அறிவியல் மக்களுக்கே

A POLICY BRIEF FOR PUBLIC DISCUSSION

THE RIGHT TO **HEALTHCARE**

Why, What & How

Prepared by
Arogya Iyyakkam Resource Collective.
A Tamil Nadu Science Forum Publication

The Right to Healthcare:
— A Policy Brief for Public Discussion.
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Written by:
Dr. T. Sundararaman & Dr. Ganapathy Murugan
In consultation with other members of the
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Foreword

The current Tamil Nadu government has a deep commitment towards economic growth, social justice and federalism. Ensuring the right to health and health care of every person in this state is one of the most important dimensions of fulfilling these commitments. Yet this is much easier said than done. Though Tamil Nadu has been in the forefront of improving maternal and child survival and achieving population stabilization it now faces emergent infectious diseases, and a huge epidemic of non-communicable disease. Rising costs of healthcare lead to more impoverishment, push back all our efforts at poverty reduction. It is the poor and the socially marginalized who are affected most. Now we have move forward and consider a right to healthcare as part of an overall effort to ensure the right to health and "the attainment of the highest possible of health" and as purpose and means to achieve its aspirations of becoming a one trillion dollar economy.

However the path to realization of the right to health and healthcare is not easy. Different stakeholders- political leaders, administrators, health professionals, healthcare workers, industry, private health sector and different sections of the public all have their own perspectives, preferences and priorities. There is no single correct solution that will satisfy all stakeholders. It is only by public discussion and that too a public discussion where the voices of the more marginalized sections are heard that we can find a way forward. Moving forward also needs the creation of a political will. And the only way to creating a political will for it, is through making the Right

to Health an important part of the public discourse and the public consciousness.

For these reasons I welcome this book as an important contribution to the ongoing public debate. This book is a simple introduction to the right to healthcare as a sub-set of the legal frameworks required for achieving the Right to Health. It sets out the legal basis of these rights and international experience in this regard. Most important it cautions that unless the Law is well drafted it will be difficult to implement and even then, implementation requires advances in a number of collateral fronts. We may not all agree to these views and recommendations of this set of authors on the very many different aspects that go into an effective law, but we must all admit the necessity of a public discussion and debate around everyone of these issues.

I congratulate the authors and all those associated with this effort, and look forward to the discussions and feedbacks that would follow.

Dr. J. Amalorpavanathan,
Member, Health, Tamil Nadu State Planning Commission,
Chairperson, Committee on Health Policy,
Prof and Head (Retired) (Vascular Surgery, Madras Medical College),
Now Senior Consultant, Vascular Surgery and Head Transplant Medicine, MGM Hospitals,
Chennai

To all those
Unsung
Health Workers
and
Professionals
who lost their lives
when responding to
the COVID pandemic...

1

Why must Peoples Movements in Tamil Nadu raise a demand for Right to Health (RTH) now?

1. We are happy that the political party which won the elections and formed the Government of Tamil Nadu in 2021 has promised to enact a Right to Health Act. This is one of the most needed reforms. The announcement to introduce such a bill in the legislature within the next year was welcomed by a large number of civil society organisations.

   We also note that this party has come to power in the promise of social justice, which is a key plank of Dravidian politics. The right to health, along with the right to education and social security, food and employment are all essential aspects of social justice. Other political parties which subscribe to socialist, or social democratic or welfare state politics also support such a move as an essential part of building a modern, democratic society.

2 The Right to Health is not an option. It is an obligation on the Indian government and the state governments. It is long overdue in India, and even more so in Tamil Nadu which now has the economic, social and technical capacity to achieve this. The only reason that the administration hesitates is that they do not want it to be an obligation on them. The only reason people demand it is because it must become an obligation on the government.

3. Many democratic movements and people's movements have for long been demanding such an act. But as many state governments take up this challenge, we, concerned public citizens as an important constituent of the people's health movements want to clarify why we have been asking for a Right to Health Act, and what it means and how it can be delivered.

4. We note that across the world 73 countries have guaranteed the right to medical care services and many other aspire to protect this right (as of 2011). And 48 countries either guaranteed or aspired to guarantee public health. Amongst our

neighboring countries Thailand, Timor – Leste, Indonesia, Nepal, and Maldives have laws guaranteeing the Right to Health Act. In some countries like Thailand this has made a huge difference. Though it is still a developing country Thailands health outcomes are much better than most countries in the world including developed nations. In others like Nepal it is too early to tell as the law was made recently. Within India, Assam has passed a Right to Health Act but it has made no difference at all to health services.

5. From this we learn that passing a bill is not enough - it's also having a system that can deliver these rights. The key elements of such a system should be enshrined in the law. This policy brief is meant to reach people and peoples organizations, explaining why we want the law, what difference could it make, what we want to see in the law and how will such a law lead to better health.

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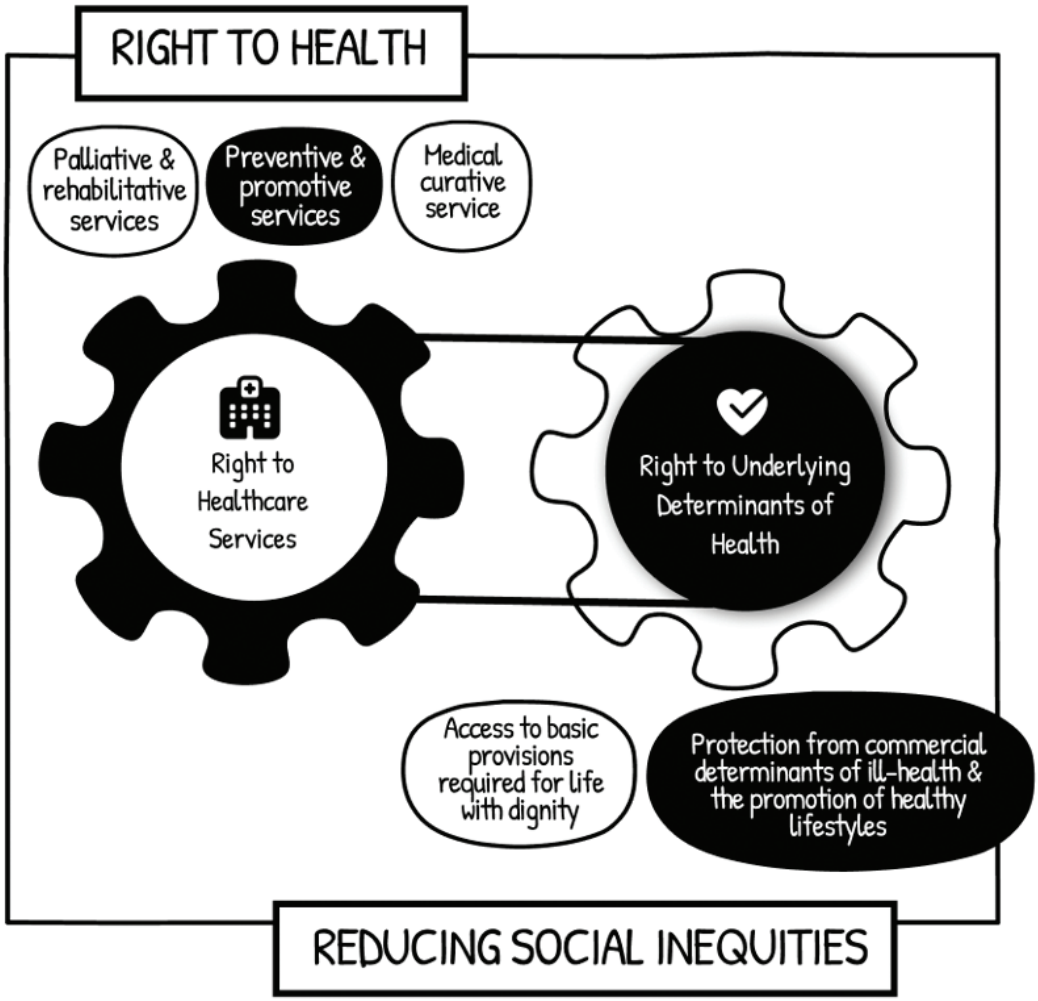
What exactly do we mean when we talk of the Right to Health?

