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RIGHT TO HEALTHCARE IN INDIA – THE VOICE UNHEARD

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When we remind ourselves that we possess a right to live a dignified life and our existence is not merely confined to what we call an *animal* existence, that right encompasses within itself various other rights which are essential and central to our understanding of 'right to live in dignity.' The right to live with dignity includes, amongst others, access to adequate food and nutrition, safe and potable water and sanitation, safe and healthy working conditions, etc. which are determinants of health. Although right to health has been recognized in various international and regional human rights instruments, but it is yet to attain the status of an enumerated fundamental right in the Constitution of India.

Although human rights violations are independent of any public healthcare emergencies, but there is no denying the fact that the healthcare emergencies like Covid-19 health crisis has highlighted the vulnerability of healthcare system in India, which ultimately has had a huge impact on human rights. The denial of medical treatment, due to shortage of healthcare workers or healthcare facilities or infrastructure, or due to country's low investment in healthcare system has resulted in loss of multiple lives during the global pandemic, and clearly depicts the failure of states to comply with their human rights obligations.

The present paper seeks to examine the status of public healthcare system in India, and the effect of public healthcare emergencies on fundamental human rights of people. The author seeks to analyse how the state has failed to establish a healthcare system for emergent situations and highlight the factors responsible for denial of health rights in times of such crisis. The author would also attempt to look into the legal structure of healthcare system in India and the preparedness of the State to tackle them, both in urban and rural areas. The paper also seeks to explore whether the Indian legislative framework meets the objective of 'public health' during an epidemic.

HEALTH AS A HUMAN RIGHT

Right to Health is a basic universal right to which every individual is entitled to. The right finds place in various national and international legal instruments. Right to health includes within itself economic, social and cultural right which each individual must enjoy without any restrictions.

The Constitution of World Health Organization defines 'Health' as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*"[1] Other international human right instruments mention right to health and seek to define it along with other basic rights. "*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*."[2] The concept of health has also been addressed in International Convention on Elimination of all forms of Racial Discrimination, International Covenant on Economic, Social and Cultural Rights, Convention on Rights of Child and so on.

Being citizens of the most populous democracy in the world, human rights are inevitable to our very existence. Human rights subsist because they are rights to which individuals are entitled to because of the fact that they are born as humans. A very pertinent question which needs to be answered at this stage is with respect to the specifications of the word 'right' in the healthcare debate. A 'right' would normally imply that if we claim to have a right over something, no argument can stand against it. A right to healthcare exists in myriad forms. We do have a right to avail healthcare facilities in medical centres or hospitals of our choice; we have a right to demand a healthcare too. We also have a right to decide whether we want to undergo a specific medical procedure or not. We fail to realise here that what we do not have is the 'right to healthcare' without being into difficult financial tribulations. And here comes the role of State which truly bears the responsibility to cater the healthcare needs of its citizens.

THE HEALTHCARE SYSTEM IN INDIA – AILING AND FAILING

In order to understand how the healthcare system operates in India, it is important to look at both public and private healthcare set ups, as there exist a lot of discrepancy between the two when it comes to quality and coverage of medical treatment in India. According to the figures

[1] Preamble to the Constitution of the World Health Organization.
[2] Article 25, Universal Declaration of Human Rights, 1948

provided by the World Bank, India's total health expenditure, taking into account the money spent by the government and also the *out of pocket* expenses paid by people, as a percentage of Gross Domestic Product (GDP), was a mere 3.53% in 2017[3], which stands even lower than the Low Income Countries (5.24%), which is surely a disappointing state of affairs in the field of healthcare. The healthcare system in India is undoubtedly among the worst in the world.

Despite the fact that India has a vibrant pharmaceutical industry and we have world class scientists with dynamic research projects, and it ranks 145 among 195 countries in terms of quality and accessibility of healthcare, the fact that country has witnessed persistent healthcare failures, disparities in healthcare systems between rural and urban areas, and also between poorer and richer states, inefficient functioning of the Public Healthcare Centres show a clear paradox.

