ISSN 2321 - 4171

THE ROLE OF STATE IN THE IMPLEMENTATION OF HEALTH POLICIES AND LAWS

- Dr.S.Nataraju[1]

Abstract:

Health has been acknowledged as a fundamental right of the people. This has been echoed in the International Conventions on Human Rights. The World Health Organization (WHO) is striving to upgrade the quality of human life around the globe. The State priority is reflected through its policies and programmes undertaken by governments. A Government-constituted group at the highest level has identified six priority programme areas, namely urban low cost sanitation, urban waste water management, urban solid waste management including hospital waste management, rural environmental sanitation, industrial waste management and air pollution control, and strengthening of health surveillance and support services. There are many constitutional provisions and laws pertaining to the environment and its protection and improvement. Besides; there is no comprehensive legislation on environment and health. The evolving appropriate laws and enforcement of laws in achieving the goal is an important process. Public Health Acts, which constitute the legislative framework for public health service provision. Health is a State subject in India. However many states do not have a clear Health Policy. The strategies of the states are mostly guided by the National Health Policy and the National Programs. The period after 1983witnessed several major developments in the polices impacting the health sector by adoption of National Health Policy in 1983, 73rd and 74th Constitutional Amendments in 1992, National Nutrition Policy in 1993,National Health Policy in 2002 and the proposed National Health Policy 2011. However, the State has to play a central role in helping develop an organized system of health care as against the prevailing laissez-faire approach. The existing health care services will have to be restructured under a defined system and its financing organized and controlled by an autonomous body. To facilitate such restructuring a well defined system of rules and regulations will have to be put in place so that minimum standards and quality care are assured under a system. Public health may receive more attention in the near future. Several factors increase Indian vulnerability to a devastating AIDS epidemic -widespread poverty, illiteracy, poor nutritional and health status, social inequalities based on caste and gender, inadequate health infrastructure, taboos about sex, lack of political commitment, and a persistent denial of the AIDS epidemic in many states.

The Institution created at the local and national levels, which can play powerful roles in public health. The Panchayat Raj Act has placed emphasis on building local government, and devolving health activities to them. Through the 73rd and 74th Constitutional Amendment Acts (1992), the local bodies (Municipalities and Panchayat) have been assigned 29 development activities, which have a direct and indirect bearing on health. These include health and sanitation (covering hospitals, PHCs and dispensaries), family welfare, drinking water, women etc. The LSGs and NGOs play a pivotal role in combating various health issues. The integrated approach and inter-sectoral coordination is expected to overcome with the existing problems. This paper reviews the fundamental obstacles to effective implementation of health policies and existing laws in India, and also indicates that the outcome of the measures taken by the Government in the States.

I. Introduction:

In a civilized society, health of the citizens is an important sector for the Government. The Government is responsible to provide health services to the public. In India the health services

[1] Associate Professor of Law & Chairman, PG Department of law, JSS Law College, (Autonomous) Mysore.

are provided both by the Central and State Governments. But the available resources with governments are not enough to cover all citizens under health care services. Hence, services provided by private practioner, hospitals and nursing homes are predominant. There is a big difference in availed services. Poor people cannot afford small fees. As a result, there is a heavy rush of patients at Government hospitals for minor ailments as well as graves one. The out come is the exploitation of poor and innocent people by the both public and private sectors in the wake of providing health services. Today in the era of globalization where public services are slowly being privately operated and open to market forces, access to them becomes a correlate of income distribution in which the poorer sectors have to fend for themselves in an increasingly unequal society. What we require is a large number of public hospitals with easy access for the poor, and public health care centers in every village rather than huge five star hospitals in every mega city. Right to health and emergency medical care is an aspect of right to life under Article 21 of the Constitution, it has been acknowledged as a fundamental right of the people. This has been echoed in the International Conventions on Human Rights. The World Health Organization (WHO) is striving to upgrade the quality of human life around the globe. The WHO (1948) defined health as "Health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity". The UN Declaration of Human Rights provides right for the physical and mental health of every human being.[2]The Ancient Hindu texts also reveal the role of the state in the maintenance of public health. The sacred scriptures of the Vedas gifted principles of administration and medical care. The *Rigveda* focuses on the administration of justice by the king and identifies the importance of the basic five elements viz. Earth, Water, Air Fire and Ether (space), the *Atharva Veda* deals with the large number of herbal medicines from which the early version of ayurvedic medicine take its origin. The *Charaka Samhita* deals with elaborate code of practice of physicians with regard to their training, duties, privileges and their social status.The *Kautilya's Arthashastra* (third century BC) and the *Shusruta Samhita* were considered to be the great contributions to the field of medicine, ethics and law.

