VOLUME 2 | ISSUE 4

INTERNATIONAL JOURNAL OF ADVANCED LEGAL RESEARCH

DEBATING THE CONTOURS OF RIGHT TO HEALTH

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Abstract

In the Neo-liberal era a question which is analogous to an endless maze pertains, what is health? Is it a right or a commodity? Are we obliged to receive good health services or we are consumers who need to purchase them? This debate intensified much after the pandemic COVID-19 when human rights and our subsequent right to health were exploited by the state and private players equally. Indian constitution does not explicitly include the Right to health as a constitutional right however there have been several instances where the supreme court of India has upheld the validity of the Right to health as a part of Article 21 of the Indian constitution still the ambiguity remains. This has majorly been the reason for the exploitation of the masses especially the poor in the health sector. This paper, therefore, attempts to understand the idea of the right to health, and how has it been interpreted constitutionally. It further advocates the inclusion of the right to health as a fundamental principle such that it becomes justifiable. The debate of health as a right or a commodity is discussed in the last section with the help of the debate between liberals and opponents and supporting theories and John Rawls and Amartya Sen have been used as a framework to claim the right to health as fundamental.

Keywords: Right, Health, Neoliberalism, Commodity, Fundamental, Constitutional, Public Health, Private Health, Marketisation, Pandemic

Introduction

The pandemic COVID-19[2] gave enough instances to think and realize why health, be it individual or community's is important. Nevertheless, it has been a subject of discussion

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[2] www.who.int.com retrieved from https://www.who.int/emergencies/diseases/novel-coronavirus-2019

amongst nations. What is the nature of health, how should it be maintained, who is responsible for preserving it? These are question whose answers keep fluctuating. These discussions and debates intensified with liberalization and globalization spreading as global phenomenon. As liberalization eased trade norms and allowed foreign companies to enter the Indian market it was assumed that it would aid the ailing post-independence economic condition of the country however to add to the disappointment it produced a parallel structure driven by market where everything has an economic value. Health sector was not left untouched as the effect liberalization on this sector has been hard-hitting and no less to say it converted a service sector to 'for profit' industry (Baru, 2003). Under this system the notion of 'health care for all' has been in continuous threat as it aids people who have the capacity to pay often leaving behind the economically and socially marginalized. This new structure represents a paradoxical system where health, a primary good (Rawls, 1982) is treated as a commodity (Appadurai, 1986)). It is to understand this system this chapter begins with exploring the constitutional principles with respect to health in India, to know what the legal provisions of the subject. Moving further the chapter explores the reasons that has been affecting public health that which is failing to accommodate the idea of 'Health for all'. Lastly the chapter elaborates and proposes a framework to justify right to health with the help of Rawl's (1982) ideas of primary good and Amartya Sen's (1993) capability approach.

Constitutional Principles of Right to Health

World Health Organization[3] (WHO) in their preamble define Health as a,

> "*State of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*

This definition given by WHO does not restrict the idea of health to mere physical wellbeing it rather broadens the scope of the subject to encapsulate the overall of state wellbeing of an individual, community or society. Moreover, health as according to the preamble of WHO constitution is a fundamental right and it makes the states responsible in achieving the agenda of "health for all". Health and good health as a state of being remains the utmost necessity of human beings. As much it is important for individuals to realize it, that much is it crucial for

[3] www.who.int.com retrieved from https://www.who.int/about/who-we-are/constitution

any state or governments to take adequate measures to ensure health for all. It is with this purview that the Alma Ata declaration of 2002 adopted the agenda of "health for all". United Nations (UN) charter[4] in chapter 9, article 55, 57 and chapter 10 article 62 directs the responsibility of states in providing adequate health care to their citizen even though all its signatories members are bound to follow the principle but a recent study[5] published in the journal global public health showcased that out of 193 members only 73 U.N member countries (38 percent) guaranteed the right to medical care services, while 27 (14 percent) aspired to protect this right in 2011. When it came to guaranteeing public health, the global performance was even poorer: Only 27 countries (14 percent) guaranteed this right, and 21 (11 percent) aspired to it.

India being a member of United Nations since 1948 is yet to recognize the importance of right to health as a fundamental right. The constitution of India does not guarantee health as a fundamental right which means neither the state nor any government is duty bound to ensure optimum health care whose demand is neither enforceable nor justifiable. This does not mean that the framers of the Indian constitution have been insensitive with their approach rather it has directed the responsibility to the states but not very strictly. The subject of health and public health finds mentioning in the directive principle of state policy under part IV of the Indian Constitution. As the name suggests directive principles are directives given to states to perform their duty guided by these principles. These directives unlike fundamental rights are non-justifiable and non-binding which means the choice to follow these principles are left with the government. Moreover, no citizen can claim these rights/principles in the court of law. The makers of Indian constitution categorized the matter of public health under these directives in articles:

- Article 38: To promote welfare of people by securing a social order permeated by justice-social, economic and political in order to minimize inequalities in status, facilities and opportunities.
- Article 39(e): Preservation of health and strength of workers and children against forcible abuse and opportunities for healthy development of children

[4] www.united nation.co retrieved from uncharter.pdf
[5] www.sciencedaily.com retrieved from A constitutional right to health care: Many countries have it, but not the U.S. -- ScienceDaily

- Article 41: To secure the right to work to education and public assistance in cases of unemployment, sickness and disablement.
- Article 42: To make provisions for just and humane condition of work and maternity relief.
- Article 47: To raise the level of nutrition and standard of living and to improve public health.

At the administrative level as per seventh schedule of Indian constitution public health is a subject of the state list which means respective governments are entitled take care of public health needs of the people. Similarly, the 11th and 12th schedule empower the panchayats (Article 243-G) and the municipalities (Article 243-W) respectively in matters of public health.

The term "Right to Health" as a fundamental right is nowhere mentioned in the Indian Constitution, yet the Supreme Court has interpreted it as a fundamental right at various avenues under article 21 "Right to Life". The court has time and again played a pivotal role in making the state accountable towards its citizens by invoking right to health as a fundamental right. In that purview it is important to go through some of the landmark judgments made by the judiciary to ensure the essence of democracy and constitutionalism. It began with the judgement passed by the honorable Supreme Court in the matter of Parmanand Katara vs Union of India (1989)[6], where the court interpreted that the right to emergency medical care is a fundamental right under Article 21 that cannot be denied by any hospital, clinic or any other health care service. Which was an important reminder for the state and medical bodies about their duties. Another significant decision in the line of acknowledgment of right to health was given by the Supreme Court in the matter of Indian Medical Association vs V.P. Shantha[7] (1992), wherein, it was held that providing medical services whether therapeutic or diagnostic for monetary consideration amounted to service within the meaning of service as per the Consumer Protection Act, 1986 and hence any medical practitioner or hospital found guilty of negligence or deficiency in services shall be held liable as per the Consumer Protection Act. Here the court prevented commodification of health services by the virtue of it being fundamental and basic.

In the Consumer Education and Research (CER) vs. Union of India (1995)[8] case where an NGO (CER) petitioned mandatory compensation to workers for occupational hazards and diseases or death to employees who did not qualify for such coverage under the existing labor legislations, to provide adequate mechanisms for diagnosing and controlling asbestosis and to provide compulsory health insurance for employees, and finally to award compensation to those suffering from asbestos. Supporting the rights of the worker the court held the right to health, medical aid to protect the health and vigor of workers while in service or postretirement as fundamental right under Article 21.

