics are not taught to young doctors, and ethical reviews and prescription audits are seldom held in hospitals. Thus we
have a situation in India where unnecessary test and unnecessary medicines are often prescribed leading to inflated medical costs.

Patient rights are also an ignored area in India. While the discipline of medical social work exists in schools of social work, this professional is absent from most hospitals. The HIV/AIDS programme introduced the counsellor, but the practice of counselling patients about their options and choices is not practiced routinely in any other discipline. As corporate medical care is becoming more popular in India, hospitals have started introducing coffee shops, florists, nutritionists, patient liaison executives but clinical counsellors or medical social workers are seldom part of the routine services offered to patients.

Another area which is emerging as an area of concern with regard to ethics and rights is the area of clinical research. India is emerging as an important place for clinical and drug trials. Many of these take place among the poor in urban and rural India. These procedural anomalies were highlighted when it came to light that a few tribal girls died after participating in a trial with HPV vaccines. The case shows that principles of informed consent require more vigorous attention among vulnerable populations.

**Attention to Social Determinants**

Attention to social determinants of health differentiates right to health approach from a somewhat limited attention to the right to healthcare alone. On the one hand these include factors like safe drinking water and sanitation and hygiene, and on the other they also include food availability and nutritional intake as well as the social status of a person which determine their access to these factors. For a long time the attention to these factors was low and it was very recently that the World Health Organisation set up a Commission on Social Determinants of Health

12 For more details see Vaccine trial’s ethics criticized: Collapsed trial fuels unfounded vaccine fears Nature 474, 427-428 (2011) | doi:10.1038/474427a

13 For more details see Closing the Gap in a Generation : Health equity through actions on social determinants of health, Final Report 2008
which reported that it is often these determinants rather than the availability of medical care, that affect the longevity and health of individuals and population groups. The role of water and sanitation in health has been known for over two hundred years, but the attention to these factors for health concerns continues to be very low. The campaign against polio is a good example. Polio is spread through a virus which spreads from the contamination of drinking water by stool or faecal matter. The global polio campaign was launched in India very vigorously and thousands of crores of rupees was spent in explaining the virtue of the vaccine, administering the vaccine and in testing the stool of children with suspicious paralysis. However not one additional rupee was spent on improving the water supply and sanitation of the poor crowded localities in smaller cities of Uttar Pradesh where this disease was the most rampant. Today hopefully the children from these poorer parts of India are free from polio, but lakhs continue to die from diarrhoea because the water and sanitation condition is probably worsening.

The importance of food as a right is evident from the Supreme Court interventions in the ‘right to food’ case. The government is supporting the availability of food for the poorest of the poor through a number of schemes like the Integrated Child Development Scheme (ICDS), the Mid Day Meal Scheme and the very recent National Food Security Act. The progress on the ‘right to food’ shows the role that citizens can have to compel the government to take steps to fulfil its human rights obligations. Another social determinant that the National Human Rights Commission has taken cognizance of within the framework of right to health has been the issue of silicosis among workers in mines. The Supreme Court has also addressed the issue of air pollution by banning old cars which spew a lot of pollutants from operating in big cities like Delhi. However the overall emphasis on social determinants is low and is not part of the core mandate of the Health department.

**Governance and Accountability Mechanisms**

Accountability is a distinguishing characteristic of a rights based approach. It is the one feature which allows the citizen to ask questions about the
intentions and performance of the state. If the state has a strong and well performing health programme and the citizens by and large healthy and satisfied, the need to ask questions is diminished. However, it is only when the state has provisions for citizens to ask questions, and mechanisms through which it explains its actions, the conditions for a rights based approach are satisfied. Governance is the mechanism through which a system deliberates, implements and reviews its actions. In India the health governance system is complex, in parts chaotic, and results in poor management, slipshod execution and reviews rarely inform practice in a direct or systematic way. India has a three tiered governance structure, with the third tier or local self government hardly being an effective mechanism of governance having insufficient mandate, capacity or resources. Health falls in the constitutional ‘state’ list of subjects, while family planning is in the concurrent list. This means that actual planning and implementation of health related issues falls within the jurisdiction of the state administration. The national government extends its influence at the level of the state through National Programmes which are substantially funded by the Centre, but the final call is that of the state government. Thus, it is the national government which is the signatory on International treaties and accountable for India’s human rights performance, but the ultimate responsibility of meeting the right to health is with the state governments who have no explicit international obligations. Thus different states have differential outlays on health, different laws, different salary scales for its doctors and nurses, different names for its clinics and hospitals and different ways in which various health services are financed and provided.