Public health services are conceptually distinct from medical services. They have as a key goal reducing a population's exposure to disease – for example through assuring food safety and other

[2] December 12th 1948 when the Universal Declaration of Human Rights (UDHR) was proclaimed, India was a party to this. Article 25 "Every one 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…''

health regulations; vector control; monitoring waste disposal and water systems; and health education to improve personal health behaviors and build citizen demand for better public health outcomes. For various reasons, mostly of political economy, public funds for health services in India have been focused largely on medical services, and public health services have been neglected. This is reflected in a virtual absence of modern public health regulations, and of systematic planning and delivery of public health services.[3] Several policy thrusts of the newly-independent India also detracted from public health service provision. To begin with, the overarching policy vision emphasized developing heavy industry rather than health and education. Public health services were merged with the medical services in the 1950s.Although the National Health Policy (NHP) in India was not framed until 1983, India has built up a vast health infrastructure and initiated several national health programmes over last five decades in government, voluntary and private sectors under the guidance and direction of various committees (Bore, Mudaliar, Kartar Singh, Srivastava), the Constitution, the Planning Commission, the Central Council of Health and Family Welfare, and Consultative Committees attached to the Ministry of Health and Family Welfare. The period after 1983 witnessed several major developments in the framing of health policies and its adoption.

II. National Health Policies initiatives:

A policy is a course of action. Generally, having a policy involves implementing several laws over the period of time during which you keep that policy. A law is more formal and has to be passed by a legislative body of a state or country. *The Alma Ata Declaration, the International Conference on Primary HealthCare, 1978 held at* Almaty (formerly ***Alma-Ata***), currently in Kazakhstan, USSR gave an insight into the understanding of primary health care. Chapter III of the declaration advocates that "All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors". It viewed health as an integral part of the socio-economic development of a country. It provided the most holistic understanding to health and the framework that States needed to pursue to achieve the goals of development.The Health Planning and Development Committee's Report, 1946 (popularly known as the Bhore Committee

[3] Refer article by Monica Das Gupta '*Public Health in India –an overview'* Published by the Development research group, World Bank, Policy research working paper 3787 p.1.

Report*)* is the first organized set of health care data for India. The Report was based on a countrywide survey in British India where the emphasis was made on the role of the State in maintaining Public health. The Committee strongly felt that the health programme in India should be developed on a foundation of preventive health work and proceed in the closest association with the administration of medical relief. It strongly recommended for a health services system based on the needs of the people, the majority of whom were deprived and poor. They recommended that State Governments should spend a minimum of 15% of their revenues on health activities. The National Planning Committee (NPC) set up by the Indian National Congress in 1938 under the chairmanship of Colonel S. Sokhey stated that the maintenance of the health of the people was the responsibility of the State.

After Independence, India adopted the welfare state approach, which was dominant worldwide at that time. As with most post-colonial nations, India too attempted to restructure its patterns of investment. During that time, India's leaders envisaged a national health system in which the State would play a leading role in determining priorities and financing, and provide services to the population. Health is a State subject in India. However many states do not have a clear Health Policy. The strategies of the states are mostly guided by the National Health Policy and the National Programs. The first National Health Policy in 1983 aimed to achieve the goal of `Health for All' by 2000 AD, through the provision of comprehensive primary healthcare services. It stressed the creation of an infrastructure for primary healthcare; close co-ordination with health-related services and activities (like nutrition, drinking water supply and sanitation); the active involvement and participation of voluntary organizations; the provision of essential drugs and vaccines; qualitative improvement in health and family planning services; the provision of adequate training; and medical research aimed at the common health problems of the people. Some of the policy initiatives outlined in the NHP-1983 have yielded results, while, in several other areas, the outcome has not been as expected. The NHP-1983 gave a general exposition of the policies which required recommendation in the circumstances then prevailing in the health sector. The noteworthy initiatives under that policy were;

- A phased, time-bound programme for setting up a well dispersed network of comprehensive primary health care services, linked with extension and health education, designed in the context of the ground reality that elementary health problems can be resolved by the people themselves;

- Intermediation through ‘Health volunteers’ having appropriate knowledge, simple skills and requisite technologies;
- Establishment of a well-worked out referral system to ensure that patient load at the higher levels of the hierarchy is not needlessly burdened by those who can be treated at the decentralized level;
- An integrated net-work of evenly spread specialty and super-specialty services; encouragement of such facilities through private investments for patients who can pay, so that the draw on the Government’s facilities is limited to those entitled to free use.