In State of Punjab & Ors vs Mohinder Singh Chawla (1996)[9] when the petitioner (government employee) demanded an inquiry in case of charges claimed by All India Medical Services for room rent post operation/surgery. The court withholding the right of the petitioner reprimanded the institute claiming that "Each case for medical reimbursement with respect to diet, stay of patient, stay of attendant employed either in a hospital or anywhere else during the period of treatment should be considered on its own merits keeping in view the facts and circumstances of a particular case"[10]. In this case the apex court reaffirmed that the right to health is fundamental to right to life and should be put on record that the government had a constitutional obligation to provide health services.

The Supreme Court has also emphasized on the need for primary health care in the Paschim Banga Khet Mazdoor Samiti vs. State of West Bengal (1996)[11] case where a victim of train accident was denied medical treatment due to lack of primary medical facilities at any state-owned institution which resulted to his death due to negligence. Here the court held that it is obligatory on the part of the state to provide necessary primary healthcare and the excuse for insufficiency of fund cannot absolve the state from performing its duty. The court questioned the accountability of the state while reminding them of their primary duty towards their citizens. While protecting right to health, Supreme Court not only meant human health or ensuring

medical services but, in the petition, filled by Vellore welfare association (1996)[12] the court has emphasized on the need for fresh air, water and pollution free environment as a part of right to health but also environment and community health.

At times the court has tried to widen the scope of article 21, in Kirloskar Brothers Ltd. vs. Employees State Insurance Corporation, 1996 Supreme Court interpreted that[13] "Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. Government hospitals run by the State and medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of the hospital to provide timely medical treatment in need, will result in violation of his right to life guaranteed under Article 21".

Given no explicit recognition of the right to health or healthcare under the Constitution, the Supreme Court of India in Bandhua Mukti Morcha vs Union of India & Ors (1997)[14] evoked the principles of right to health as fundamental where right to dignified living formed the primary basis of the judgement. In this case the petitioner challenged the working conditions of the workers working in stone quarries of Faridabad, the petitioner claimed that environment was inhumane and unjust. The court reviewed the petition under article 32 and believed the claims made by the petitioner were right and thus the judgement was passed in the favor of the workers to whom the court entitled with right to dignified living and quality health under article 21 of the Indian constitution. It not only invoked fundamental right but also reminded the state of its duties by interpretating article 39 (e), (f), 41 and 42 of directive principles of state policy. It is by exercising this exclusive power of judicial review the Indian judiciary has protected the right to health for citizens. This nature of judicial activism was not required if the provision of health by nature would have been a fundamental right not a directive principle. It is this structural-legal difference between fundamental right and directive principles which leads to the conflict and intervention through judicial activism.

Why fundamental right when the provision for health care remains in the directive principle which is a set of directives for the state. A mention in directive principles is a mention in the

constitution thus a part of the basic structure doctrine, then why is there a need to have it as a fundamental right? It is important for right to life to be listed in the fundamental principles because fundamental rights unlike the directive principles are justiciable which means no body/institution or state itself can deny it to the citizen. Citizens are empowered to demand for the implementation of their fundamental right under article 32 of Indian constitution. Whereas in case of directive principles they are directives which are to be adhered by the state but are not binding on the state which means it is upon the discretion of the state whether to follow the principle or not. Neither can the non-implementation of policies as per directive principles can be challenged in court. Hence the constitutional inclusion of public health in directive principles makes it weak as it remains a non-binding duty of the state but not the primary duty. It is this provision and the coming of liberalization policy in India combined together has impacted the condition of public health adversely. It is no less to say such policy changes have led to the commodification of health care where health has been reduced from a right to a commodity which has an economic value and is a subject of profit and loss. The following section will elaborate upon the nature of change that health care underwent post-liberalization and how has it been impacted.

What Impacted Public Health

The Era of Liberalization

The then Finance Minister of India Dr. Manmohan Singh introduced the historical reforms of the 1990s in his budget speech on 24 July 1991, where he explained the rationale of economic reforms to the world. As a result of which the rupee was devalued by 20%, he addressed the nation with the following remarks:

'I do not minimize the difficulties that lie ahead on the long and arduous journey on which we have embarked. Victor Hugo once said, "no power on earth can stop an idea whose time has come." I suggest to this august house that the emergence of India as a major economic power in the world happens to be one such idea. Let the whole world hear it loud and clear. India is now wide awake. We shall prevail. We shall overcome.'

—Budget Speech, July 24, 1991[15]

24 July, 1991 was the historic date which decided the economic fate of Indian economy. Economic transition occurred when India as a nation shifted from an import substituting economy (ISI) towards trade-led growth economy (TLG) under the process of neo-liberalization. Liberalization is generally associated with a set of policies implemented in the 1980s by the International Monetary Fund, the World Bank, and the United States of America in an effort to help crisis-stricken developing countries by prescribing a series of reforms, the so-called 'Washington Consensus' policies. Such policies aimed at achieving macroeconomic stabilization, reducing government's role in the economy, privatizing public assets, and reducing public expenditure (Sakellariou and Rotarou, 2017). Liberalization a tool of the neoliberal ideology which is associated with an orientation towards market-based approach that emphasizes on deregulation, minimalization of the state, privatization, and the emergence of individual responsibility.

Neoliberal adjustments have proven problematic for advancing sustainable solutions in global public health. Advancement of global neoliberal adjustments have resulted in significant public health challenges—in particular, as a consequence of the declining capabilities of public health care systems. It is important to know how these adjustment programs have affected the health care structure. the commercialization, corporatization and marketisation of health care are a phenomenon of the last quarter of 20th century. The process received a boost during in late 1970s and early 1980s thanks to a global recession, which enveloped both developed and developing countries, imposed a fiscal constraint on government budgets and encouraged them to cut back on public expenditure in the social sectors. This increased the space for the growth of the private sector in provisioning of health care. This process was accelerated during the 1980s and 1990s with the growth of the pharmaceutical and medical equipment industries and their seeking out markets for their products. The fact that multilateral agencies have an influential role in shaping national policies, particularly in the health sector, multinational corporations have systematically targeted them for policy influence, defining priorities for disease control program, provisioning of health care, and medical research at the national level (Baru, 2003).