As compared to the global data, India has the lowest spending on healthcare. The country imports nearly 80% of all medical devices and there is a dire need to boost the local manufacturing of these devices. In 2019, the total government spending on healthcare remained at 1.23% of its GDP; the healthcare sector expects a higher allocation in the proposed budget of 2020-21. The budget 2020-21 presented, offers an allocation of Rs. 69,000 crores for the healthcare sector, out of which, Rs. 6400 crores is for PM Jan Arogya Yojana. [4]

Going by the aforesaid figures, it is indisputable that due to an incapable public healthcare system, the private healthcare systems have evolved, expanded and gained momentum with time. However, most of such systems are limited to urban areas, and the rural population is left at the mercy of *Primary Healthcare Centres* (PHCs). Unfortunately, unavailability of resources is an important factor for the unsatisfactory performance of the Primary Health Centres in India. Among various states in the country, the primary healthcare system in states of Bihar and Uttar Pradesh has fallen to pieces. Talking about Bihar, as per norms usually 1 Primary health centre would cater 30,000 people but the reality is that 1 PHC caters to about 1 lakh people, which is more than three times the standard population size for a PHC to function efficiently. According to the National Health Profile, 2019 one doctor in Bihar caters to a population of 28, 391 persons.[5] Uttar Pradesh ranks second with 19,962 people per doctor. Moreover, as per the NITI

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[3] World Health Organization Global Health Expenditure Database, Accessed at https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS on 13 November, 2020.
[4] Available at www.indianbudget.gov.in, accessed on 13 November, 2020.
[5] National Health Profile of India, 2019 – Ministry of Health & Family Welfare, Government of India, Available at http://www.cbhidghs.nic.in/showfile.php?lid=1147 accessed on November 14, 2020-11-14 01:15 hours.

Ayog Health Index Report, 2018 Kerala ranked the best state in healthcare while Uttar Pradesh is at the bottom.[6]

IS HEALTHCARE A 'RIGHT' IN INDIA?

In August, 2016 the image of a tribal carrying the corpse of his dead wife for 12 kms after a local government hospital refused him transport, shocked the whole nation. Suing the government for such inhumane actions appears unlikely. Despite being the world's second most populous nation, India spends less on healthcare, way less than poorer nations. More than 50% of Indians seek healthcare in the private sector due to poor delivery in the public healthcare sector. And yet, forced expensive healthcare, in no way, guarantees better health outcomes. The only hope is that 'right to healthcare' becomes a reality in its true sense.

Talking about Right to Health, the first and foremost question that strikes our minds is that what health rights do we have in India? Although there is no specific recognition of 'Right to health' in the Indian Constitution, few articles of the Constitution do mention about achieving the same and these have been included as directives for the state to make Law on it.

Article 39 (e), one of the Directive Principles of State Policy mentioned in Part IV of the Indian Constitution lay down a mandate for the state to secure health of workers. Article 42 further directs the state to provide just and humane conditions of work. Also, article 47 imposes a duty on the state to raise the level of nutrition and improve overall public health. Thus, although there is no definite and explicit recognition of right to healthcare under the Indian Constitution, but the supreme judicial body in the country has definitely not left any stone unturned to expand the scope of 'Right to life' as mentioned under article 21. Supreme Court of India has, time and again, tried to read 'right to health' as an indispensable part of right to life, and it should be put on record that the state, undoubtedly, has a constitutional obligation to provide health services.

Constitution has divided legislative powers between the Centre and the states, which means that both the Central government and state governments can legislate on the issue of 'public

[6] The National Institution for Transforming India (NITI) Ayog brought out a publication in 2018 titled, "Healthy States: Progressive India". It was a compilation of the state of health systems prevalent in states or union territories in India. The Health Index Report was published in collaboration with the Ministry of Health & Family Welfare with technical assistance from World Bank. The Report is available at www.social.niti.gov.in, accessed on November 14, 2020-11-14 01:27 hours.

health'. Having said that, there needs to be a co-ordination between Centre and the state governments on a crucial subject like 'Health'.