The Right to Health - has many aspects:



Social inequities can be - based on gender, caste, class, religion, ethnicity or other social status related factors. A law, by itself, cannot ensure reduced social inequality. But a law can ensure that there is a greater allocation of resources, as well as special additional efforts to ensure access for the relatively less privileged sections of the population.

The other set of underlying determinants are access to the basic provisions of life- food, clean water, sanitation, housing, education, healthy (pollution free) environment and just as important a livelihood which provides an income, and that ensures freedom from poverty and deprivation.

Being healthy requires more than the right to the access of these services. It is also very much dependent on our lifestyles. It's not just what governments do, it is also about what families and communities do. However the lifestyles we follow are often determined by the media and the culture that is propagated- and therefore protection from different forms of persuasion to follow harmful life styles and providing information and encouragement to follow healthier alternatives is also part of the right to health.

The commercial determinants of ill health are now a huge and increasing problem in Tamil Nadu and require to be seriously addressed. Lifestyles also relate to access to healthy food, exercise, rest and recreation. Many urban surroundings are such that there is no place for physical exercise. They are unwalkable neighborhoods - having no parks, gardens, open grounds or even sufficient pavements. In many public places there is no healthy food available. Commercial foods are - far too rich in saturated fats or sugar or salt, all of which contribute to our current non-communicable disease epidemic. The need to universalize health education, protect population from commercial determinants of ill health and promote healthy lifestyles should be covered by a separate policy that should evolve into health promotion act.

3

Can we address all these concerns with just one law - or do we need several?

There is a need for at least three separate laws. Of these the proposed Right To Healthcare services, is the main focus of this book. Another is on the underlying determinants of health. Fortunately, Tamil Nadu already has such an act in place- the Public Health Act of 1939, which few other states have and which has played an important positive role. And the third law required is on the regulation of the private sector. Here too, Tamil Nadu has a Clinical Establishments Act in place.

a Tamil Nadu's Public Health Act that was passed in 1939. This law has been amended many times since. This law addresses many of the underlying determinants of health and lays down the governance structure to enforce this. This law covers provision of

safe drinking water, food safety at normal times and during fairs and festivals, hotel sanitation, general sanitation including drainage and waste management, mosquito control , prevention and notification of disease outbreaks and control of noise pollution. There is a need to strengthen this Act further and implement it better (as discussed later).

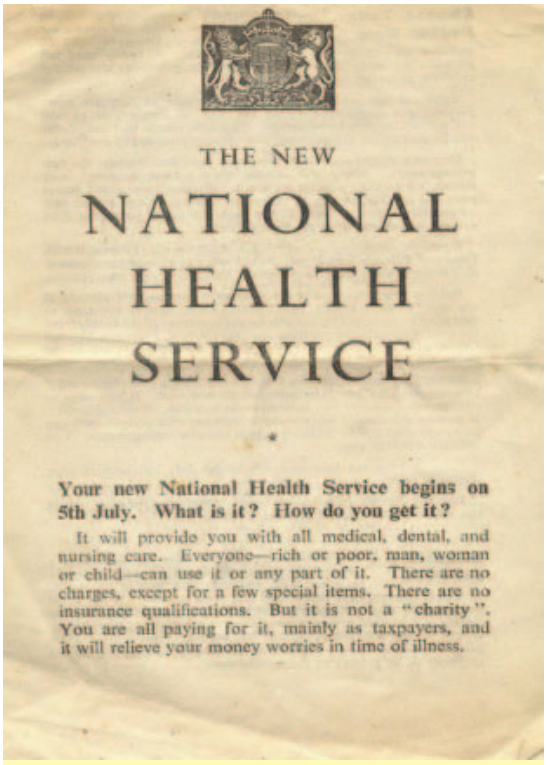
b. For regulation of private health sector, Tamil Nadu has passed a Clinical Establishments Act in 1997 and much later in 2018 has framed rules for it. The expectation of the law is to protect the citizen by ensuring quality of care and ethical practice and reasonable prices . In practice the current Tamil Nadu law only calls for registration and display of qualifications, and preventing people without qualifications from running clinics. Even this it does not do adequately. The ways to strengthen this Act must be taken up as a separate important issue.

c. For health promotion, to begin with the government would need to articulate a multi sectored policy for promotion of health life-styles and protection of individuals and families from commercial determinants of ill health. Many countries have articulated policies or laws for health promotion that we can learn from.

Tamil Nadu needs a Right to Healthcare Act for ensuring universal access to affordable and good quality health care. This act should ensure that everyone gets whatever healthcare is required and that this healthcare is of sufficient quality and that is free or almost so. As it stands today such a right can be enforced only in a government hospital or health centre. If a private hospital refuses to see a poor patient who cannot pay, or turns away an insured beneficiary, who they do not want to treat, they could do so. We can try to bring private sector also under a Right to Healthcare Act, but in practice both the legal challenges and professional resistance would be far too much. It is better therefore to begin by making a law that makes it an obligation for the government to provide healthcare services for all those who opt for seeking healthcare with a government provider.

4

Is this demand for making healthcare free and accessible to all feasible ?



THE NEW

NATIONAL HEALTH SERVICE

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

"At the birth of the National Health Service (NHS), United Kingdom, in 1948, this is the leaflet that every household received; It is one of the most profoundly beautiful social contracts in history....."

Prof. Gavin Yamey, tweet.

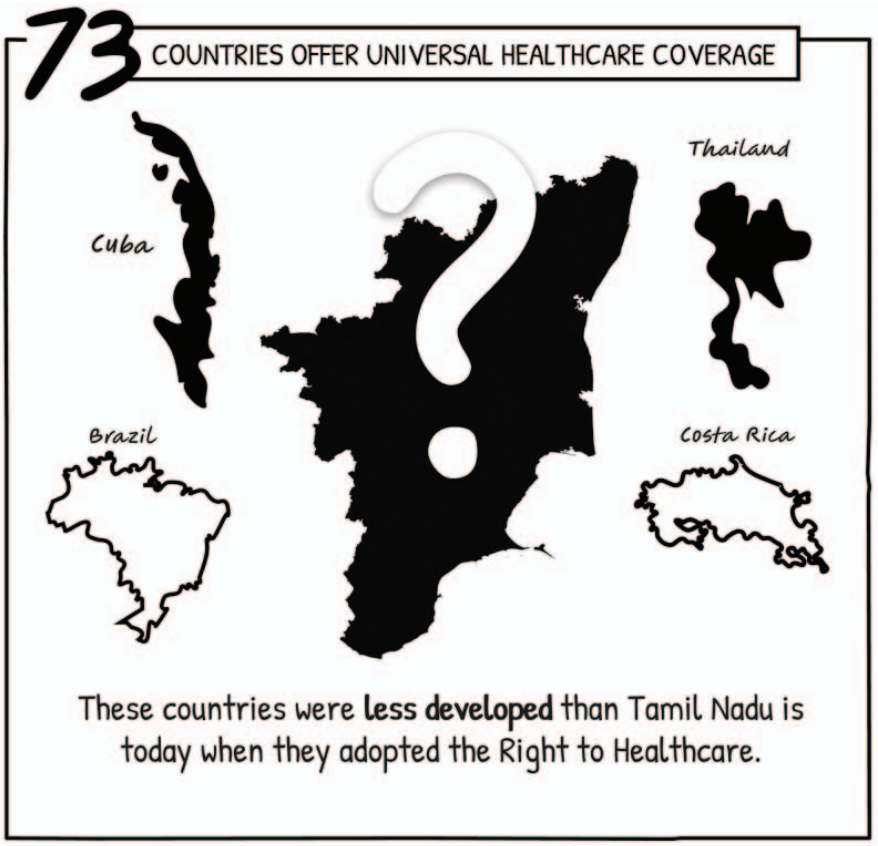
Free healthcare services to all is not a new concept- it is the accepted international principle. With the exception of the USA, all developed nations in the world, (the global North as it is called) have this system. It is not because they are rich that they have this system. Most of them put this in place just after the Second World War when they were relatively poor and with very limited resources.