Government initiatives in the pubic health sector have recorded some noteworthy successes over time. Smallpox and Guinea Worm Disease have been eradicated from the country; Polio is on the verge of being eradicated; Leprosy, Kala Azar, and Filariasis can be expected to be eliminated in the foreseeable future. The period after the announcement of NHP-83 has also seen an increase in mortality through ‘life-style’ diseases diabetes, cancer and cardiovascular diseases. The increase in life expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem.

Another area of grave concern in the public health domain is the persistent incidence of macro and micro nutrient deficiencies, especially among women and children. In the vulnerable sub-category of women and the girl child, this has the multiplier effect through the birth of low birth weight babies and serious ramifications of the consequential mental and physical retarded growth.NHP-1983, in a spirit of optimistic empathy for the health needs of the people, particularly the poor and underprivileged, had hoped to provide ‘Health for All by the year 2000 AD’, through the universal provision of comprehensive primary health care services. In retrospect, it is observed that the financial resources and public health administrative capacity which it was possible to marshal, was far short of that necessary to achieve such an ambitious and holistic goal.

India released her second National Health Policy (hereafter NHP-2002) in 2002, nearly 20 years after the formulation of the first one in 1983. The Policy is released at a time when the Indian Health Care System is looking for financial means, organizational structure and procedures to

respond to the emerging new diversity brought into the system by several new situations hitherto uncommon to it. The policy is formulated in such a way that it will respond to the emerging needs in a more flexible and efficient manner. A glance at the strategies suggests that they encompass all the four control knobs concerning the health system viz., financing, organization, regulation and incentive.

*The seven strategies that concerned with **financing** are as given below:*

- Raising health care expenditure from 5.2 per cent to 6 per cent of the GDP by 2010.
- Earmarking 2 per cent of the GDP for public health.
- Raising state resources from 5.5 per cent of budget to 8 per cent and Centre's share from15 per cent to 25 per cent.
- Allocating 55, 35 and 10 per cent of the budget meant for health to primary, secondary and tertiary health sectors respectively.
- Spending two per cent of health budget for Government-funded medical research by 2010.
- Reviving Primary Health Care System by providing essential drugs under the Central Government funding and through the decentralized health system.
- Providing adequate health care to the poor under the cover Social health insurance.

*The six strategies that aim at streamlining **organizational** set-up are:*

- Implementation of public health programmes through local self governments.
- Set up of organized urban primary health care infrastructure.
- Co-operation of private health practitioners in national disease control programmes.
- Integrated disease control network from the lowest rung of public health administration to the highest level under the Central Government by 2005.
- Identification of specific programmes targeted at women's health and
- Baseline estimates for the incidence of TB, Malaria and Blindness by 2005.

*Six other proposals deal with the aspects of **regulation** in the health care system:*

- ❖ Setting up of a Medical Grants Commission.

- ❖ Raising postgraduate seats in 'public health' and 'family medicine' to 25 per cent.
- ❖ Legislation for minimum infrastructure standard by 2003.
- ❖ Legislation for minimum quality standard by 2003.
- ❖ Strengthening of food and drug administration and
- ❖ Securing worldwide commitments to lighten restrictive features of TRIPS in its application to health sector target regulation.

The lone strategy pertaining to incentive is 'providing commercial health services to overseas care seekers'. Hence, the strategies are in favour of financing followed by organization, regulation and incentives. The main objective of the revised National Health Policy, 2002 is to achieve an acceptable standard of good health among the general population of the country and has set goals to be achieved by the year 2015. The major policy prescriptions are as follows:

- Increase public expenditure from 0.9 percent to 2 percent by 2010.
- Increase allocation of public health investment in the order of 55 percent for the primary health sector; 35 percent and 10 percent to secondary and tertiary sectors respectively.
- Gradual convergence of all health programmes, except the ones (such as TB, Malaria, HIV/AIDS, RCH), which need to be continued till moderate levels of prevalence are reached.
- Need to levy user charges for certain secondary and tertiary public health services, for those who can afford to pay.
- Mandatory two year rural posting before awarding the graduate medical degree.
- Decentralising the implementation of health programmes to local self governing bodies by 2005.
- Setting up of Medical Grants Commission for funding new Government Medical and Dental colleges.
- Promoting public health discipline.
- Establishing two-tier urban healthcare system - Primary Health Centre for a population of one lakh and Government General Hospital.
- Increase in Government funded health research to a level of 2 percent of the total health spending by 2010.

- Appreciation of the role of private sector in health, and enactment of legislation by 2003 for regulating private clinical establishments.
- Formulation of procedures for accreditation of public and private health facilities.
- Co-option of NGOs in national disease control programmes.
- Promotion of telemedicine in tertiary healthcare sector.
- Full operationalisation of National Disease Surveillance Network by 2005.
- Notification of contemporary code of medical ethics by Medical Council of India.
- Encouraging setting up of private insurance instruments to bring secondary and tertiary sectors into its purview.
- Promotion of medical services for overseas users.
- Encouragement and promotion of Indian System of Medicine[4].