Since the World Health Organization declared Covid-19 outbreak as a pandemic, the public healthcare systems all around the world, have fallen apart. Although a smooth coordination between the Centre and the States is crucial, it would be beneficial for the states if *health* remains as a subject in the State List rather being in the Concurrent List. Regular fiscal aids to the states along with the requirement to deal with public health emergencies would help make states realize their responsibilities and would make them legally accountable too. It has been witnessed during the ongoing pandemic that few states have seen to be more alert, and have invoked the Epidemic Diseases Act, 1897 much before the Central Government invoked the National Disaster Management Act, 2005 in March.

Although there are multiple references in the Indian Constitution about public health and how state owes a duty to provide a certain standard of care for its citizens, the fact that right to health is not covered under Part III as a fundamental right, is one of the very significant factors why India has a weak healthcare system. A very apt example is the Covid-19 pandemic, which has proved to be an eye-opener for all of us, and which has made us recognize the need of 'health as a fundamental right' in India.

The *Pradhanmantri Jan Arogya Yojna* in Jharkhand revealed that the scheme nudges patients towards the private sector under the guise of free healthcare only for them to incur exorbitant expenditure over the course of treatment. [7] When patients are given the option of choosing between public and private hospital, they prefer the 'better' service. Under the scheme in the state of Jharkhand, the patients were promised free treatment but the private hospitals had them pay midway citing reasons such as the treatment packages have been exhausted, resulting in heavy payments made by the patients beyond their capacity. Thus poor patients are constrained to borrow loans from their relatives, and end up working for extra hours to repay the same.

[7] D'cruze, N. (2020). Risky Insurance - The Pradhanmantri Jan Arogya Yojana in Jharkhand. *Economic & Political Weekly*, *55*(45). Retrieved 12 November 2020, from.

HEALTH RIGHTS IN INDIA – A STATE OF DENIAL

We often hear of instances where in case of a medical emergency, patients are left unattended by doctors for want of procedural formalities, especially if the patient is a victim of an accident or a crime. A medical emergency is an unforeseen, sudden situation which demands urgent medical attention, and responding within the 'golden hour' is crucial in most of the cases. The significance of emergency medical care has been discussed in various International human rights documents as well. Article 25[8] of Universal Declaration of Human Rights and article 12[9] of International Covenant on Economic Social & Cultural Rights can be good examples. The question which is of utmost concern here is whether a doctor is duty bound to treat emergency patients? or is the obligation same for government and private hospitals? The Supreme Court of India has, time and again, categorically stated that there cannot be any second chance when it comes to preservation of human life. Thus, the judiciary has decided that "a doctor, whether at a government hospital or a private one, is duty-bound to extend medical assistance for preserving life.

No law or state action can intervene to avoid or delay the discharge of the paramount obligation cast upon them. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way."[10] Also in another case where the patient was denied treatment at the various Government Hospitals which were approached even though his condition was very serious at that time and he was in need of immediate medical attention. The Supreme Court was of the view that "*in hospitals run by the State, the State cannot avoid its responsibility for such denial of the constitutional rights guaranteed under the Constitution.*"[11] Even the Calcutta High Court had observed that it is the duty of the doctor to accommodate an emergency patient in any of the department, if there is no bed available in the concerned department.[12] The Supreme Court also went a step ahead and appointed the '*Skandan*

[8] Article 25, UDHR: "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."

[9] Article 12.1, ICESCR recognizes the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health."

[10] As observed by Justice Rangnath Misra in *Pt. Parmanand Katara v. Union of India and ors.* A.I.R. 1989 S.C. 2039.

[11] *Paschim Banga Khet Mazdoor samity v. State Of West Bengal & Another*, 1996 S.C.C. (4) at p. 37.