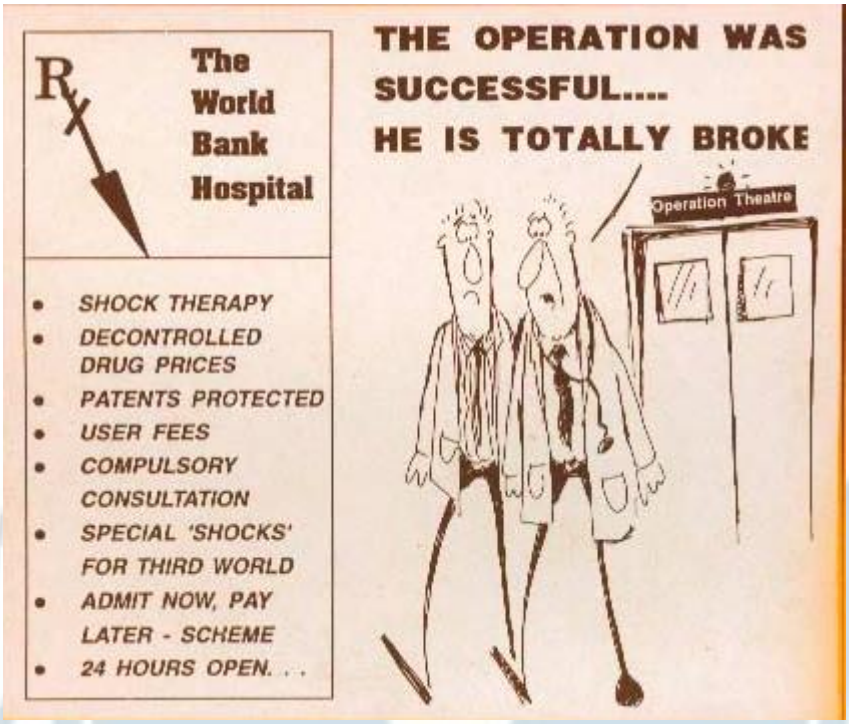

Figure 1.1: A satirical illustration of hospitals post-liberalization in India

Source: Public Interest Research Group, 1994

As Rama Baru (2003) argues private corporate giants gained largely from these new economic reforms as this policy of liberalization and privatization led to the "commodification and marketisation" of health services in India. During this period health care transitioned from healthcare 'for all' to 'for profit' health care. Globalization led to the commercialization of health sector which began with pharmaceutical companies and the medical equipment industry entering the sector for selling their products. Multinational corporations, pharmaceutical industry, hi-tech medical technology providers, international insurance firms and healthcare corporations all of them started to influence global policy, multilateral institutions, public policies and government policies very soon (Baru, 2003). As per the data released by the Department of Industrial Policy and Promotion in 2014, the healthcare sector dominated 80 percent of the entire market in India. The sector consisted of hospitals, diagnostics, pharmaceuticals, telemedicine, health insurance, medical devices, and equipment, as well as other goods and services related to medical care.

The rising demand for healthcare services in the global market generated immense opportunities for corporate owners in the sector, as a result, it turned out to be a potential investment for multinationals. Economic reforms of 1991 were adopted due to the balance of

payment crisis which third world countries were facing after being indebted with heavy loans from the World Bank and Indian Monetary Fund. What economic reforms did was it liberalized economic policy of the country by omitting the age-old license raj system and allowed global markets and private entities to usher in the Indian economic diaspora. As a result, state control over matters like trade, commerce and industry was reduced. Private firms had the freedom to build and monopolize the market. Both the Bretton woods institutions supported privatization through the introduction of structural adjustments and targeted program that were designed to regain their debts from third world countries.

A report titled “Investing in Health" (1993)[16]suggested that public expenditure on health should be reduced and existing expenditure be reallocated. Thus, targeting the private sector investment in third world countries for cost-recovery. The popular hypothesis for reforms to happen was that they (economic reforms) were pushed by the International Monetary Fund (IMF’s) and their implications were largely economic, however spillover of these reforms was visible on health care structure quite soon. There were various reasons attributed for this, primary being the lack of support from any political lobby in India. Bhore committee 1946 which was appointed to devise a comprehensive plan for healthcare in India put forth a proposal with the philosophy that every individual regardless of their economic conditions should receive adequate medical facilities. The committee made suggestions for preventive health care, 3 tier system of healthcare services where each district was to be divided into blocks with primary health care centers in each block and secondary care centers for specialized care. However even after independence most of the suggestions made by the committee have remained unimplemented in order to serve the private capital. As state investment in the following years after independence till now has remained biased towards heavy industries, MNC’s and other economic infrastructures thereby neglecting the social sector.

Post-liberalization the entire focus of the Indian government shifted towards industrialization and economic development. The adoption of the structural adjustment program did not occur to reform the economic structure but only to pay and repay the debts of the country and which is where all the funds of the Indian state were diverted post-liberalization. As per the economic survey data of 1993-94, total external debt in the year 1993 was Rs. 2760.7 billion and the expenditure on health services was Rs 5.59 billion as compared to the year 1989-90 where the

debt was Rs. 1350.0 billion and expenditure and on health was Rs. 3.48 billion. As is understood from the data the debts kept rising since 1980s due to which there was a shift towards heavy industrialization to repay loans, even with the low budget resources were utilized to benefit industrial workers- the section considered of utmost importance to the national economy (Public Interest Research Group, 1994). The first health measures, Employees State Insurance Act 1948 which provided medical aid benefitted the industrial workers (who at that time were a minority). State investments were directed towards the growth of private capital like growth of pharmaceutical and drug industry and increasing support to private medical practitioner. As a part of the structural adjustment program few more rearrangements at policy level occurred (Public Interest Research Group, 1994):

- Introduction of user-fees in the public health sector during the eighth five-year plan (1992–7) was the very first health policy measure adopted post reforms. As policy makers believed thar user-charges could mobilize funds for the economically marred Indian health sector. This surplus money would help in enhancing the quality of care, increasing utilization and improving access to health services for the population, especially for the poor (reduce the inequity in access to healthcare).

- Another major reform was the decentralization of healthcare system which was carried out in 1990s as part of the government reform process in the country. The decentralization of governance implied the transfer of authority and responsibility from the central government to the district and lower level to make development more locally sensitive and participatory. As per this new administrative arrangement, local governments would have more power in allocating resources and delivering services (including health) in accordance with the need of the community.

- Another drastic policy change was the decline of public spending on health during the period of economic liberalization. This reduction on public health expenditure affected further at the state level in the 1990s, first half of 2000s till today. This decline in spending has failed in meeting the public sector demands of healthcare. Together, the reduction in public health investments and increase in user-fees in the public sector helped the private sector to fill the space and exploit the market opportunity.

- The introduction of a new Drug Price Control Order (DPCO) under new economic policy affected the health care sector adversely. According to the DPCO, 1995, out of

the 500 bulk drugs, most were taken out of the statutory price control, leaving only 74 drugs in price control. Further the pharmaceutical sector was further liberalized in 2002 Both these developments together led to steep rise in drug prices which affected the notion of access to quality and affordable health care.

Crisis of Public Health Sector

Moving on from the preceding debate it is well understood that liberalization led to major cost cutting from the public health sector by the state. As privatization provided avenues for revenue generation and income production the state focus became development of the private health. Today the private health sector accounts for more than 80% of total healthcare spending within India. Apart from government expenditure the healthcare sector has managed to attract Foreign Direct Investment (FDI) worth US$ 6.09 billion between April 2000 and March 2019. Asia's largest healthcare company is slated to emerge as India's second largest private sector player[17] . Rupa Chanda (2001) in her article "Trade in Health Sector in India" explains how globalization aggravated the problems of the public health sector further. One of the key developments in the neo-liberal period was the increase in medical tourism in India. As per the data recorded by Confederation of Indian Industries (CII), approximately 150,000 patients arrived in India in 2005 from across the globe for medical treatment, which is expected to increase by 15% each year (Confederation of Indian Industries and McKinsey & Co. 2002). According to Chanda (2001) this nature of liberalisation in the health sector has both negative and positive repercussions, however the former are grave. Positively medical tourism offers the free flow of knowledge and expertise across the border, it aids in the development of the host country. In contradiction because of its (medical tourism) privileges, it has become a mode of revenue generation pushing the state focus on medical tourism enthusiastically. Nonetheless medical tourism has largely benefitted the secondary and tertiary care level but it has completely neglected primary care. Therefore, continued state focus on medical tourism in the larger run, as Chanda argues, can lead to rupture of the public health system especially primary care further making health care expensive. To quote Chanda (2001) she proposes "consumption of trade abroad could also result in a dual market structure, by creating a high-quality, expensive segment that caters to wealthy nationals and foreigners, and a much lower-quality, resource-