Through the 73rd and 74th Constitutional Amendment Acts (1992), the local bodies (Municipalities and Panchayat) have been assigned 29 development activities, which have a direct and indirect bearing on health. These include health and sanitation (covering hospitals, PHCs and dispensaries), family welfare, drinking water, women and child development, the public distribution system and poverty alleviation programmes. The Common Minimum Programme announced by the UPA government in 2004 has proposed to rise public spending on health to at least 2-3 percent of the Gross Domestic Product (GDP) over the next five years, with focus on primary healthcare. The present Government has proposed to take all steps to ensure availability of life saving drugs at reasonable prices through revival of Public Sector Units in the manufacture of critical bulk drugs. The budget 2004-05 has proposed three major initiatives in the health sector. They are: (i) redesigning the Universal Health Insurance scheme introduced in 2003 to make it exclusive for below poverty level people with a reduced premium (ii) introduction of Group Health Insurance scheme for members of Self Help Groups and Credit Link Groups at a premium of Rs 120 per person for an insurance cover of Rs 10000, and (iii) exemption of income tax for the hospitals working in rural areas.[5]

[4] http://www.searo.who.int/en/Section313/Section1519_10849.htm visited on 31/08/2011

[5] Ibid 4 at p.2

The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. Overriding importance would be given to ensuring a more equitable access to health services across the social and geographical expanse of the country. Emphasis will be given to increasing the aggregate public health investment through a substantially increased contribution by the Central Government. It is expected that this initiative will strengthen the capacity of the public health administration at the State level to render effective service delivery. The contribution of the private sector in providing health services would be much enhanced, particularly for the population group which can afford to pay for services. Primacy will be given to preventive and first-line curative initiatives at the primary health level through increased sectoral share of allocation. Emphasis will be laid on rational use of drugs within the allopathic system. Increased access to tried and tested systems of traditional medicine will be ensured.[6]

The newly created Department of Health Research (DHR) of the health ministry formulated a draft National Health Research Policy (NHRP) first in March 2010 (Department of Health Research 2010) which was subsequently finalized in February 2011 and has been placed in the public domain for feedback[7]. The final draft provides a vision for health research in India and acknowledges various stakeholders in health research. The draft provides objectives and proposes new institutions to steer health research at national level and identifies the underlying values for such a policy. The draft mentions the importance of equity in health research highlighting equity as one of its values. The draft interprets equity as the need to focus on health problems of socially underprivileged groups (tribes, women, and other marginalized groups) and population living in hard-to-reach areas. The National Health Research Management Forum (NHRMF) is proposed as an overarching body at the national level that is expected to steer health research in the country. It is expected to make annual and five-year national research plans. The draft proposes to improve ethical guidelines in India and their harmonization with international standards. The 10-point action programme proposed by the draft mentioning the need to promote other specific types of health research such as basic and fundamental as well as

[6] http://mohfw.nic.in/ visited on 25-08-2011

[7] Refer: National Health Research Policy, Published by the Department of Health Research, Ministry of Health & Family Welfare, Government of India, New Delhi, February 2011.

translational research. Vision of National Health Research Policy is to maximize the returns on investments in health research through creation of a health research system to prioritize, coordinate, and facilitate conduct of effective and ethical health research and its translation into products, policies and programmes aimed at improving health especially of the vulnerable Populations.

The broad objectives of the National Health Research Policy are:

- Identify priorities for effective and ethical health research to enable the achievement of the objectives of NHP 2002, NRHM, Bharat Nirman and National Food security Act as well as global commitments such as MDG and IHR, ensuring that the results of health research are translated into action
- Foster inter-sectoral coordination in health research including all departments within the Government, Private Sector and the Academia to promote innovation and ensure effective translation to encourage/ accelerate indigenous production of diagnostics, vaccines, therapeutics, medical devices etc..
- Focus on the marginalized, the vulnerable and the disadvantaged sections of society.
- Strengthen national networks between research institutes, academia and service institutes, and encourage PPP
- Put in place strategies and mechanisms for assessing the cost effectiveness and cost benefits of interventions for health. Develop and manage human resources and infrastructure for health research and ensure that international collaborative research contributes to national health.

There are many players in health research, the public and private sector, autonomous organization and NGOs, bilateral and multi-national agencies. The players in health research are increasing and so is the funding. Better coordination would be the key to judicious use of resources. The other policies enunciated by the Government of India (Population Policy 2000, Health Policy 2002, Science & Technology Policy, 2003) have equivocally stressed the importance of health research to improve health of the nation.