[12] *Smt. Labonya Moyee Chandra vs State Of West Bengal & Ors.,* (1998) 2 Cal. Law Times 494 (HC)

Committee'. [13] In the year 2019, 1.54 lakhs people got killed due to road accidents[14] and the number could be halved if timely medical aid was available. It is seen that many private hospitals are hesitant in providing medical aid to such victims of accidents and they would insist on a copy of an FIR (First Information Report), which is to be filed with the police as soon as an accident occur. The Skandan Committee very rightly recommended that any doctor who refuses to attend or treat a road accident victim must face disciplinary action, that will be subject to the rules framed by the Medical Council of India. Now with the abolition of the Medical Council of India,[15] and the National Medical Commission (NMC) emerging as the new regulatory body, to what extent the recommendations of the Skandan Committee will be followed in spirit or how far these recommendations will be effective is something time will only tell us. Despite this push by the Supreme Court, the government has failed to come up with any specific legislation on regulation of road accidents victim or for that matter how patients in need of emergent medical care can be ensured that they would not be denied their health rights on grounds of inadequate facilities or are not made to run from one hospital to another for medical treatment. Thus 'access to healthcare' holds significance.

UNEQUAL ACCESS TO HEALTHCARE IN INDIA

A bitter truth about India is that our health parameters are worst in the world. Access to healthcare is asymmetric between rural areas and urban areas in India. Those residing in urban areas have the privilege to choose between public and private healthcare facility, whereas the rural population scarcely get such a choice to make. Undoubtedly India has a vast public healthcare structure with numerous Primary healthcare centres across the country. In any village community, a Primary health centre is the first point of contact between the patient and the doctor, followed by Community Health Centres (CHC), which are believed to be more equipped with medical specialists and other diagnostic facilities etc. but unfortunately due to lack of adequate resources, healthcare professionals, insufficiency of properly trained staff, and scarcity of modern diagnostic equipments, there is a shift in the rural population turning to cities even for basic illnesses. This shift is not only limited to movement from rural to urban

[13] *Skandan Committee* was a committee headed by K. Skandan, Additional Secretary of the Ministry of Home Affairs, to come out with a 'directive' to protect Good Samaritans who save the lives of accident victims.
[14] National Crime Records Bureau Report, 2019, Available at www.ncrb.gov.in
[15] In pursuance of the provisions of section 60(1) of National Medical Commission Act, 2019, the Indian Medical Council Act, 1956 stood repealed w.e.f 25.09.2020.

India, but mainly from public healthcare to private healthcare sector, which becomes a preferred choice for the rural population. Another fact which needs mention here is that *rural illness* and *rural indebtedness* are interlinked. The high cost of so called ‘effective healthcare in private sectors’ leave the rural migrants in heavy debts, which definitely calls for a sustainable economic model that can provide healthcare to all irrespective of the geographies.

The National Rural Health Mission was launched in 2005 to provide accessible, affordable and quality healthcare to the rural population, especially the vulnerable groups. The thrust of the mission is on establishing a fully functional, community-owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. [16] NHRM has the prime functionary named ASHA (Accredited Social Health Activist), who in fact, happens to be an ‘activist’ and not a worker, in the healthcare system. ASHA receives performance based compensation in contrast to a fixed salary. The scheme is weakened by the absence of any contingency plan in case the chief administrator, ASHA, decides to leave the system. In such an event, due to a yearlong rigorous training that ASHA receives, it would be cumbersome to appoint a similar person and start afresh. Another drawback of NHRM is that its central functionary cannot act independently and is dependent upon other actors such as Auxiliary Nurse Mid-wife (ANM) and the Aanganwaadi Workers as well. Yet another weakening factor is the absence of proper infrastructure and funds. [17] NHRM was a time based program which aimed at achieving certain outcomes like reduction in infant mortality rates to 30/1000 live births, reduction in maternal mortality ratio, and therefore although we cannot say that the scheme was a total failure but these outcomes could not be met. Also, the scheme-wise expenditure on NRHM, during 2007-2012, on public healthcare expenditure revealed that 90% of the allocated resource on health was spent on family welfare program and merely 7.7% for disease control. [18] Thus, limited spending on public health have resulted in scarce resources, which ultimately lead people to spend in private sectors, where they end up spending more, all of which, is out of pocket expense.

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[16] National Rural Health Mission, 2005, Available at www.nhm.gov.in, Accessed on November 16, 2020-11-16 at 14:07 hrs.

[17] C Lahariya, H Khandekar, J Prasuna, Meenakshi. A critical review of National Rural Health Mission in India. *The Internet Journal of Health*. 2006 Volume 6 Number 1.