We also note that all former socialist countries had this in place, and even today Cuba has such a system. In the third world there are countries like Thailand, and Costa Rica that has universal access to free quality healthcare services available as a right. Most of these nations had put such a rights based universal healthcare system in place when they were in the level of development that Tamil Nadu is in today.

In fact, it can be argued that it is because they put such systems in place, that they are rich today. The healthier the nation, the wealthier the nation. The

wealthier the nation, the healthier the nation.

Just like health and education, social security, elderly care and employment must also be seen as a basic right that the government has to guarantee. The health sector is a huge source of employment. If most of this is in the form of public services, then there is a great benefit to the community, as well as a huge source of good quality employment that has social security cover. The demand for free and universal healthcare is therefore a demand for economic growth with justice, a different type of economic growth from the present model which increases wealth for the few but at the same time increases inequality. Economists have also long held that the current form of growth based on inequalities between countries, extraction of natural resources and exploitation of care-providers and wage labourers is not sustainable.



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But why should medical care be free? – Why should it not be paid for like other services- like say hotels, and restaurants?

Medical care differs from all other services in many important ways:

i. There is uncertainty about when someone in the family will fall sick

ii. There is uncertainty about whether the service we buy will give the outcomes we want.

iii. The patient has little or no knowledge of what is the correct service he needs- he has to trust the doctor (Information asymmetry).

iv. The doctor's financial interest is not often aligned to the patients' health interest.

v. And there is professional power

Or in other words, unlike many other services, markets do not work for healthcare. That is why governments have to step in.

A commodity is something that is manufactured largely for the purpose of selling to others. The relationship is one of producer/manufacturer to consumer. Healthcare is not such a commodity. It is a right. The care provider guides the people on how to stay healthy, and people do the rest. The provider and service user are co-producers of health. Healthcare is a relationship between provider and service user that requires a high level of trust. And one of way of ensuring is that the clinical decision a doctor makes should make no difference to the income he / she gets.

6

But do governments understand this? Is this the official view?

The Government of India has a legal obligation to achieve the Right to Health that flows from both its international obligations and from rulings of the Supreme Court.

In annexure 1 we detail the international legal provisions and the rulings of the Indian Supreme Court under which making all of health and healthcare as a basic human right and a fundamental right under the constitution is not a choice – but an obligation.

Who should create the "Right to Health Care Act"? Union or State?

Union Government

1. Because it has more funds to implement the law
2. Because it has an obligation and under international law and therefore an international accountability to ensure that all states have a right to healthcare in place. So even though health is a state subject, the union can intervene. Like it has done for the rights of the disabled.
3. Because it has the greater capacity (knowledge, systems, to make and implement such a law).

State Government

1. Because health is a state subject. The union should not intervene in it, goes against the federalism principle. Education on the other hand was in the concurrent list- which means both union and state share responsibility.
2. States are at different stages of development, and the design of laws and rules should be appropriate to this. States that show good progress like Kerala and Tamil Nadu have not done it because of central guidance. They have done it on their own.
3. The center's current thrust is towards privatization. Its budgetary support for public services, which are the basis of a right to health act is limited and decreasing. The center has been pushing for excessive centralization where it has control- like in medical education (NEET, Medical Education), health insurance (PMJAY) and much of it relates to central command over regulatory institutions. A right to health act in central hands is likely to only push for more of this.

So, what should be the people's demand?

It should be a state act for the Right to Healthcare, but there should be a provision by which the proportional financial support from the center is assured. Also, the center can ensure that states that do not have their own law are obliged to follow a law that the center has made for union territories directly under central control and for states that ask the center to legislate on their behalf, as it has done for clinical establishments Act.

7

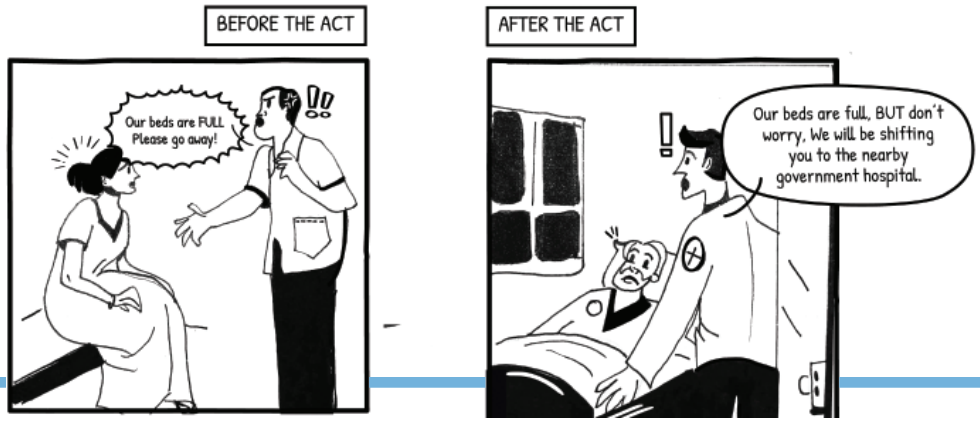
What should be the main features of a Right to Health Care Act (RTH)

The law on Right to Health Care Act as proposed must promise that every person in need of healthcare services currently resident in the state shall have guaranteed access to a set of healthcare services.

This Right to Healthcare Act must further guarantee

1. That these services are timely.
2. That these services have quality.
3. That these services can be accessed without facing financial hardship.
4. That these services are provided with complete respect to dignity, comfort and human rights of the service users
5. That these services are available without discrimination.

An Act must make it an obligation of the state to make arrangements for the delivery of healthcare services. If a person, however poor or marginalized is unable to get these services, it would constitute a denial of service, a breach of the law and therefore be justiciable- actionable by a court. The court can also intervene if it holds that the government has not made the required provisions for the delivery of services.