III. Right to Health:

a. Constitutional and other statutory initiatives: The Indian Constitution provides a framework for welfare, socialist pattern of development. While civil and political rights are enshrined as Fundamental Rights that are justifiable, social and economic rights like health, education, livelihoods etc. are provided for as Directive Principles for the State and hence not justifiable. The latter comes under the domain of planned development, which the State steers through the Five Year Plans and other development policy initiatives. The Constitution has made health care services largely a responsibility of State governments but has left enough maneuverability for the Centre since a large number of items are listed in the Concurrent list. The Centre has been able to expand its sphere of control over the health sector.[8] When we look at right to health and healthcare in the legal and constitutional framework, it is clearly evident that the Constitution and laws of the land do not in any way accord health and healthcare the status of rights. There are instances in case law where, for instance the rights to life, Article 21 of the Constitution, or various Directive Principles have been used to demand access to healthcare, especially in emergency situations or references made to the International Covenants. The liberal interpretation by the Supreme Court referring to Article 21 read with Articles 14, 46, and 47 in various situations reiterated the importance of right health and medical care is an aspect of right to life and personal liberty of the citizens. Articles 41, 42 and 47 of the Directive Principles enshrined in Part IV of the Constitution provide the basis to evolve right to health and healthcare.[9] The social security, social insurance, decent standard of living, and public health coupled with the policy statements over the years,

---

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

[9] **Article 41.**Right to work, to education and to public assistance in certain cases: The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to

Which in a sense constitutes the interpretation of these Constitutional provisions, and supported by international legal commitments, form the basis to develop right to health and healthcare in India. 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. 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.

In *Parmanand Katara vs. Union of India*[10], a petition filed by a human rights activist seeking directions against the Union of India that every injured citizen brought for treatment should be instantaneously given medical aid to preserve life and thereafter the procedural criminal law should be allowed to operate in order to avoid negligent death. It is the professional obligation of all doctors, whether government or private, to extend medical aid to the injured immediately to preserve life without waiting legal formalities. In *Paschim Banga Khet Mazdoor Samiti vs. State of W.B.*[11] the issue before the Supreme Court was the legal obligation of the Government to provide facilities in government hospitals for treatment of persons who had sustained serious injuries and required immediate medical attention. The petitioner who had suffered brain hemorrhage in a fall from the train was denied treatment at various government hospitals because of non-availability of beds. It was held that, denial of medical aid by the government hospitals to an injured person on the ground of non-availability of beds amounted to violation of right to life

---

public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want. **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 endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

[10] AIR 1986SC424

[11] AIR 1989 SC2039

under Art.21 of the Constitution. In *Labonya Moyee Chandra vs. State of West Bengal*[12] case reflected the lack of seriousness of the State in executing its duties and the implementation of the directions and recommendations in Paschim Banga Khet Mazdoor Samiti case. The patient was an old woman residing in a village near the city of Burdwan who was denied admission in SSKM, a state hospital on account of non-availability of bed even though her condition was recorded as critical. This hospital was also involved in the earlier case of Paschim Banga Khet Mazdoor Samiti. In *Supreme Court Legal Aid Committee vs. State of Bihar*[13] the Supreme Court held that the responsibility to provide immediate medical treatment to an injured person in a medico-legal case extends even to the police. Thus, where the deceased who was lynched by the mob for attempting to rob passengers of train, died because of negligence of the police in taking him to a hospital on time and also for the inhuman manner in which he was bound up and dumped in the vehicle, the Court held that this amounted to a violation of right to life and the State was bound to pay Rs.20, 000 as compensation for the loss of life. In a historic judgment in *Consumer Education and Research Centre vs. Union of India*[14] held that the right to medical care is a fundamental right under Art.21,it is essential for making the life of the workman meaningful and purposeful with the dignity of person. The right to health in all its forms and at all levels contains the following interrelated and essential elements namely; (i) *Availability* of public health and health-care facilities, goods and services, *(ii) Accessibility* (both physical and economically affordability) *to* health facilities, without discrimination, within the jurisdiction of the State .(iii) *Acceptability of* 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. (*iv) Quality***,** access to the quality 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.[15]

[12] SC decided on 31/7/1998
[13] (1991) 3 SCC 482
[14] (1995)3SCC 42
[15] Refer: Article *"Healthcare Case Law in India"* –Chapter-I, Right to health and health care, theoretical perspectives by, Ravi Duggal, edited by Adv.Mihir Desai, Adv. Dipti Chand, published by; Centre for Enquiry into Health and Allied Themes (CEHAT) And India Centre for Human Rights & Law (ICHRL) p.11-15

The laws relating to public health can be categorized into, laws framed by the state from the perspective of environment and health, occupational safety and health laws, Mental health care, reproductive rights, regulating the institutions involving in medical education, protecting the individuals as a consumer of services and to protect the publics from economic exploitation.