[18] Barik, D., & Thorat, A. (2015). Issues of Unequal Access to Public Health in India. *Front Public Health*, *3*, 345. https://doi.org/10.3389/fpubh.2015.00245

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HEALTH EMERGENCIES AND LEGAL RESPONSES

A public health emergency is defined as "*an emergency need for health care (medical) services to respond to a disaster, significant outbreak of an infectious disease, bioterrorist attack or other significant or catastrophic event."*[19] Also, the term 'Public Healthcare Emergency of International Concern' is defined as "*an extraordinary event which is determined, to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response"*.[20] This definition implies a situation that is serious, unusual or unexpected; carries implications for public health beyond the affected State's national border; and may require immediate international action.[21]

Covid-19 has had a crippling effect on the whole world and India is not an exception. The effect of the pandemic has worsened in India due to the combination of population density and limited infrastructure. Unavailability of employment in the rural areas has led to migration of people to urban areas in large numbers for their survival. Because in the last few decades, this urban growth has been unplanned, it has resulted in concentration of urban poverty in unplanned settlements, for which, the government has no reliable data. There exist almost no information about the actual number of people who live in such informal settlements, which in turn, adversely affects the availability of accurate health data in India. Also, Covid-19 pandemic has exposed the vulnerability of the Indian healthcare system in various ways. India suffers from 'transmission vulnerability' due to large population and social mixing; it also suffers from 'health system vulnerability' due to lack of intensive care and the vulnerability to control measures, including social protection failures are some of the causes of serious concern.[22] Given the population and housing density in India, the probability for social mixing is higher, and there are very limited options for social distancing. More importantly, in a country like India, where more than 22% of its population live below the poverty line, and struggle for their day to day survival, safeguarding the livelihood is an imperative. So on an individual level, when a person falls sick, his/her response will depend upon competing priorities, especially the need to make a living, and this is how 'life' takes a backseat and

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[19] As defined by the National Disaster Medical System Federal Partners Memorandum of Agreement
[20] As defined in the International Health Regulations, 2005. Available at https://www.who.int/ihr/procedures/pheic/en/
[21] Ibid.
[22] Wilkinson, A. (2020). Local response in health emergencies: key considerations for addressing the COVID-19 pandemic in informal urban settlements. *Sage Journals*, *32*(2), 503-522. https://doi.org/https://doi.org/10.1177%2F0956247820922843

becomes vulnerable to 'livelihood' concerns. This calls for an *affordable public healthcare system* in India so that those who cannot afford to fall sick, apparently because they do not want to lose their earning, are not left behind.

EPIDEMIC DISEASES ACT, 1897 – DOES INDIA NEED THE LAW?

Any Law, when enacted, is expected to meet its objectives. Epidemic Diseases Act was enacted with the aim of effective regulation and monitoring of measures to control the spread of '*bubonic plague*' in erstwhile Bombay. Unfortunately the legislation failed to curb the spread of the plague and it spread to other cities. The Act of 1897 has failed to serve the purpose. Major shortcomings of the Act include the lack of any clear definition of 'Dangerous epidemic diseases' or 'pandemic' for that matter. The Act fails to mention any criteria on the basis of which, a disease can be declared as 'dangerous' or 'epidemic'. Further, the Act absolutely contains no provisions on circulation of drugs or vaccines and the quarantine measures to be taken.

In case of covid-19 pandemic in India, the Act was invoked along with the Disaster Management Act in order to control the spread of viral disease. The Act also underwent an amendment in April, 2020 by way of Epidemic Diseases (Amendment) Act, 2020 has been enacted which primarily aims at protecting healthcare personnel engaged in combating the coronavirus. The amendments also expanded the powers of the central government to prevent the spread of such diseases. Thus the amendment, like the Act, is limited in scope too. All the Act focuses upon is the power of the government during an epidemic and it clearly fails to spell out the duties of the government or the rights citizens would be entitled to, in case the government fails to achieve the control measures. Thus, the absence of accountability on the part of the government in times of crisis is a major factor that weakens the legislation. The Epidemic Diseases Act, 1897 is also silent on the human rights principles, which deserve protection at all times and all places, even during an epidemic outbreak. We have witnessed how the nationwide lockdown imposed by the Central Government by invoking the provisions of the Act, has left no option with the poor labourers but to re-migrate from distant corners of the country to their homes, which has resulted in large numbers of deaths too. It is an irony that the Indian Judicial system which is famous for its 'activism' and which has delivered hundreds of judgements reading various human rights in article 21 of the Indian Constitution, sat in utter