These set of healthcare services shall include in the least:

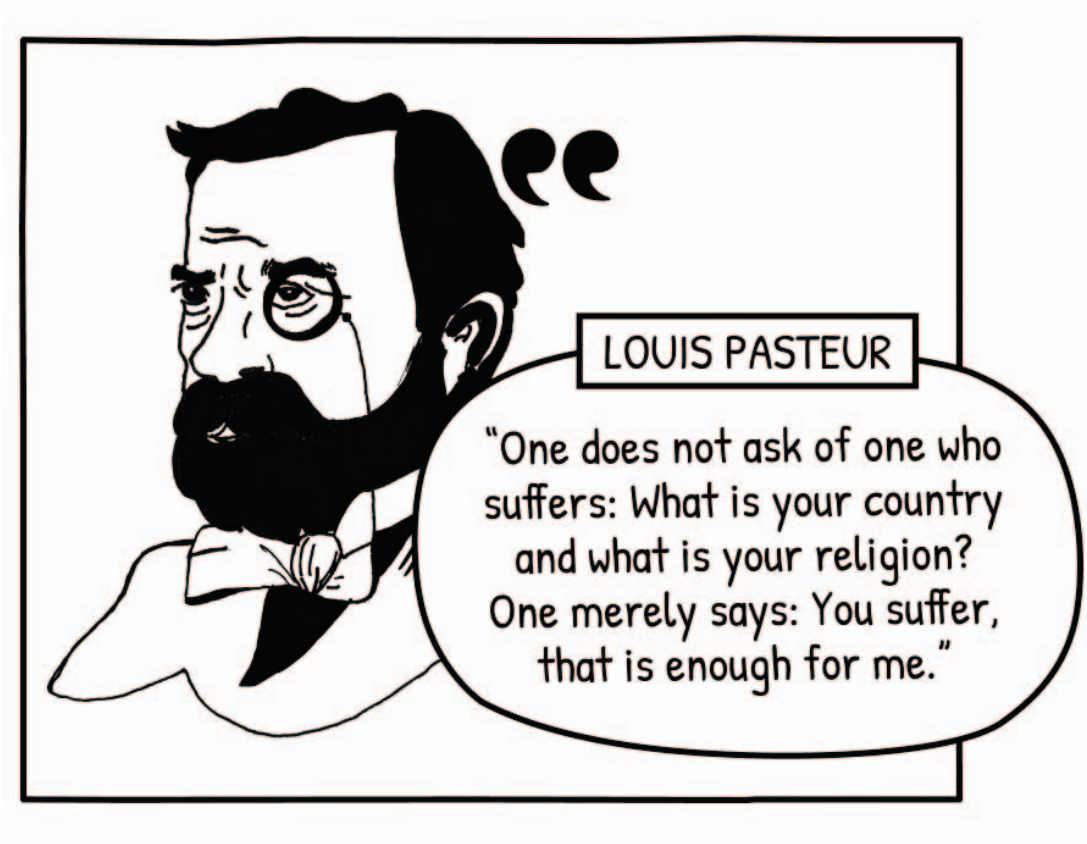
1. Preventive and promotive health care services – both as required by individuals and communities
2. Curative Healthcare services for all acute illness- whether minor or major, whether simple and self-limiting or complex and requiring tertiary healthcare
3. Curative Healthcare services for all chronic illness- communicable and non-communicable
4. Emergency Medical Services
5. Palliative care
6. Rehabilitative care
7. Maternal Health care services
8. Sexual and Reproductive healthcare services
9. Neonatal, infant, child, and adolescent health services
10. Healthcare services for the elderly

In many countries with the right to healthcare like Thailand, Brazil ,UK, Costa Rica etc., the law is that ALL healthcare is necessarily a part of essential health services. The government can only specify, based on evidence, those services which it deems as non-essential or as not cost-effective. Any health services that is not specifically excluded is included.

8

Other essential rights related to healthcare that the law must ensure:

Further this Right to Health Care Act must make it an obligation of the government to ensure that the dignity and human rights of the individual is respected. The law must ensure that there is no exclusion, or barriers to access healthcare for those who are poorer or more marginalized and there is affirmative action taken as required to ensure equity in access and in financial protection from the costs of healthcare. Other Important human rights that the law must assure are:



1. *Right to information of the service user*: on the illnesses they have, the treatment options and treatment being provided.
2. *Right to confidentiality*: providers should not reveal information about a patient
3. *Right to privacy* (the right not to share the personal information of an individual with others).
4. *Right for informed consent*: before giving me treatment, especially surgeries, the treatment must be explained to me and permission taken.
5. *Right for second opinion*: the patients right to consult another doctor before deciding to follow a particular treatment.
6. *Right to dignity*: The right to be spoken to politely and treated as an equal with respect for personal dignity.
7. *Right to measures against avoidable pain, suffering :* The right to be protected from any unnecessary pain, suffering or discomfort during my care
8. *Rights related to death*: the right to die with dignity and after death, the body to be treated with dignity.

9

What essential features of the proposed Act will ensure that every person in Tamil Nadu is able to get its benefits?

The law must contain essential features related to the organization of service delivery and its financing that ensure that health services are delivered as an entitlement. Without such a provision in the law, the rights remain on paper, like what has happened to the RTH in Assam. Though grievance redressal mechanisms and courts have a role when there is a persistent denial of rights, they are only options of last resort which would be effective only if a health system designed to deliver universal health care is in place.

What are these features?

1. **Universal Comprehensive Primary Health Care System:** The law should ensure that the government is legally committed to the provision of universal comprehensive primary health care (CPHC) through a network of publicly owned and financed primary health care teams/centres as part of a strengthened integrated district health system. The design of these centres is consistent with the proposed Health and Wellness Centres (HWC) which are already part of the National Health Policy 2017 and the National Health Mission and Ayushman Bharat Scheme. The demand is to implement it in all seriousness and on scale.

2. **Universal Registration at neighbourhood HWC (or equivalent)**: The law should require that every person/household can register themselves at a HWC near their residence. The primary care team at the HWC will cater to all primary care needs of the registered persons. Further this registration will also help them access all secondary and tertiary care as required. Those who migrate, can shift their registration to a different HWC up to, say two or three times a year.

3. **All services are included- only exclusions to be certified by board.** This law must

state that these primary care centres must have the capacity to provide comprehensive primary health care package. Exclusions should be clearly justified, and this is decided by a suitably constituted representative technical board that has professionals with an understanding and/or experience of providing primary health care services. For all those conditions that are included, appropriate, scientifically sound, context specific standard treatment guidelines and care pathways would be assured by the board. These care pathways would specify the referral chain and clarify what care would be provided at the different levels.

4 **Free of charges to the patients at the point of care:** . In this understanding government health care is free at the point of care but is not free care. It is care that has been pre-paid for by people through inclusion of insurance premium in taxation. The public understanding must be created that general taxation includes the healthcare premium. Providers are paid by the government- either directly from the government budget, or from social insurance schemes like ESIC, CGHS etc.

5 **Every approved facility will be entitled to be reimbursed the costs of care**: The law would specify such reimbursement and further that costings shall be based on scientific estimates using acceptable methodology as approved by a board. This reimbursement to government facilities could take the form of the payment of a budgetary allocation to facility for the coming year based on the previous years record of service utilization, as currently done for medical supplies under TNMSC. Reimbursements could be from social insurance schemes as well.

6 **There will be an effective grievance redressal mechanism in place.** This would include community oversight. Where grievance redressal fails courts can step in, to ensure these rights.

All countries which have effective RTH in place have the above feature. As an example we describe Thailand's experience in annexure 2

10

Some Background Information:

What is Primary Health Care?

The Alma Ata declaration of Health for All by 2000 AD, adapted in 1978 called Primary Health Care the key strategy to the achievement of Health for All.

Primary health care is an approach to the organization of healthcare services which is characterized by the following features:

1. **Comprehensive**- includes all components (preventive, promotive, curative, rehabilitative, palliative) and all illnesses.
2. **Population Based**- the health of the population is the objective- not only those who sought care but those who did not.
3. **Community Based –** near to people, and people as active participants
4. **People-Centred-** responsive to individual needs and convenience, and ensuring continuity of care across levels, and responsive
5. **Includes Referrals**- secondary and tertiary care too – in other words the entire district health system
6. **Gateway:** Acts as entry point and facilitated access to all levels of care.