constrained segment catering to the poor. Availability of services, including physicians and other trained personnel, as well as the availability of beds may rise in the high-standard centers at the expense of the public sector, resulting in a crowding out of the local population". She further claims that expenditure on corporate hospitals has led to the diversion of public funds from the public health sector, thereby creating a two-tier structure: one the private segment and second a public segment. The private segment which provides high-tech treatment and services but not basic services for social needs. She defines the consequence in a term called "cream skimming" which implies "those who need less but can pay more are served at the expense of the poor and more deserving". She challenges the neo-classical theory which states that the inflow of foreign funds and outflow of health professionals can help in increasing the income source of the host country. Instead, she argues that the rise in domestic prices of health care services due to medical tourism can lead to negative distributional impact on poorer sections of the population, unless and until the resources and income gained are appropriately redistributed in the society. Rama Baru (2003) traces the reason for poor public health funding and she proposes that two crucial factors have led to the ordeal: one increase in privatization of the health sector and two the expansion of the middle class. She argues from both the demand and supply perspective, supply of private hospitals increased because the demand for private health increased, as it is considered qualitative and modern. This demand is prominently witnessed amongst the middle-class group especially after the emergence of the new middle-class post 1990s. As liberalization opened the gates for global access the main beneficiary turned out to be the middle class who accessed global education and employment. From the knowledge and revenue generated abroad many middle-class and the new middle-class group got an exposure to world class technology and treatment which lured them to establish similar corporate hospitals and private health structures in their home state. The same new middle class became the consumer as well, high tech treatment and services appealed to this class. Such nature of demand led to poor public funding to public health services as resources and funds were diverted to private entities. In a demand and supply scenario like this state government supported corporate houses by providing land, material and licenses at much cheaper rates without hassle. Indian government since the 1980s provided concessions and subsidies for import of medical equipment which steadily increased in the 1990s onwards (Baru, 2003). It was during this period that multinational corporations like Philips, Siemens, General Electric, Becaton and Dickinson entered the Indian market with many other companies for assembling

equipment. The increasing ration of private beds to public beds especially since the 1990s has been a marker of privatization. Privatization led to the increase in indirect cost of public health funding especially in highly inequal societies of South Asia. Which ultimately led to nothing but exploitation of the poor and denial of their basic rights (Baru, 2003). Duggal (2004)agrees with the privatization phenomenon as he argues, structural adjustment and economic reforms have shrunk resource allocations for public health services. In the mid-nineties the 5th pay commission added to the catastrophe leading to allocative inefficiencies due to budgetary allocations being sufficient only for financing salaries. The recovery from this has only been marginal but the introduction of user fees struck the final blow for the poor who are the vast majority of users of public health facilities. He further provides an evidence of the collapse of public health facilities from another national survey of public health infrastructure, which reveals that in 1999-2000 the critical public health facilities were grossly inadequate. The 2002 National Health Policy acknowledges this severe indictment and recommends that public health investment and expenditures need to be more than doubled in the coming years in order to provide a reasonable level of primary health care. A decade and two ago, the condition of the health sector was not like this. When India became independent of British rule in 1947, the private health sector provided only 5-10% of total patient care. Today it accounts for 82% of outpatient visits, 58% of inpatient expenditure, and 40% of births in institutions. Successive governments post- liberalisation has also not bothered to invest in the public health sector rather they have promoted and facilitated the growth of the private health sector through various means (Sengupta and Nundy, 2005). State subsidised the private sector by releasing prime building land at low rates (as long as a quarter of patients are treated free—a condition that is rarely met), by exemptions from taxes and duties for importing drugs and high-tech medical equipment, and through concessions to doctors for setting up private practices and nursing homes. The Bhore committee recommended 12 percent of total outlay to health (public) but unfortunately the expenditure never crossed more than 3 percent. This nature of underfunding led to the stagnation in public health services from mid 1980s to 1990s (Baru, 2003).

These developments make it evident that the growth of private health sector has been at the cost of public health sector. This process Baru (2003) terms as marketisation in health sector which initiated during the last quarter of 20th century with globalization. It was the growth of pharmaceutical companies, export of medical technology, international insurance firms and health care corporations which accelerated marketisation, commercialization and

commodification of health care. Marketisation, commodification and commercialization are termed often used post liberalization to explain market relations in health systems. Globalisation changed functioning of market and trade relations in developing countries. Commercialization, commodification and marketisation are presupposed with globalization as they by default allow trade in health sector, production of services for profits, private insurance which values individual payment (Mackintosh, 2003).

Access to Primary Care

The Bhore committee report 1946 was instrumental in introducing three tier health care model in the Indian health infrastructure. The committee was headed by Sir Joseph William Bhore who took charge of assessing health conditions in India post-independence. Out the of various valuable recommendations made, the committee is lauded for its inputs that led to the establishment of primary health care centers (PHC) in India. Keeping in mind the socio-economic variations and huge regional disparities of the country the committee recommended to have a district health scheme, also known as the 'three million plan'. According to the plan average districts population was proposed to be organized in a 3-tier system with primary a unit at the community level, followed by a secondary and tertiary unit to take care of intense health conditions. Each Primary Health unit was supposed to be 75 embedded with 6 doctors, 20 nurses, 6 public nurses and a host of other paramedical staff catering to 10,000 to 20,000. These centers were to be equipped with ambulatory services to be linked with the secondary units when the need arises for secondary level care. The organization and administration of these primary units were left with individual districts with guidelines for adherence to quality and safety. Bhore committee made a case for primary health care at national level however the essence of primary care structure has been recognized globally[18]. Alma Ata 1978 Declaration is important in this regard as it focused on PHC system based on principles of social inclusion, equity and comprehensiveness. The declaration emphasized on the need for primary health care as it believed that[19]:

- It is essential health care based on practical and socially acceptable methods made universally accessible to individuals and families in the community. Moreover, it is cost-effective as the community and country can afford to maintain at every stage of their development.
- It forms an integral part of both the country's health system and overall social and economic development of the community.
- It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.
- Primary health care reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical, health services research and public health experience.
- It addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly.
- It involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.
- It requires and promotes maximum community, individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources.
- It should be sustained by integrated, functional and mutually supportive referral systems leading to the progressive improvement of comprehensive health care for all and giving priority to those most in need.
- It relies at local and referral levels of health workers, including physicians, nurses, midwives, auxiliaries and community workers as well as traditional practitioners, suitably trained socially and technically to work as a health team and respond to the expressed health needs of the community.

- 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 will be necessary to exercise political will to mobilize the country's resources and to use available external resources rationally, to achieve primary health goals.
- All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country.

The Astana Declaration 2018[20] reflected similar commitment for achieving the target of primary care. The declaration resolved to establish PHCs in accordance with national legislation, contexts and priorities. For which it aimed to invest in PHCs to enhance capacity and infrastructure for primary care. The declaration announced to prioritize primary health needs through comprehensive preventive, promotive, curative, rehabilitative services and palliative care. Further focusing on making PHCs accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, continuous with integrated services which are individual specific and gender sensitive.

Interestingly despite being an advocate of primary health care, the failure of the health system in India arises from the ruptures at the primary care level itself. Five years post the recommendations made by the Bhore committee; government of India laid out plans for primary health care in the first five-year plan 1951-55. Primary health care began with community development program in rural India where most of the population was centered post-independence.