silence and failed to take any *suo moto* action or passed any direction to the central or the state governments to regulate the re-migration of daily wage earners in time of distress. To sum up, the Act has failed to address the significant issues during the covid-19 pandemic such as denial of medical assistance, shortage of beds and ventilators in hospitals, sanitization in public places etc. The Act also lacks any strict measures to be imposed in case the measures taken by the government are flouted. The Disaster Management Act assigns specific roles and responsibilities to public authorities at district, state and national levels but the definition of disaster under section 2(d) of the Act does not relate to cases of an 'outbreak' related to an epidemic.

As *Joseph Raz* rightly puts it, "*All laws should be prospective, open and clear….(the law's) meaning must be clear. An ambiguous, vague, obscure or imprecise law is likely to mislead or confuse at least some of those who desire to be guided by it*"[23] India has scattered legislations, with fragmented provisions, which, to author's mind, cannot address the concerns posed by a pandemic. We need to balance the rights and entitlements of healthcare workers and healthcare professionals, and talking about the Indian framework, to an epidemic response seems ill-equipped. Therefore, instead of referring to multiple enactments relating to pandemic, one comprehensive, lucid legislation is the need of the hour.

NATIONAL HEALTH BILL, 2009 AND MORE – EFFORTS IN VAIN

The bill recognizes health as a fundamental human right and states that every citizen has a right to the highest attainable standard of health and well-being. The constitution of India, under Articles 14, 15, and 21, recognizes the right to life as a fundamental right and places obligations on the Government to ensure protection and fulfilment of the right to health for all, without any inequality or discrimination. The basic tenets of the Bill include the peoples' right to health and healthcare, the obligations of the governments and private institutions, core principles/norms/standards on rights and obligations, the institutional structure for implementation and monitoring, and the judicial machinery for ensuring health rights for all. The bill provides itemized lists of the obligations of the central and state governments. Chapter III of this bill provides elaborate rights to health care, including terminal care, for everyone. A heartening point is that the bill guarantees that no person shall be denied care under any

[23] Joseph Raz, *Concept of Rule of Law*

circumstances, including the inability to pay the requisite fee or charges. Prompt and necessary emergency medical treatment and critical care must be given by the concerned health care provider, including private providers. As per the bill, the health care provider, including the clinician, would be obligated to provide all information to the patients regarding the proposed treatment (risks, benefits, costs, etc.) and any alternate treatments that may be available for the particular condition/disease. There is a clause in this chapter that demands that the user (i.e., the patient) respect the rights of the health care providers by treating them with respect, courtesy, and dignity and refrain from any abuse or violent or abusive behaviour towards them or to the rights provided to them. The bill envisages the establishment of National- and State-level Public Health Boards to formulate national policies on health, review strategies, and ensure minimum standards for food, water, sanitation, and housing. These boards would also lay down minimum standards and draw up protocols, norms, and guidelines for diverse aspects of health care and treatment. The bill provides for elaborate mechanisms for monitoring at the government and community levels. There is a need to have wider discussion on the scope and activities of these monitoring agencies and regarding dispute resolution and redressal mechanisms listed in the Bill.[24]

Another Draft Public Health Bill, 2015 focuses on critical healthcare issues and says that the government may pass the health rights bills to ensure health as a fundamental right. The periodic consultations that have been happening around the draft health policy, 2015 stressed on the rights of the citizens and the responsibility of the states. It further focuses on the cost sharing mechanism between Centre and the states, because when it comes to expenditure in any sector, the states are dependent upon the Centre for funds. The Bill emphasized on three elements of public health, protection of health, environmental conditions, prevention and control of diseases.[25]

In 2017, the Ministry of Health & Family Welfare came up with The Public Health (Prevention, Control, and Management of Epidemics, Bio-terrorism and Disasters) Bill 2017[26] which seeks

[24] Available on http://mohfw.nic.in/nrhm/Draft_Health_Bill/General/Draft_National_Bill.pdf accessed on November 19, 2020-11-19 at 15:06 hrs.