Primary Health Care is different from primary *level* care. The opposite of primary health care approach is hospital centric approach to health care. Secondary and tertiary health care complements primary level care.

Primary Health Care was always meant to be comprehensive. We are now explicitly talking of comprehensive, so as to differentiate it from its earlier distortion as selective primary healthcare.

Why do government primary health centres and sub-centres have a poor reputation?

Because they were designed and instructed to give only a very limited package of services- ante-natal care in pregnancy, child immunization, family planning and some elements of TB and vector borne disease control. So persons going there for any other needs would be given some trivial medication and/or just turned away. This did not happen because the doctors wanted it that way. It was due to a policy, promoted by the World Bank , that called for limiting public services to these few conditions and leaving the rest to the private sector. But once this happened, doctors lost their skills and motivation to go beyond these trivial illnesses. People do not know that it is a policy decision. They only know that when they went to a PHC, they did not get quality care for most of their health needs. There were other factors also- but the main culprit was this policy of selective primary level care.

What are Health and Wellness Centres?

Health and Wellness centres (HWCs) are the name given in India to the primary level centres/teams that provide primary *level* care under the Comprehensive Primary Health Care Approach. These HWCs were proposed in the "Report of the Task Force on Comprehensive Primary Health Care Rollout" published in the year 2016 and this became part of the National Health Policy in 2017. The HWCs are financed under the National Health Mission and Ayushman Bharat scheme. HWCs are created by upgrading all health sub-centres and primary health centres from providing selective health care package, to providing a comprehensive primary health care. The target was the creation of 150,000 such centres across the country by 2023, Though considerable progress has been made in many states - especially in deploying a mid-level health care provider, establishing out-patient services at the sub-centre level and screening for 2 to 3 NCDs- the main objective of making for a comprehensive package of 12 services still remains a challenge. Tamil Nadu began well, but however after doing a good pilot programme, the programme stagnated, and now they are merely declaring them as HWCs without either the staff or functionality of what a HWC is supposed to be.

What is the relationship of Health and Wellness Centres and Comprehensive Primary Health Care

HWCs are an essential part of CPHC, but there is far more to CPHC than just creation of HWCs. HWCs deliver primary *level* care. For a comprehensive primary health care approach the entire district health systems- including secondary and tertiary care and linkages between the levels of care must be strengthened. There are also reforms in human resources management, community engagement, access to medicines and diagnostics, and health information management that must go along with the creation of HWC.

Does not Makkal Thedia Marutuvam (Medical Outreach to People) a good state government approach to providing primary health care?

Makkal Thedia Maruthuvam is a scheme that calls for screening for 3 NCDs- hypertension, diabetes and cancer cervix, and for reaching medicines for two chronic illness – hypertension and diabetes to the door-step of people. It is mainly delivered by a woman health volunteer selected by local SHG and paid a honorarium. Though quite similar to the ASHA, these volunteers cater to 5000 population.

Such is the great need for these services, that this scheme has been widely welcomed. However this is just a small expansion in the scope of services compared to what is needed or what is promised under Ayushman Bharat. And given this minimal staff, even this service reaches to only a small part of the population. If this is seen as a first step towards CPHC, this is welcome. But if it becomes a token gesture to cope with the pressure for services, then it is more publicity than public health.

We have a similar understanding of the Mohalla clinics in Delhi. It is a step forward- but if it stops at the current level of development, it is only a dispensary not a part of CPHC.

11

Health and Wellness Centers -and the road map to Universal Health Care

The Tamil Nadu Government began well with upgradation of its sub-centers to health and wellness centers. But despite clear evidence that it was making an immense difference, the government diluted its commitment to the same. However without a network of such centers to which the entire population is registered it is difficult to conceive of a way of effectively and efficiently delivering good quality, comprehensive health care as an entitlement.

To summarize:

What was required was that:

A. As per the current norms, there was to be one HWC for about 5000 population. (One per 3000 in tribal areas. Which means a requirement of about 14,000 HWCs. Government could have achieved at least 80% coverage or about 11,000 HWCs by now.

B. Every resident should have been registered for receiving primary health care in their nearest HWC. This includes screening for common diseases, preventive and promotive services, and access to follow up care and medication for all chronic illness. Such registration in the HWC would also be their gateway of entry to receive secondary and tertiary care.

C. To deliver this, each HWC should have had at least one mid-level healthcare provider (MLHP) and three multipurpose health workers (MPWs), and about 5 ASHAs (community health workers) along with necessary medicines and diagnostics.

D. Such a system would have enabled that people received over 90% of the required healthcare free, and close to their homes, in a friendly manner at a cost that the government could easily afford.

Instead what the state government has done is :

a. Initially sanctioned only one HWC per 9000 population, which was to be achieved by upgrading 7291 sub-centers and the 2295 PHCs. And then diluted this even further by limiting upgradation to only 4848 sub-centers.

b. Not made mandatory registration in HWC a form of access to entitlements. The government did introduce a population-based registry, but this was diverted to being used to generate data for commercial interests rather than ensure healthcare as a right.

c. Even the 4848 sub-centers have only one MLHP, one MPW and one community health worker (called women health volunteer or WHV) for 5000 population. The rest of the sub-centers have only one MPW and one WHV. The system of referral is weak- and while the HWC does act as a gateway to some secondary services, most services are not included.

d. As a result the care available in most sub-centers and PHCs remains at 10 to 15 % of what is required. In those upgraded to HWCs, patients seeking care has gone up to over 50 per day (from less than 5) but this is still likely to be covering only about 25 % of health needs.

In short, the governments, state and centre, know the road-map to achieving universal health care, but is under no pressure to deliver on that promise. We, the people, need to be able to persuade the government to walk down that road.

12

What is required for making these HWCs effective vehicles of Comprehensive Primary Health Care?

1. **Adequate Human Resources:** To be effective, each of these centres catering to a population of 5000, must have the appropriate number of staff with appropriate training. This is at least one MLHP (mid-level health care provider), and three multipurpose health workers of which at least two are women with a minimum of ANM level of training, and 5 community level workers or ASHAs- a total of 9 health workers. Currently, in a sub-centre upgraded to HWC, Tamil Nadu is putting in place one mid-level healthcare provider (MLHP) which is GNM or B.Sc. nurse with additional training, one female MPW with ANM qualification and one - Woman Health Volunteer (WHV)- only three persons. This is far less than all other states in India. When all other states could afford this, the costs of upgrading the human resources cannot be an excuse for the Tamil Nadu state government. Similarly, in a primary health centre there should be at least three medical officers and 5 nurses with GNM qualification and the necessary supportive staff. In addition, there is a case for a full-time administrative manager who also does data entry and records. If such a workforce is there- then one would be able to deliver the proposed healthcare services as envisaged for comprehensive primary health care.

2. **Community Health Workers and Community Engagement** : Currently Tamil Nadu has opted for one woman health volunteer (WHV) per 5000 population. We needed one per 1000 population, which will make on par with the ASHA program. Tamil Nadu has not opted for a state level ASHA program on the grounds that they did not want to include a semi-volunteer work force with limited training and future prospects. But the WHV is just that, with far less training than the ASHA, and far more households to cover and much worse working conditions. This is leading to very limited coverage for very limited illnesses. The WHVs links with the community

and community institutions also require to be strengthened. Currently the functioning of village health committees is almost non-existent, and the involvement of self-help groups and the gram panchayats in health is very limited. But community institutions are essential for encouraging utilization of preventive and promotive services and local action on the underlying determinants of health. The WHVs could play a role of linking with the community institutions and building their capacity and engagement.