Another committee known as the Muralidhar committee was appointed at the end of the second five-year plan (1956-61) which proposed to limit the population served by PHC's to 40,000 with an improvement to quality of care. Further in 1973 Kartar Singh committee recommended to divide each PHC into various sub centers for a population of 3000 to 3500 people. Every sub center to be equipped with one male doctor and one female doctor. This was model adopted for rural areas in urban areas primary care was delivered through PHC's, 1 PHC for a population of 10,000 and community health centers. Till 2018 the hierarchy of primary health structure in

rural areas was: community health centers (which served as a bedded hospital and a referral unit for PHCs) followed by primary health centers (With a referral unit for sub centers and 4-5 bedded hospital), sub center (peripheral unit linking the primary health center and the community.

National Rural Health Mission (NHRM 2005) and National Urban Health Mission (NUHM 2013) the sub scheme under the national health mission 2013 emphasized on the need to strengthen PHCs in rural and urban areas. Th core strategy of the NHRM is to provide better human resource development, quality standards, community support and a united fund to enable local planning and action at sub central level and PHC level in rural areas. It made provisions for 30-50 bedded Community Health Centers per lakh population for improved curative care.

The NUHM made provisions for primary health care for the urban poor. The mission enabled the establishment of Urban Primary health centers (U-PHC) one for a population of 50,000 each located in within or near slum areas. UPHC maintained preventive and promotive health care by providing OPD consultations, basic lab diagnosis, drug/contraceptive dispensing service and counselling for other communicable and non-communicable disease. U-PHCs are followed by Urban Community Health Centre (U-CHC) which serve a population of above 5 lakhs for impatient care. NUHM also enables outreach services through ANM (Auxillary Nursing Midwifery) or Female Health Workers (FHWs) to targeted groups like slum dwellers, vulnerable population to provide preventive and promotive care.

Ayushman Bharat Scheme 2018 launched by government of India to address health (covering prevention, promotion and ambulatory care), at primary, secondary and tertiary level by adopting a continuum of care approach. For enhancing the existing primary care infrastructure, the scheme provides for the creation of 1,50,000 Ayushman Bharat Health and Wellness Centers (AB-HWCs) as an upgrade to the existing sub-health centers. (SHCs) and PHCs in rural and urban areas. The aim of the program is to provide comprehensive PHC by expanding and strengthening the existing reproductive & child health (RCH) services and Communicable Diseases services and by including services related to Non-Communicable Diseases through AB-HWCs (Lahariya, 2018). According to the rural health survey 2018-19, there are 30045 primary health centers (PHCs) (24855 rural + 5190 urban) functioning in India. Further, out of 24855 rural PHCs, 8242 PHCs have been converted into health and wellness centers (HWCs) in rural areas and out of 5190 urban PHCs, 1734 PHCs have been converted into HWCs in urban

areas. There are a total of 5685 Community Health Centers (CHCs) (5335 rural + 350 urban) functional in the country (Rural Health Survey data, 2019).

However, in terms of the rise in number of PHC's from 2005 to 2019 India has performed fairly well (Rural Health Survey Report, 2019) and the impact assessment of AB-HWCs are yet to be undertaken as it is a fairly new scheme but a study of six states in India titled "Challenges to Health Care: The five A's" revealed that many of the primary health center's (PHCs) lacked basic infrastructural facilities such as beds, wards, toilets, drinking water facility, clean labor rooms for delivery, and regular electricity (Kasthuri, 2018). Most of the PHC's in rural and urban areas are ill-managed majorly because of the non-availability of doctors.

As per the estimates provided in an article by Business Standard[21], India still has a shortfall of 9,000 doctors in about 25,000 PHCs and nearly 2,000 of them don't have even a single doctor. In PHC's which have a doctor most of them are under qualified or incompetent to serve the need of the local people. This kind of situation directs our attention towards a problem scenario. Apart from the primary requirement of a doctor, lack of basic drugs, electricity and piped water poses a major challenge in fulfilling the primary health care needs of the community. India still has a long way to go to keep the Alma Ata promise of "Health for All".

As Rao (2019) observes that there is deficiency of more than 3,800 PHCs to serve the total population. Additionally, there is need to address inadequate infrastructure as well as manpower for better service and delivery of primary healthcare. Rao (2019) notes that the current primary healthcare structure is extremely rigid and does not effectively cater to local realities and needs. He focuses on the need to explore and understand reasons that prompt people to visit private health facilities and reasons driving them away from free government care to effectively deliver public health demands. Moreover, it is essential to keep in mind large diversity in India for local adaptation of the basic healthcare package and its delivery mechanism. Therefore, the task is to reform, revitalize, and resource primary health systems to deliver different levels of service aligned to local realities, ensuring universal coverage, equitable access, efficiency and effectiveness, through an empowered cadre of health personnel.

Institutional Failure: Case of the Oxygen Crisis during Pandemic

"Beg, Borrow, Steal, it is a National Emergency"

-Delhi High Court to Centre [22]

In this powerful voice Delhi high court directed the Centre to intervene during the oxygen crisis faced in the pandemic. It started when second wave of COVID-19 hit India in late days of March 2021. According to the data collated by PRS Legislative Research[23] as on 28 March 2021 the number of active cases recorded were 486310 with 161552 deaths and by 13 May 2021 the number of active cases rose to 3710525 with 258317 deaths all over India. Newspaper dailies were flooded with headlines about shortage of medical oxygen. Consider the following;

MP says Maharashtra scuttling supply of oxygen concentrators[24]; No beds at hospitals, no oxygen at home[25]; Hospital almost out of oxygen police rush to help with 20 cylinders[26]; Delhi hospitals ring alarm bells[27]; Six die of Oxygen shortage at Amritsar Hospital, District Administration blamed, probe on[28]; Night 'Horror': Patients doctors all had raised alarms on goa Oxygen crisis[29]; No oxygen: East Delhi hospital halts admissions, discharges some patients[30]; For third day in a row, hospitals scramble for oxygen: Death in minutes if supply stops[31]; Delhi hospitals seek oxygen for 4th day, Covid patients die at Ganga Ram[32]; Hospitals across capital say having to cope with less oxygen than needed[33]; Demand up 67% as 22 states

seek oxygen[34]*; Grappling with oxygen, two Lucknow hospitals ask kin to shift patients*[35]*; Kejriwal sounds alarm: Oxygen and drugs running out, situation very serious*[36].

Such headlines dominated the print and electronic media platforms with the start of the second wave of COVID-19. It was a crisis for which no body was prepared- starting from masses, doctors, health systems, professionals, politician to policy makers. Covid 2.0 affected the Indian state unexpectedly. The problem was both scientific and structural as going by the nature of coronavirus, the virus mutated not once or twice but thrice, India was dealing with an exclusive Indian variant of triply mutant corona virus. Which unlike the first wave caused huge damage to life and society. The said variant was known to impact the respiratory system of the host causing problems in respiration and sudden drop in oxygen levels further weaking the entire immune system and collapse in most of the cases. Moreover, this time the virus was highly contagious and spreading at a much larger pace thereby increasing the number of per day infections rapidly. The number of per day serious cases with oxygen demand grew day by day ever since the second wave hit. Combined with this scientific problem, structurally hospitals and administrators were unable to meet the rising demand of Liquified Medical Oxygen (LMO) which resulted in a loss of life at large scale. However, efforts were made, central action was seeked, high court and supreme court utilized their power of judicial activism to question the accountability of the government in meeting the demands, it asked to beg, borrow or steal but fulfil the needs. Consider the following headlines in this regard:

Maharashtra Government, BMC write to Centre on daily oxygen needs[37]*, Kerala CM writes to PM to increase share*[38]*, Centre moves SC against HC order to raise oxygen supply for*

Karnataka[39]*, HC slams Delhi Government for Oxygen mess: if you can't manage, will ask Centre to step in*[40].