[25] Excerpts from the 2nd National Consultation on Draft Public Health Bill, 2015. The National Health Systems Resource Centre (NHSRC) was established in the year 2007 with a mandate to assist in policy and strategy development in the provision and mobilization of technical assistance to the states and in capacity building for the Ministry of Health. Available on www.nhsrcindia.org

[26] The Bill was jointly prepared by the The National Centre for Disease Control (NCDC) and Directorate General of Health Services (DGHS).

to provide for the prevention, control, and management of epidemics, public health consequences of disasters, acts of bioterrorism or threats. The Bill also proposed to repeal the Epidemic Diseases Act, 1897. According to the 2017 Bill, if any State Government or administration of a Union Territory or any district or local authority is of the opinion that a public health emergency has arisen or is likely to arise, it may, by order prohibit any such activity, which is or is likely to be inimical to public health in any area under its jurisdiction. The authorities may quarantine or restrict the movement of any person or object suspected to be exposed to any such disease.

The proposed Bill also authorizes the public authorities to ban or regulate the purchase, transport, distribution, sale, supply, storage, of any drug or of any other material which contains hazardous or toxic substance. They may also order detention of any person travelling or intending to travel or carrying any animal or plant or bio-hazardous material by any mode of transport as may be considered necessary. They can also order closure of markets, if required. Any willful or intentional contravention of any provisions of the Act or any rule or order made there under will be a cognizable offence punishable with a fine of up to Rs 1 lakh and imprisonment up to two years.[27] The positive aspect about the Bill was the terms like epidemic, quarantine, social distancing etc. were clearly defined but due to lack of adequate support, the Bill could not see the light of the day and lapsed.

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CONCLUSION

The debate whether healthcare is a ‘right’ or not may be settled in the light of international human right instruments like Universal Declaration of Human Rights that recognizes ‘Right to Health’ as a human right. Merely because of the fact that somebody is poor, or somebody cannot have access to healthcare does not mean that they can be left to die due to infirmity or disease. Access to safe drinking water, sanitation facilities, safe working conditions are some of the determinants of basic health. Non availability of healthcare facilities and also any kind of discrimination in providing healthcare is definitely a barrier to human development.

[27] Available at www.mohfw.gov.in

In order to make quality healthcare more accessible in India, critical healthcare equipment such as ventilators, wheelchairs, crutches, and medical equipments should be exempted from GST in Budget 2020. Healthcare system in Scandinavian countries is worth adopting. The system is mostly government funded through taxation and most of the hospitals are publicly owned and managed by the government too. In fact private healthcare is rare in Sweden, and whatever private healthcare systems function, they work under the control of government. As regards Nordic healthcare systems, every citizen has equal access to healthcare services. In Norway, all hospitals are funded by the public as part of the national budget. However, while medical treatment is free of charge for any person younger than the age of sixteen, a service, which should be extended for old aged people as well.

A holistic approach to a rationally structured legislative framework with various aspects of healthcare rights is the pressing need for India. A new Health Care framework, keeping in mind the loopholes of the existing Laws, will hopefully have far reaching consequences in the field of healthcare. It would also bring in accountability in the healthcare system. For this, it is important that every state has a robust public grievance system which remains functional. The author also believes that somehow Indian healthcare system has neglected the 'preventive public health measures', and that may be one of the reasons why India is facing such callous condition during covid-19 pandemic. Also, there is a need to generate timely data in quality of healthcare and on health outcomes, so frequency of National Family Health Survey must be increased. For example if the survey takes place once in 10 years, it must happen more frequently, may be in a span of 3 years. It is high time India takes a cue from healthcare models of other countries, and make healthcare more accessible, more affordable for the common man.