3. **Expanded package of services:** To be effective, the set of services should cover the major part of health care needs, should be responsive to local needs, and of good quality. For this purpose, there has to be a Board made of a mix of clinicians, public health experts and civil society organizations with experience in health rights or community healthcare. This Board reviews the set of services provided and the standard treatment protocols for the same, and therefore also recommends on the medicines and diagnostics that would be available at the centre. At the district level similar Boards may help in making adaptations. However we emphasize that the services should not be less than what was proposed for the Health and Wellness Centres under the central scheme. Health technology assessment is one tool that would provide evidence to inform these decisions.

4. **Essential Medicines and Diagnostics.** To be effective, these centres should have the essential medicines and diagnostics needed without interruption. Tamil Nadu has already developed a good system that can ensure this. Once the Board has decided what medicines and diagnostics are essential, Tamil Nadu should be able to deliver this.

5. **Good Referral Support and Continuity of Care:** To be effective these centres should have very good referral support. That we shall describe in the next section.

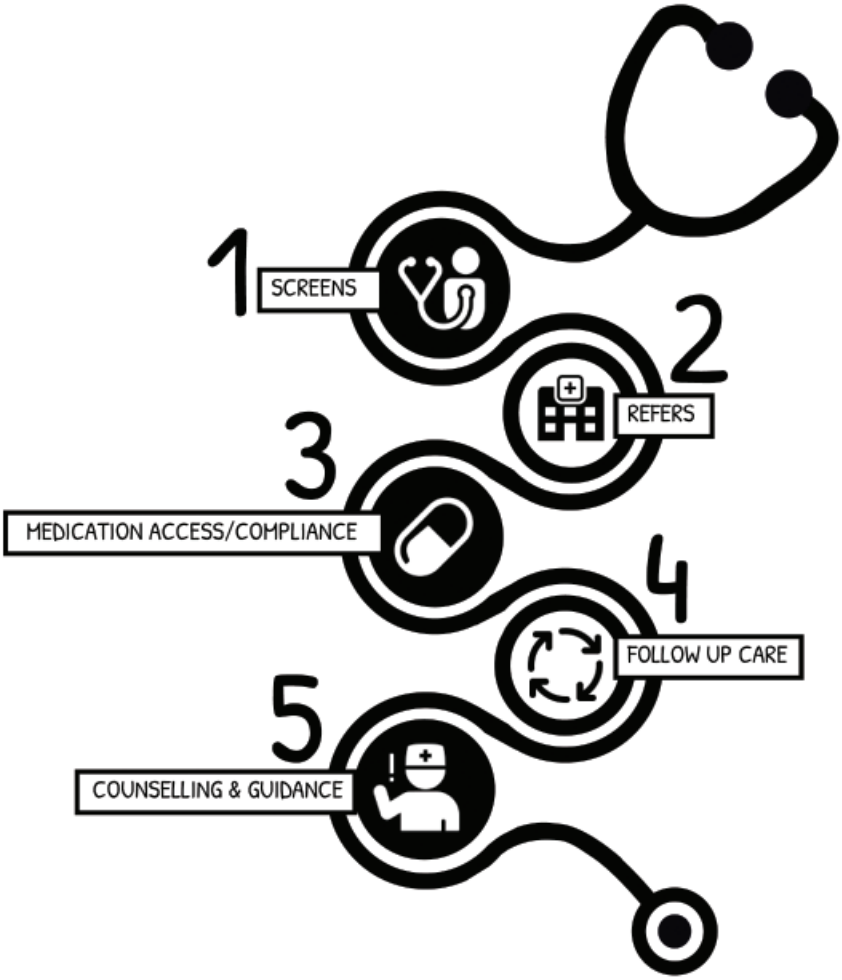
13

How does a HWC help access care for this larger range of diseases ? What is the respective role of HWC staff and of doctors/specialists?

1. **The HWC role in complex diseases** : The Health and Wellness Centres do not substitute the doctor's role in diagnosis and management. The primary care team in a HWC does five functions with respect to care for chronic illness :

   - *Screens*: Screens the individuals in its service - area to check for any signs of chronic illness. Some of it is based on symptoms and some of the screening requires diagnostics.
   - *Refers*: If disease is suspected, then it is referred to a doctor. In all chronic illness, the doctor will make the diagnosis and the treatment plan - not the HWC staff.
   - *Medication Access/compliance*: Once the plan and prescription is made by the doctor, the required medicines can be accessed locally and the HWC staff keep check to ensure that treatment is regularly taken.
   - *Follow up Care*: Based on treatment plan and their prior training routine follow up care like checking for BP, or any medicine side effects and being alert for early signs of complications is undertaken.
   - *Counselling and Guidance*: On diet and life-style changes and relevant health measures is provided. Each chronic illness has its counselling/health education requirements. Guidance would also be needed for families to access appropriate healthcare of higher levels or manage the different chronic illness at home within their personal circumstances.

2. **HWCs as gateways to specialist care:** The law would specifically ensure that for all patients using the health-centre as the gateway, the medical and specialist consultations would be free. Just as it is free currently for those registered under



publicly funded health insurance programs. In certain areas and circumstances, even patient transport would be covered. Further the law would ensure that there is clearly specified and linked referral centre for every health condition that would be referred from the health and wellness centre.

3. **Continuity of Care - between primary & higher levels** : The success of the health centre depends a lot on the continuity of care across levels. The HWC becomes a gateway that would help patient access the right medical and specialist support where this is required. Specialists must confirm the diagnosis and prescribe the

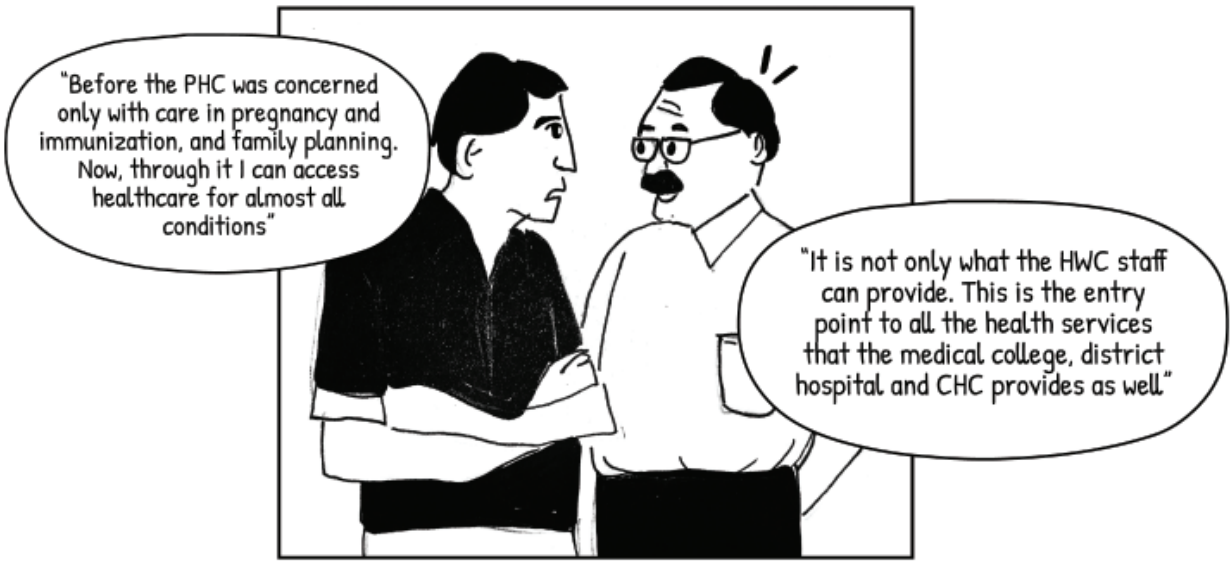
treatment plan, and refer back to the HWC for follow up care. For example patients diagnosed with hypertension would require a monthly blood pressure check as well as access to medication that can be done in a HWC. Or HWC staff could detect early signs of complications in a diabetic. Only if it is not possible to follow up locally, should follow up care for chronic illness be continued in the higher level.