I. Those laws which are enacted from the Health and Environmental perspectives are as;

The Environment (Protection) Act 1986

- The Water (Prevention and Control Pollution) Act 1974
- The Air (Prevention and Control Pollution) Act 198
- The Biomedical Waste (Management and Handling) Rules 1998
- The Indian Air Craft (Public Health) Rules 1954
- The National Green Tribunal Act 2010

II. The legislations which are directly focused on the Medical Education, health care and its Systematic functioning and controlling purpose are;

- The Indian Medical Council Act 1956 (Amended 1964, 1993 and 2001)
- The Drugs and Cosmetic Acts 1940
- The Indian Nursing Council Act 1947
- The Dentist Act 1948
- The Pharmacy Act 1948
- The Drugs (Control) Act 1948
- The Red Cross Society Act (Allocation of Property) 1936
- The Mental Health Act 1987(Indian Lunacy Act 1912,-repealed)
- The Homoeopathy Central Council Act,1973
- The Rehabilitation Council of India Act 1992
- The Clinical Establishments (Registration and Regulation)Act.2010
- The Karnataka Private Medical Establishments Act,2007

- The Karnataka Prohibition of violence against Medicare Personnel and damage to property in Medicare Service Institutions Act,2009

III. Laws which deal with the socio-economic interest and community, to protect the interest of Labour or working class and for their welfare measures are;

- The Prohibition of Child Marriage Act ,2006
- The Employees State Insurance (ESI) Act 1948
- The Plantation Labor Act 1951
- The Food Safety and Standards Act, 2006
- The Maternity Benefit Act 1961
- The Infant Milk Substitutes, Feeding Bottles & Infants (Regulation of Production, supply &Distribution) Act 1992
- The Registration of Birth and Death Act 1969
- The Medical Termination of Pregnancy (MTP) Act 1971 (Rules 1975)
- The Dangerous Machines (Regulation) Act 1983
- The Narcotic Drugs and Psychotropic Substance Act 1983
- The Juvenile Justice (Care and Protection) Act 2000
- The Child Labour (Prohibition and Regulation) Act 1986
- The Consumer Protection Act (CPA) 1986
- The Epidemic Diseases Act 1987
- The Transplantation of Human Organs Act 1994
- The Pre-conception & Pre-natal Diagnostic Techniques (Regulation and prevention of
- misuse) Act 1994
- The Persons with Disabilities (Equal Opportunity, Protection of
- Rights and Full Participation) Act 1995
- The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation, and Multiple Disabilities Act 1999.
- Drugs and Cosmetics Act, 1940
- Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954
- Patents Act, 1970
- Drugs Price (Control) Order, 1995

- The Factories Act, 1948,
- The Mines Act, 1952,
- The Dock Workers (Safety, Health & Welfare) Act, 1986
- The Employees State Insurance Act, 1948 and
- The Workmen's Compensation Act, 1923

The above classifications are purely from the academic pursuit and list of enactments are illustrative. Further, it is still important to have health and healthcare instituted as a right within the Constitution and/or established by a specific Act of Parliament guaranteeing the right. Ruth Roemer discussing this issue writes, "The principal function of a constitutional provision for the right to health care is usually symbolic. It sets forth the intention of the government to protect the health of its citizens. A statement of national policy alone is not sufficient to assure entitlement to health care; the right must be developed through specific statutes, programs and services. But setting forth the right to health care in a constitution serves to inform the people that protection of their health is official policy of the government and is reflected in the basic law of the land".

b. Judicial trends and health protection: The Indian Judiciary has made an extensive use of the constitutional provisions and developed a new jurisprudence in the protection of public health and sanitation. In one of the earliest instances of public interest litigations -*Municipal Council, Ratlam vs. Vardhichand & Ors,*[16] the municipal corporation was prosecuted by some citizens for not clearing up the garbage. The corporation took up the plea that it did not have money. While rejecting the plea, the Supreme Court through Justice Krishna Iyer observed: "The State will realize that Article 47 makes it a paramount principle of governance that steps are taken for the improvement of public health as amongst its primary duties."In *Vincent Panikurlangara vs. Union of India,* the Supreme Court observed "In a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health."[17] In *CESC Ltd. vs. Subash Chandra Bose,*[18] Supreme Court held that, "The term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensure stable manpower for economic development. Facilities of