As a result of which many countries offered their support and resources in this time of dire need. India-a nation which was known to be the exporter of medical oxygen was now seeking aid from foreign countries for LMO. As per the 2019 data of World Integrated Trade Solution[41], in total India exports of medical oxygen 5,039,170m³. Globally of which export to neighboring countries like Bangladesh 2,752,440 m³, United Arab Emirates 942,923 m³, Bhutan 604,194 m³, Nepal 324,813 m³, Sri Lanka 243,907 m³. The second wave of COVID-19 bought with itself a crisis which affected the otherwise muddled health system of the Indian subcontinent. India could produce more than 7000 metric ton (mt) of medical oxygen before the crisis hit the country however in April 2021 to meet the sudden rise in demand, Ministry of Health and Family Welfare planned to import 50,000 mt of LMO. After an abrupt increase in requirement by 76 percent in between April 12-22 from 3,842 mt to 6,785mt. Till 2019 out of the 7000mt LMO India contributed 750-800mt for medical purpose rest was used for industries.

This surge in demand for medical oxygen and irregularities in meeting the medical needs, the crisis led to nearly 35,000 COVID-19 deaths, however this number varies as the data is not official or rather data for death due oxygen shortage has not been compiled yet. Even if this number is to be considered the proportion is huge which caused a large-scale massacre. Centre identified 12 high burden states where surge for LMO grew exponentially day by day- Maharashtra, Madhya Pradesh, Gujrat, Rajasthan, Karnataka, UP, Delhi, Chhattisgarh, Kerala, Tamil Nadu, Punjab and Haryana. Indeed, the crisis was unforeseen which strained not only the health system but also administrators, policy makers, diplomats and the citizens further making it a political, social, economic and health problem. It was a state of national emergency where the number of deaths was never anticipated. However as much as the pandemic needs to be held responsible for this crisis, to a certain extent it is an amalgamation of neglect, ignorance and politics of the government at both central and state level contributed to the crisis. Two immediate reasons for this crisis can be located:

A) Transportation: A Major Cause

Liquified Medical Oxygen a substance industrially produced from naturally obtained air. Industrial oxygen has various applications in iron, steel and glass industry, hospitals, pharmaceutical industry and other vital manufacturers. Topmost manufacturers of LMO in India are Inox Air products, Linde India, Goyal MG Gases Private Limited, National Oxygen Limited and various other small and medium scale manufacturers. The process from extracting LMO to delivering it hospitals or health facility is a technical process which is meticulous. To begin with, manufacturers prepare LMO's through cryogenic distillation technique which is then stored in Jumbo tankers and then transported in cryogenic tankers at a specific temperature to distributors in urban and remote areas. These distributors then compress oxygen from LMOs and store it into cylinders or dura cylinders which are supplied to hospitals directly or to a third-party agent.

The process of extraction sounds technical but was not a hindrance in meeting the demand of oxygen, but transportation was the major cause. India lacks cryogenic tankers required for the transport of LMOs moreover there remains a shortage of cylinders and tankers in which LMOs are filled. Transporting LMO through cryogenic tankers to distributors especially to remote location is time consuming which might at maximum take 5-10 days, if the location is too remote it can take too long too. Small hospitals and distributors are vulnerable and least preferred as they often complain of not having enough cylinders and tankers for LMOs.

As per the statement recorded by a INOX official with the Indian Express[42], there were enough suppliers for urban areas, but regional areas remained unreached. Logistics of transportation remained a key challenge in delivering the demanded LMO during the crisis. Setting up manufacturing units or purchasing cryogenic cylinders was not the immediate response these are preventive measures often to taken prior to crisis but not amidst a crisis here the state failed to deliver. Express trains were made operational, airlifting or LMOs' took place in a situation where every second was important, a delay (even for logistical reason) accounted to a direct loss of life, which happened during the second wave.

B) Delay in Cross Border Movement

Large part of the LMO production is based in east and west India from states including Maharashtra, Gujarat, Jharkhand, Odisha, Tamil Nadu, Karnataka, Kerala and West Bengal however the surge in demand for LMO came majorly from North India. This involved transportation of LMO in huge amount and here is where a hue and cry about transportation being stopped at state borders was recorded. In Delhi for instance MLAs and MPs blamed neighboring states like Haryana and UP for not allowing tankers to enter Delhi. The capital with no manufacturing unit in its region depended completely on import of LMO from other states. A statement given by Delhi's Deputy Chief Minister Manisha Sisodia noted that the shortage of LMO in Delhi hospitals was due to monopoly of Haryana government that directed the supply of LMO (through Faridabad) from Delhi to Haryana[43]. There were allegations made by both the governments involved and delay in supply response was also noted. E-pass which is a pre-requisite for commercial movement from one state to another during lockdown was denied to manufacturers and suppliers as officially stated by officials of MVS engineering [44] a supplier of LMO from Okhla. Case of states appropriating registered tankers even when not in use was recorded. All of which indicated towards administrative politics which appeared dirty in testing times. This nature of neglect and mishandling by the governments during pandemic had gruesome ramification and it won't be misleading to say deaths due to COVID involved state negligence.

The Idea of Right to Health

The above pointers which affect public health sector has ignited the debate of right to health, as the implementation or health services resonates more as a commodity least as right. Nonetheless, right to health has been a matter of constant deliberation for years now more so post-liberalization where developments in health affairs posed a serious cognitive challenge of comprehending health services either as a necessity or good.

Gandhi (2009) once appreciative of the field medicine, in his later work has noted that the discipline produces commodity. In Hind Swaraj (2009) he mentioned about the existing analogy *Upas Tree*. This analogy he states has been presented by a western writer who observed that the modern system comparable to the upas tree, who branches are equivalent to the parasitical

profession like medicine and law. Gandhi (2009) affirms with the analogy as he argues that the English have effectively used the medical profession for controlling Indians. He explains his position by asserting that hospitals are the place of sin. A doctor does not remove the disease from the body but only intervene with temporary cure. He is a negative aid to all the ill-doings of man to his body. If not, doctors existed men would have taken more care of their bodies however it their existence that men have started taking their respective health for granted. Discipline of medicine is profited by the discomfort or diseases of the other and if people start taking disciplined care of their body, the profession will run in to losses. To quote Gandhi (2009):

"It is worth considering why we take up the profession of medicine. It is certainly not taken up for the purpose of serving humanity. We become doctors so that we may obtain honors and riches. I have endeavored to show that there is no real service to humanity in the profession and that it is injurious to mankind. Doctors make a show of their knowledge and charge exorbitant fees. Their preparations, which are intrinsically worth a few pence, cost shillings. The populace, in its credulity and in the hope of ridding itself of some disease, allows itself to be cheated. Are not quacks then, whom we know, better than the doctors who put on air of humaneness?"

This remark by Gandhi (2009) posed a crucial question on the existence of the discipline of medicine. As what is considered a humane profession, is it really serving humanity? His observation direct towards the profit-making aspect of the discipline which in the name of serving necessity is commodified essential needs. Gandhi (2009) made this observation even before liberalization began in India and fortunately or unfortunately his analysis was correct and more so visible in the neo-liberal period.