4. **Increasing capacity of PHCs to resolve more and refer less:** Much of the current referrals to specialists can be reduced if medical officers with MBBS qualification could do more. This is especially important where the number of specialists are very few. The skills of medical officers could be increased through short term courses in specific topics like for mental health. Another successful approach is to ensure that all medical doctors in PHCs have an opportunity to undertake a diploma or degree in family medicine. Good online training programs would also help.

14

Measures required for Assured Specialist Consultations:

- **Within the district** : Almost all medical care including specialist care needs should be met within the district. Much of the consultation required for confirming treatment and making treatment plans can be done by the medical officers in the PHC, who are trained as indicated earlier. The main site of hospitalization and consultation with specialists would be the sub-district hospital and the district hospital and medical college hospitals within the district. Reference to medical college hospitals outside the district should be required only for advanced tertiary health care.
- **Expansion of beds and specialists:** The majority of district hospitals in Tamil Nadu have ~~or~~ are now able to hire the necessary number of specialists, doctors, nurses, and paramedical staff. However, because of the overcrowding, the quality of care in these institutions suffers. To reduce this over-crowding we need the following:



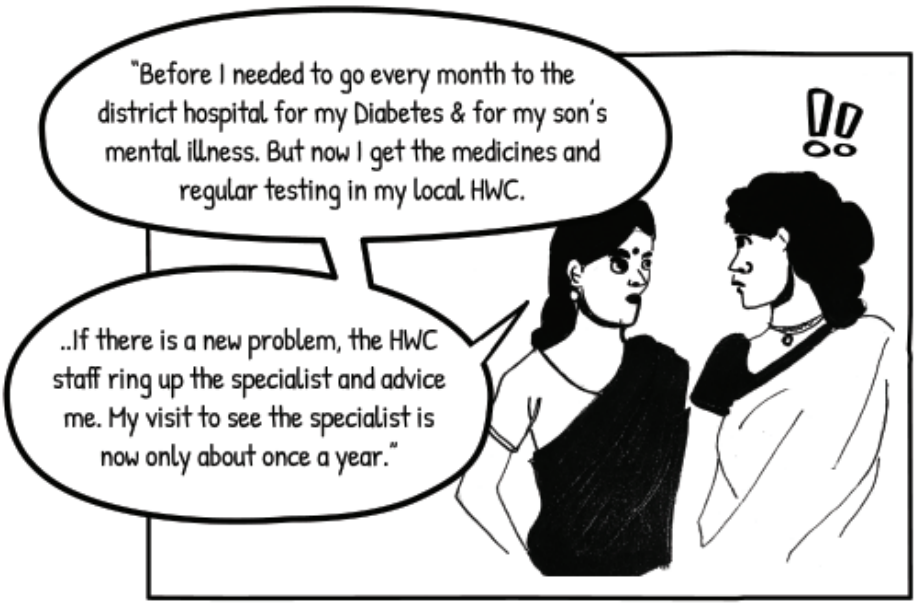
a. Make the HWCs operational so that primary care patients do not have to come to distant hospitals.
b. Increase staff position in sub-divisional hospitals (taluk hospitals) and district hospitals commensurate with case-loads.
c. Increase the number of beds in the district hospital. Over a few years, as both healthcare provision and health awareness increases, we would require at least 2 government hospital beds for every 1000 people or about 2000 beds per 10 lakh population.

- **Linkage Mechanisms:** Linkages required for referrals and continuity of care across the levels should be built up by:

  - Specialists attending clinics relating to their specialty organized in the PHC on specific days every month.
  - Special evening specialist-run polyclinics where referred patients from cluster of PHCs can be seen. This could be in a sub-district hospital or a well located PHC.
  - Tele-medicine consultations between primary care providers and Specialists in District Hospitals at fixed time
  - Patient transport to the District Hospital for specialist consultation and special investigations.

- **Feed-back from specialists:** If the patient goes to the DH or medical college hospital for a consultation, there should be feedback to the referring PHC doctor so that continuity of care can be ensured. This is not easy to ensure. To be assured of this service, there has to be help-desks in each DH/SDH and many such desks in a medical college hospital. These help-desks are to be staffed by the social workers directly recruited or through contracting civil society organizations. Their functions would be to help patients find the specialist they have been referred to and after referral further explain the care management plan and ensure that feedback documents are in place.

- **Referral to private sector hospital** : If existing government hospitals do not have the capacity to manage a given patient, due to the lack of relevant specialists or



due to their capacity being exceeded, then the patient must be referred to an empanelled private hospital. With government re-imbursing the private hospital at PMJAY or other negotiated rates. If there is no private hospital willing to do so, and there is a patient requiring that care, the government can requisition the necessary capacity from private health sector to provide these services as it was done for Covid 19.

How a Right to Health Care Law can help: It is important to examine what the Right to Health Care Law will ensure in this regard. It must be obligatory for government facilities not to turn away any patient, due to lack of services available in the facility or overcrowding or lack of appropriate specialists. It must become the obligation of that health care centre/ hospital to either provide care or facilitate access to a suitable alternative centre where the necessary care can be provided. It is our contention that Tamil Nadu's Health System has reached the maturity where this can be enforced, as it is currently enforced in all nations which have universal health care.

15

The right to healthcare is the right to quality healthcare!!

- There are many problems related to the quality of care within the district hospital and health centers. This includes, the lack of adequate communication with patients, lack of adequate signages, no practice of giving appointments, long queues at different points, poor sanitation, poor ventilation and lighting. There are also concerns about patient safety ranging from accidental fires and electric shocks to falling off the bed or medical and nursing errors. All of these are different dimensions of the quality of care. And all such problems can be prevented. The system to do it is called a "Quality Management System". There are many such systems available.
    - For government hospitals in India there is a Quality Management and Improvement scheme called the National Quality Accreditation Scheme. (NQAS). *The law should specify that all government health facilities and schemes must necessarily be registered under this scheme (or other equivalent scheme) and state level institutions should have the capacity to conduct periodic quality audits and where necessary provide the management support for every hospital to achieve an adequate level of quality.*

These quality standards include several issues about privacy, inclusivity, safety, assuring the comfort and satisfaction of service users, and ensuring that all service users and personnel are treated with dignity. According to the NQAS, internal and external quality audits must be conducted on a regular basis to identify gaps in every area of concern. These gaps must then be filled through training or additional -resources. The

state currently lacks the capacity to evaluate and take action on quality improvement across all facilities because there are no specific state level quality accreditation and quality improvement institutes. The Right to Health Care law will make it necessary to build this capability and ensure quality standards across all its facilities.

- Local self-governments, hospital development committees and technical assistance agencies should also be trained and encouraged to monitor and support these quality efforts.
- One parameter of quality of care is timeliness. The Right to Health care law allows for standards of timeliness to be built in to the rules for both emergency and elective procedures.
- One important provision that is required while legislating the right to quality as part of the right to health care is the availability for relaxations of quality standards related to infrastructure and human resources in difficult and remote areas. Good quality care should not undermine access to essential healthcare, nor undermine the scope for the small healthcare providers who needs to adapt standards to function in resource- poor settings.