[16] 1980 Cri LJ 1075
[17] AIR 1987 SC 990 - (1987) 2 SCC 165
[18] AIR 1992 SC 573,585

health and medical care generate devotion and dedication to give the workers' best, physically as well as mentally, in productivity. It enables the worker to enjoy the fruit of his labour, to keep him physically fit and mentally alert for leading a successful economic, social and cultural life. The medical facilities are, therefore, part of social security and like gilt edged security, it would yield immediate return in the increased production or at any rate reduce absenteeism on grounds of sickness, etc. Health is thus a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. In *T. Ramakrishna Rao vs. Hyderabad Development Authority*[19]**,** the Andhra Pradesh High Court observed, Protection of the environment is not only the duty of the citizens but also the obligation of the State and it's all other organs including the Courts. Environment Pollution is linked to Health and is violation of right to life with dignity**.** In *S.K. Garg vs State of U.P*[20].The Allahabad High Court held that, adequate and quality medical care is part of right to health and right to life. The Petition had been filed raising concerns about the pitiable nature of services available in public hospitals in Allahabad. Complaints were made concerning inadequacy of blood banks, worn down X- ray equipment, unavailability of essential drugs and unhygienic conditions. The Court appointed a Committee to go into these aspects and report back to the Court. In *State of Punjab vs. Ram Lubhaya Bagga,*[21] though the Supreme Court observed that the State had an obligation to provide health care facilities to government employees and to citizens, the obligation was only to the extent of its financial resources for fulfilling the obligation. In the case of *Common Cause vs. Union of India*[22] the Supreme Court laid down guidelines regarding operation of blood banks. The issue rose before the court was that the deficiencies and shortcomings in collection, storage and supply of blood through blood centers operating in the country could prove fatal.

In India, the Epidemic Diseases Act, 1897 requires medical practitioners to notify the health officer of any person with infectious disease and disclose the identity of the individual. The Goa Public Health (Amendment) Act, too, by implication, allows for disclosure/notification to public officials of an individual's HIV status by giving them the power to test and isolate such persons

[19] Writ Petition 36929/1998 T. Ramakrishna Rao vs. Hyderabad Urban Development Authority decided on 20.7.2001
[20] Decided on 21.12.98
[21] (1998) 4 SCC 117
[22] AIR 1996 SC 929

they suspect of having the virus. The weighing of the social and personal consequences is not always an easy task. In most cases, the doctor has to assess the risk of infection to a third party caused by his patient's reluctance to disclose his HIV status. He has to balance his duty to warn the third party with that of confidentiality in regard to his patient. *Dr. Tokugha Yepthomi vs. Appollo Hospital and Anr case*[23], the Apex court held that, the timely disclosure of the HIV positive status of the patient to his fiancée saved her from being contracted with HIV and hence the disclosure did not invade the right to privacy. In *Poonam Verma vs. Ashwin Patel*[24], the Supreme Court made its famous observation that, a person who does not have the knowledge of a particular system of medicine but practices in that system is a quack and a mere pretender to medical knowledge or skill, or to put it differently, a charlatan. The Court went on to observe that no person can practice a system of medicine unless he is registered either under the Central Indian Medical Register or the State Register to practice that system of medicine; and only such persons as are eligible for registration and possess recognized degrees as specified under the concerned Central and State Act may so practice. The mere fact that during the course of study some aspects of other systems of medicine were studied does not qualify such practitioners to indulge in the other systems. Medical negligence gives rise to both civil and criminal liability of the doctors. In *Indian Medical Association vs. V.P. Shantha*[25] the Court held that proceedings under the Consumer Protection Act are summary proceedings for speedy redressal and the remedies are in addition to private law remedy. The issue was whether patients are consumers under the Consumer Protection Act and could they claim damages for injury caused by the negligence of the doctor, hospital or nursing home. Access to cheap drugs is an essential aspect of right to healthcare. The Pharmacy Act requires that only a registered pharmacist may prepare and compound drugs. The expectation from the legislation and executive would be that cheap, effective, sufficient and high quality drugs are available to the people at large. Affordable drugs are an integral component of universal health care and accessible health care. Drugs need to be easily available and of good quality, and should neither be spurious nor damaged. They should be able to achieve what they claim to do. Public hospitals are responsible for providing free or subsidized drugs to patients. But the State has been moving away from its responsibility,

[23] AIR 1999 SC 495

[24] 1996)4 SCC 332

[25](1995) 6 SCC 651

reducing investment in healthcare and consequently, on drugs, increasing user charges, and so on.[26] The major purpose of enacting the Drugs and Cosmetics Act, 1940 was to ensure quality of drugs and prevent sub standard drugs from flooding the markets. Apart from this are the Patents Act and its recent amendments that increasingly play an important part in making the right to health substantial for the people. The Drugs and Cosmetics Act regulates the quality of drugs, its Manufacture, distribution and sale. It applies to all variety of drugs such as Ayurvedic, Unani, Allopathic and Homeopathic. The Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954 is to prevent self-medication and the inducement to take drugs for certain specific disease, condition or disorder, by advertising its alleged magical properties or healing power.