Before moving ahead, it is important to understand the idea of commodity or commodification. The popular definition of commodity is expressed by Arjun Appadurai (1986) who regards it as **"**anything intended for exchange or any object of economic value." In health sector this definition is understood as the production of health services, technology or facilities for profit-making for economic value but not for service. This commodification in health structure started post-1990s however this section will not elaborately deal with it (Baru, 2003)

The nature of commodification of health especially in the neo-liberal period changed the reality of health care from what it ought to be. Today one gets access to better health care facilities if

one has the willingness and capacity to pay for it. The more one is capable to pay, better health care entitlements they own. This paradoxical situation has given enough groundwork to the debate between paternalistic and the traditionalists in the laissez faire economy where the paternalists, believe that health care has unique economic characteristics (of public good, merit good, etc.) which deviate from the basic prerequisites of competitive market model, argue in favor of free provision of health care services by the state. Liberals, on the other hand, claim that healthcare is in no significant way different from other economic goods and services, and thus demand for leaving the provision of health care to the private market (Kethineni, 1991).

The debate is foregrounded on the vast boundaries of health and whose responsibility is it ensure good health: individual or the state and its institutions. If we understand this through the Gandhian lens, then the individual is solely responsible for maintaining and taking care of their health. For Gandhi state intervention in health is a negative intervention which makes the individual irresponsible towards himself/herself. However, in the Lockean schema it is the responsibility of the state to protect and ensure the availability of natural rights to their citizen. One of the natural rights being right to life under whose umbrella right to health is understood in recent times which makes the state accountable.

The Tavistock Group which was an association of people with experience of health care and ethical debate formulated certain principles that was published in 1999 in the British Medical Journal to revive ethical principles in medicine. However, these principles were not backed by any scientific evidence but have been refined through constant debates and criticisms. Debating in favor of the idea of right to health these principles proposed (Berwick, Davidoff, Hiatt and Smith, 2001):

- *Right to health and health care*
- *Balance between individual and community health as along with individual health taking care of community health is equally important.*
- *Comprehensiveness—Which argues in favor of preventive health care to minimize long term major illness.*
- *Cooperation—Which is integral amongst each other but also within the health care community, between health care workers and individual/community.*
- *Improvement*—Improving health care infrastructure, facilities and services to meet community needs in a sustainable manner should be thrust of every government.

- *Safety—It is important to maintain safety in health structures and services such that it should not cause any unnecessary harm to the patient or community concerned.*
- *Openness—In health care it is important to maintain transparency to build trust and cause less damage to the party concerned.*

Any institution or government agreeing with the tavistock principal takes the responsibility and accountability to provide necessary health services to their citizen on ethical grounds. Out of all the principles laid by the tavistock group one which remains crucial is that of treating healthcare as a right. The groups argue in favor of treating health as a vital virtue as against the commodity debate and lays down arguments in favor of the same. They propose that while the individual remained the claimant of a right to health, the delivery of the necessary services in response to that claim must be on the state and its institutions. Secondly, as a human right, the right to health cannot be bought and sold in the marketplace like other commodities seen in the context of community nor can the right to health be limited by the ability to pay. Governments have an obligation to fund medical education, training and research, to make provision for sustainable investment in support of health care professionals, and to ensure that knowledge is exchanged freely and without regard for institutional affiliation and claims of ownership. Tavistock group and the supporters of the idea of health maintain a Lockean stand as they believe that right to health is a human right, and it is the responsibility of state to maintain the same. Even the Benthamite stand states that for every rights holder there must be an obligation provider. These providers are not "in nature" or ever existent but created or availed by the state through its constituent institutions andlegislations (Berwick, Davidoff, Hiatt and Smith, 2001).

However, liberals argue against the idea of right to health which they feel is not a human right and thus they do not burden the state with the responsibility of fulfilling health care needs of the society and community. Liberals maintain this stand based on the following arguments, First, demand for right to health lacks rational and utilitarian basis. Secondly the idea of holding the state responsible for providing health care services is problematic, even for the provision of basic care. Third, opponents argued that any definition of health care would have to take account of a wide range of social, economic, organizational, scientific and technical issues and relationships before any general agreement on the extent of the right could be reached. The entire debate over right to health streams between whose duty is it to fulfil the health care needs in society is it an

individual duty or the state responsibility. This debate therefore requires a precise lens to be comprehended with necessary conclusion.

Understanding the concept of right to health from a Rawlsian perspective might provide a clear picture. John Rawls (1982) talks about a theory of justice in a well-ordered society where he introduces the idea of primary good. A good or as Rawls (1982) terms it 'claims' are personal, political, social and economic demanded by individuals respectively. Personal claims are those for which individual thrive by themselves to achieve however the latter claims concerns abiding to principles of justice. In unequal society political, social and economic claims are to be redistributed without harming others. For example, to own a house is a personal claim which an individual will work hard towards to fulfil with loyalty and dedication however if one tries to illegally acquire other persons land to build their house it becomes problematic and unjustified. The notion of primary good addresses this moral and practical problem. To quote Rawls (1982) here:

"Citizens do not affirm the same rational conception of the good, complete in all its essentials and especially its final ends and loyalties. It is enough that citizens view themselves as moved by the two highest-order interests of moral personality (as explained below), and that their conceptions of the good, however distinct their final ends and loyalties, require for their advancement roughly the same primary goods, for example the same rights, liberties and opportunities, as well as certain all-purpose means such as income and wealth. Claims to these goods I shall call 'appropriate claims', and their weight in particular questions of justice is determined by the principles of justice."

These social and political goods are appropriate claims for Rawls (1982) in the claim of which no person's liberty and individuality is to be harmed under a well-ordered society. These claims can be different and varied in nature and mean differently for individuals in society thus locating them exactly is a difficult task. However, for convivence Rawls (1982) listed the basic principles on which these claims should base or say the preamble to these appropriate claims are as follows:

- Claims of basic liberties like freedom of thought and liberty of conscience; freedom of association; and the freedom defined by the liberty and integrity of the person, as well as by the rule of law and political liberties.

- Freedom of movement and choice of occupation against a background of diverse opportunities.
- Powers and prerogatives of offices and positions of responsibility, particularly those in the main political and economic institutions.
- Claims of Income and wealth
- The social bases of self-respect.

These principles are an integral part of individual's right to appropriate claim especially the last principle: social bases of self-respect. For this thesis, these principles are important as right to health is a major constituent of individual self-respect. As Rawls (1982) underlines, "when we feel that our plans are of little value, we cannot pursue them with pleasure or take delight in their execution. Nor plagued by failure or self- doubt can we continue in our endeavors. It is clear why self-respect is a primary good. Without it nothing may seem worth doing, or if some things have value for us, we lack the will to strive for them. All desire and activity become empty and vain, and we sink into apathy and cynicism. Therefore, the parties in the original position would wish to avoid at almost any cost the social conditions that undermine self-respect."

In a well-ordered society, self-respect is the catalyst/ motivation behind individuals thrive for primary and higher good. Without self-respect he/she can never reach the height of their potential. Self-respect is seeked, sometimes through individual action and by the action of other in the former case individual act of achievement, hard work, fame or other social conditions brings that self-respect and in the latter case recognition by the other like state or its constituents bring that recognition. For instance, affirmative action guaranteed by the state for the marginalized section of the society becomes instrumental in gaining individual self-respect. For David DeGrazia (1991) amongst other social conditions the vital condition that significantly affects esteem and self-respect are bigotry, unemployment, access to decent education, and lack of access to health care. It is to be noted here that access to health care is substantial in aiding the higher goals of employment and finally self-respect.