Within this complex governance mechanism around health, administrative accountability mechanisms are weak. However the High Court and Supreme Court have emerged as important platforms, and the Public Interest Litigation an important mechanism for ensuring accountability. Some landmark cases have already been alluded to, and some others which are particularly important from a rights perspective include:
- Ramakant Rai and others vs Union of India\(^{14}\) (Supreme Court) for establishing quality standards and quality compliance mechanisms in the context of the national family planning programme

- Laxmi Mandal vs NCT Delhi\(^{15}\) (Delhi High Court) for establishing reproductive rights as part of the overall right to health and human rights and for making free medical care for pregnancy and delivery mandatory

However, as mentioned earlier, courts are not the most efficient method to ensure accountability. The National Rural Health Mission had included a three-pronged accountability approach but that has not been fully operationalised. Common review missions are organised annually and there is an increasing frequency of large-scale health surveys. But the community monitoring component of this three-pronged approach has been implemented in a very limited manner. However what is most important is that the overall triangulation between the three different sources of information has never been attempted. For a complex governance arena like the health sector it is perhaps appropriate to set up a periodic ‘reporting - observations – explanations’ mechanism as used in the International human rights arena. The National Human Rights Commission can play the role of the UN Human Rights Council or that of different treaty monitoring bodies in this case, and civil society organisations can be encouraged to submit ‘shadow reports’. This mechanism can be supplemented by the Health Regulatory Authority of India which would regulate the functioning of the private sector hospitals and a revitalised Medical Council providing oversight to individual practitioners. A State level ombudsperson with district level complaints and grievance redressal mechanism should also be established to ensure that decentralised and simple mechanisms are universally available without taking recourse to courts and litigation.

\(^{14}\) Ramakant Rai v Union of India, WP (C) No 209 of 2003

\(^{15}\) Laxmi Mandal v NCT Delhi, WP 8853/2008
• Ramakant Rai and others vs Union of India\textsuperscript{14} (Supreme Court) for establishing quality standards and quality compliance mechanisms in the context of the national family planning programme

• Laxmi Mandal vs NCT Delhi\textsuperscript{15} (Delhi High Court) for establishing reproductive rights as part of the overall right to health and human rights and for making free medical care for pregnancy and delivery mandatory

However, as mentioned earlier, courts are not the most efficient method to ensure accountability. The National Rural Health Mission had included a three-pronged accountability approach but that has not been fully operationalised. Common review missions are organised annually and there is an increasing frequency of large-scale health surveys. But the community monitoring component of this three-pronged approach has been implemented in a very limited manner. However what is most important is that the overall triangulation between the three different sources of information has never been attempted. For a complex governance arena like the health sector it is perhaps appropriate to set up a periodic ‘reporting - observations - explanations’ mechanism as used in the International human rights arena. The National Human Rights Commission can play the role of the UN Human Rights Council or that of different treaty monitoring bodies in this case, and civil society organisations can be encouraged to submit ‘shadow reports’. This mechanism can be supplemented by the Health Regulatory Authority of India which would regulate the functioning of the private sector hospitals and a revitalised Medical Council providing oversight to individual practitioners. A State level ombudsperson with district level complaints and grievance redressal mechanism should also be established to ensure that decentralised and simple mechanisms are universally available without taking recourse to courts and litigation.

\textsuperscript{14} Ramakant Rai v Union of India, WP (C) No 209 of 2003

\textsuperscript{15} Laxmi Mandal v NCT Delhi, WP 8853/ 2008