Safe abortion services have been mandated to be available to women in India since 1971 when the Medical Termination of Pregnancy (MTP) Act came into force. Earlier, because abortion was illegal, it was practiced in a clandestine manner. The passing of the Act made medical termination of pregnancy legal, with certain conditions for safeguarding the health of the mother. This law guarantees the right of women in India to terminate an unintended pregnancy by a registered medical practitioner in a hospital established or maintained by the Government or a place being approved for the purpose of this Act by the Government. In *Cehat and Ors. vs. Union of India*[27] a public interest litigation filed for the implementation of the Pre-Natal Diagnostic Techniques and (prevention of misuse) (PNDT) Act. The act was amended during the course of this petition and the Apex Court passed various orders for the effective implementation of the Act. In this case, CEHAT, MASUM an NGO and Sabu George an individual activist filed a petition before the Supreme Court stating that the PNDT act was not being implemented properly resulting in the falling female child sex ration in the country. The Supreme Court came down heavily on the central government and also the state government for failure to implement the act. It stated in its order that the so called economically progressive states were also lagging behind in the female child sex ratio and had failed in the proper implementation of the Act.

[26] Refer: Article on '*Drugs and Public Health'* by ,Adv. Mihir Desai and Adv. Dipti Chand, published by; Centre for Enquiry into Health and Allied Themes (CEHAT) And India Centre for Human Rights & Law (ICHRL) Chapter VII,P. 87-88

[27] AIR 2003 SC 3309

Although there are good number legislations passed by the legislatures, the real implementation of the laws and policies are ensured through the judicial mandates. The credit goes to the NGOs, activists groups and voluntary organizations for their commitment for the public cause, with the support of the proactive judiciary.

IV. Conclusion and Suggestions:

Health is a social, economic and political issue and above all a human right. Inequity and poverty are the root cause of ill health leading to malnutrition and starvation deaths in the marginalized sections of the society. All the existing laws have been formulated in response to a specific situation or an issue. There has never been an attempt to legislate a comprehensive law covering the major aspects of health and healthcare. Historically India had two opportunities, one in the Bhore Committee Report on the eve of Independence, and the second post Alma Ata when the 1982 National Health policy was formulated. The NHP- 2002 aims to provide health care the primary, secondary and tertiary care level. But the opportunities to translate the policy into law were lost because the approach to health and healthcare was a programme based one and not a comprehensive approach to establish universal and non-discriminatory access to healthcare. However, few programs undertaken by the Central and Some State Governments through socio-economic measures are laudable. The recent there is a lack of comprehensive legislation on health and healthcare in India. We have laws that cover selective aspects of health and healthcare that often these violate the principles of universality and non-discrimination. Comprehensive health legislation becomes an important tool for implementation of health policy and provides the managerial and administrative basis for the development of health systems. The proposed draft on National Health Research Policy is intended to achieve an acceptable standard of good health among the general population of the country and has set goals to be achieved by the year 2015.In the advanced stage of medical science and technology, the affordability of medical services to the poor sections of the society and specially the rural community appears to be a distant dream. Hence, in the light of socio-inclusive and exclusive policy scheme, there is need to give more focus towards the downtrodden and vulnerable sections of the society. To achieve the constitutional aspirations and other intended goals, some of the suggestions as follows;

- The existing legal mechanisms should to reinforce in a systematic way by way of framing a holistic National Health law which cover all the aspects of health care system.

- Making rural health service a mandatory for those who are involving in all levels of medical practice.
- Adequate budgetary allocation to rural health services through the urban and local self governmental institutions.
- To eradicate the corruptive and unethical medical practice, there is need of strengthening the task force and also a medical ombudsman.
- Need of imposing specific duty in the enforcement of duty imposed on private hospitals and practitioners to treat emergency situations.
- Government has to take adequate measures and to ensure the availability of essential medicines at all times with assured quality and at a cost that the community and individuals can afford.

Comprehensive health legislation becomes an important tool for implementation of health policy and provides the managerial and administrative basis for the development of health systems. The responsibility lies not only on the Government sector but the help of private organizations is required to achieve the norms of national health polices and the effective implementation of health related laws. Therefore, the comprehensive health policy and programs to be undertaken in an integrated way for the development of medical education, research and health services established to serve the health needs and priorities of the country.

* * * * *