The following example can help in understanding this argument better, consider a person from economically and socially marginalized background meets with an accident in which he loses one of his legs. This adult although not well-off enough had plans utilizing his physical strength

to gain employment and support his/her family. However, the accident and his existing social condition added to his misery. Unable to afford treatment he must live with ailment knowing the fact that he longer can help his family economically. Here, the person will lose his self-respect, it is not motivation or willingness which has impaired him from employment, but affordability of health care services has disempowered him. If the necessary treatment had been affordable and subsidized for him, he would have got treated over the period and probably resumed work and gained back his self-respect, but it is not the case. As the person is aware of his social and economic condition which does not allows him to afford the treatment thereby, he is forced to live a hopeless and helpless life.

To understand the interlinkage between self-respect and right to health with precision another example is presented, consider a woman who just delivered a premature baby, the child remains in fragile state and requires timely and repeated medication. The mother belongs to a remote location in India which does not has access to adequate medical facilities. The mother previously worked as a laborer in the city but had to return to her hometown for childbirth. However, the medical condition of her child does not allow her to resume work, one because the child is fragile and two inadequate health care infrastructure compels her to travel to distant location for primary health care needs. This condition of the women in a way negatively affects her self-respect, as she was working woman who once earned her own money but now is left with no choice but to stop her earning. Had there been access to better medical facilities in her village she would not waste time travelling and maybe find some temporary work in the village itself. Since childcare and other logistics do not support her, she is unable to utilize her potential to gain back her self-respect.

Both these examples help us in understanding the correlation between self-respect and right to health which makes a case for idea of right to health included in the principles of primary good that form the basic structure of a well-ordered society. Redistribution of this primary good is important and individual claim for this good is appropriate claim as outlined by Rawls (1982). He holds the state responsible in providing the necessary framework within which citizens can further ends or achieve their good, provided it does not violate basic liberties of the other. To ensure such a case or issue of violation to not occur Rawls (1982) listed out two principles that must be followed for distribution to be fair and justice met equally. These principles are:

1. Each person has an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberties for all.

2. Social and economic inequalities are to satisfy two conditions: they must be (a) to the greatest benefit of the least advantaged members of society; and (b) attached to offices and positions open to all under conditions of fair equality of opportunity.

However, Rawls (1982) quest is to make the necessary precondition for achieving primary goods available, how to achieve it, what measures are adopted to achieve the same or how well does the good serve its purpose is not the Rawlsian concern. It is here where Amartya Sen's (1993) capability approach becomes important but before moving further to elaborate this argument it is important to note that the liberal criticism of right to health not being based on rational principles gets negated within the Rawlsian framework. As right to health under the principle of self –respect forms the important principle/basic structure of the society and is a rightful claim of the citizen which the state is entitled to provide.

Amartya Sen (1993) has the answer to the problem of utilization of primary goods and how well are the principle implemented. Capability approach proposed by Sen (1993) is a two-dimensional approach which unlike the Rawlsian framework is concerned beyond the accumulation or acquisition of good. Sen (1993) begins with the thought that every individual desire for a function which are of two types: lower and higher, where the former includes functions like cooking, driving, typing, cleaning and other day-to-day activities, the latter function includes functions of higher purpose like becoming something or achieving/accomplishing a desired goal for instance tapping his/her potential to become a renowned sportsperson. The lower set of functioning are not desirable or pleasurable goals nonetheless the higher functioning is intrinsic and involves emotions and desire of achievement. Higher functioning involves capabilities or capacity to perform tasks directed towards the goal with necessary skills. It is important for these capabilities to become functioning to live a life with purpose. Here state becomes the important medium which can bridge the gap between capabilities and goals. As sometimes individual might have the freedom or realization about their capabilities but lack the means to utilize their potential in this case their goals remain unachieved.

For instance, X village has the supporting condition and means to produce healthy sportsperson in the future however there is lack of access to facilities like coaching, health care or education

which can tap in the capabilities of the person for the benefit of the individual and society. Here then role of state becomes important who can provide the necessary medium between the individual capability and functioning to bridge the gap between the two and provide a pleasurable life to the individual. Sen (1993) unlike Rawls (1982) in not concerned only with the availability of good but also the capability of the individual in transforming it into functioning with the help of state and its constituent units. If this framework is applied in the right to health debate, then right to health is justified in achieving the desired functioning of individual. Assume a person wants to cure his ailment for the achievement of his lower and higher functioning and cannot because of lack of access to affordable health care. In this case then he is denied of his basic liberty or basic right. Thus, it is vital to protect that liberty and right of the person and institutions are responsible in doing the same. Sen's (1993) framework negates the second liberal criticism of right to health which makes the state accountable for provision of right to health as Sen (1993) entitles the state with this responsibility. Rawls (1982) gave the answer of what is right to health that is a primary good, Sen helped in understanding who is entitled to ensure right to health that is state. However, one question remains how will state ensure right to health what model it will adopt to assure discrimination is avoided to the least.

Since right to health is a broad terminology and particulars of these rights are not defined it is difficult to comprehend what accounts to right to health. Two people availing the right to health will have different notions about the same for one it would equate to primary health for the other it can be free medicine. In this case then how is it possible to achieve the goal of right to health. Surprisingly, the answer to this question lies in the field of law in the Theory of Incompletely Theorized Agreement as formulated by Cass Sunstien (1995), who developed this theory to understand certain judgements made by principal stakeholder where they agreed for a broad principle without getting into the particularities of the same. According to Sunstein (1995) such agreements are common in law and society, and it does not entail that the agreement should be made null and void. Incompletely theorized agreements are a part of democracy with heterogenous population where individual and policy makers have different opinion on the same issue. In this case an incompletely theorized agreements suits public policy as it arrives at a general principal without formulating the particulars of the principle.

Incompletely Theorized Agreement provide a framework to the right to health debate where the question of what constitutes right to health forever remains. Following Sunstein framework then

it is important for policy maker to first accommodate the general claim of right to health leaving behind disagreements on the particulars of the claims. This way a general theory can be obtained which suits heterogeneity and diversity. With this the third and the last liberal criticism about the diversity of the right to health claim is taken care of as right to health can be a part of an Incompletely Theorized Agreement.

Conclusion

This chapter explored various constitutional provisions for health care in India where it was located that right to health is not a fundamental right however at several occasion has been interpreted by the judiciary as a fundamental right under article 21. This non-inclusion of right to health as fundamental has led exclusion and class difference in matters of availing health facilities thereby the chapter advocates the inclusion of right to health as a fundamental principle such that it becomes justifiable. Further the reasons affecting public health, due to limited state intervention, like the impact of liberalization, crisis of public health, access to primary care and institutional failure where elaborated which showcased the status of public health system. The status of public health as understood from the reasons outlined is due to the blurred understanding of the concept of health: what it is, a right or a commodity? Which is discussed in the last section with the help of the debate between liberals and opponents where liberals opposed the idea of health as a right, on the grounds that the demand lacked rational and utilitarian basis However Rawl's idea of primary good provided the rational principle for the demand which is embedded in the notion of self-respect that forms the basic structure of society. Another liberal critique: who is entitled to fulfill healthcare needs under the right to health model, was countered by Amartya Sen's capability approach which makes the state responsible in bridging the gap between individual functioning and capabilities. Lastly the chapter proposes a public policy approach namely the Incompletely Theorized Agreement which can help in the implementation of policies for right to health.

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