16

Aligning Health Professional Education to Health Rights

Policies and laws related to Health Professional education today are shaped by three motives

i. To serve society's needs for health care and health equity (the first principle).

ii. To ensure equal and/or fair opportunity for students coming from different to enter a lucrative career (the second principle).

iii. As an opportunity for private investment leading to a large profit (an avoidable reality).

These three motivations push in different directions. It is important that whenever there is conflict between these three motives, the first principle should prevail. The rules for access to health professional education, the curriculum and the process of placement after completion of education should all be examined for consistency with the first principle and aligned with it. Policies and laws related to health professional and technical education should ensure that it is aligned to the organization of equitable, affordable, good quality health services for the population. Such objectives are inconsistent with the third motive and therefore health professional education as an area of private investment for profits should be curtailed.

- To align current Health professional and technical education we need policies that:
    - *Estimate required medical seats.* Do not over-supply: The number of medical colleges should be based upon an estimate of the need for doctors and specialists in the state health system. If too many doctors are provided, they set up clinics where there are not enough patients, and competition for the paying patients is so high that the doctors are easily persuaded to adopt unethical practices. It is a good idea to have one tertiary care public hospital in

every district. But these need not be a medical college, and even if we aim for this, the seats could be limited to the estimated requirements.

- *Disallow profit making in health professional education:* The main emphasis should be on government colleges since fees have to be curtailed and the spirit of public service built up. Only few private medical colleges, which have a clear commitment to public service, should be allowed. There should be a tight control on fees charged- with no capitation fees allowed and strict monitoring to prevent illegal charges. Management quotas in medical seats, should be restricted or banned. In today's system, many poorly qualified students enter private medical studies through paying huge fees. On graduation, these students have to seek highly paying private sector jobs to re-pay their loans, and it is difficult to earn much in ethical practice in both public and private sector.
- *Provide Fair opportunity to enter a health professional course:* The laws must uphold the right of every student to have fair opportunity to enter one of these courses, but as subordinate to the first principle. Fair opportunity is not necessarily equal opportunity. Selection process could give priority to selection of candidates of a particular region to specific course. Reservation for SCs and STs must be continued, but proactive measures would be required to ensure that we have enough applicants from under-serviced districts and communities. We understand that a good educational process would be able to bring everyone, even those starting with less privileged backgrounds to the same level of achievement. The challenge is of selecting for education and for recruitment those persons who are happy to be living and working with under-serviced communities and as part of public services.

- *Ensure that Medical College Hospitals are poor-friendly* and students are trained within such an ethic. All medical college hospitals should necessarily be empanelled for PM-JAY/CMCHIS scheme- and most patients should therefore be receiving free care. Private medical colleges which are not viable in the absence of capitation fees and of patient rates that are in line with PM-JAY pricing, should either be taken over by the state or permitted to continue with just tertiary care.

- Build a rights approach into the functioning of medical colleges: Medical college hospitals must also be compliant with all the human rights principles of the Right to Healthcare Act as described earlier. Further all medical college hospitals must also all be under a Quality Management System and accredited for quality- and quality care must be part of the training.

How the Right to Health care Act could help:

a. The Right to Health care Act could state the general principle that medical and nursing and paramedical education policies, including matters related to admission, educational fees and expenses, syllabus, skills imparted, should stand the test of being appropriate to the priority task of providing equitable healthcare through public services to where it is needed most.

b. With the above mandate the RTH Act could mandate an empowered Health Human Resources Advisory board, that will ensure that policies related to HRH are in harmony with the principle that health professional education must serve societal needs for healthcare and must teach and practice the principles

of human rights in health care delivery as described in the RTH Act. This will mean inculcating the spirit of public service, quality of care, subsidized affordable professional education and the phasing out profit oriented medical colleges.

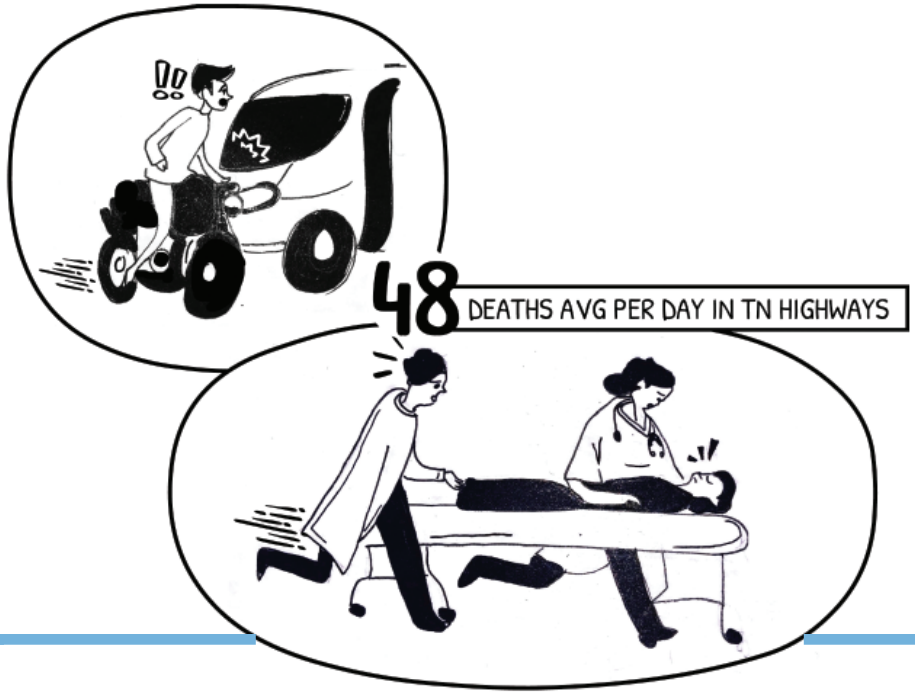
One major problem is that the entire legislation around health professional education has been taken over and centralized by the National Medical Commission Act, the National Allied Healthcare Workers Act and the Nursing Commission Act. The space for state governments to intervene and makes laws and rules to suit their health systems has been greatly limited. This problem is seen in Tamil Nadu's unsuccessful but well-reasoned opposition to the imposition of the National Eligibility cum Entrance Test (NEET) as the sole criteria for admission to medical colleges of the state. The current central government policy promotes private medical colleges to take high paying students under the management quota even if they score very poorly and denies different fair means by which preferences are given to candidates who are more likely to opt for public service in more vulnerable populations. Tamil Nadu's proposed Right to Health care Act - cannot overrule the central acts- but hopefully it can create a space for review and dialogue within the legislative, judiciary and executive institutions. This would be an important aspect of strengthening federalism.

17

Ensuring Right to Emergency Care Services:

The Right to Emergency Medical Services is an important part of the Right to Healthcare. In Tamil Nadu the government is considering a separate law for the Right to Emergency Health care. This law would ensure:

- That a person facing a medical emergency can go to the nearest appropriate hospital, public or private, and
- The hospital will be bound to treat the patient free of charge for at least 48 hours. The hospital that provides the free care will be reimbursed at a rate that government has decided, based on transparent and fair costing studies.
- If treatment is needed beyond it, patient can choose to continue treatment there but at fixed cost. But If he or she cannot pay, patient must be shifted to a hospital where free care is available. This is usually government provider but it could be contracted private provider.



- The law will also ensure assured emergency ambulance services.
- The law will also make it an obligation of the government to provide a trauma care and emergency medical services capable hospital within one to two hours' drive of any village or residence.
- These emergency medical services would have to meet quality standards.

It is worth noting that the Tamil Nadu is well on its way to achieving these goals under the Tamil Nadu Accident and Emergency Care Initiative (TAEI).

a. Tamil Nadu already has a network of "Dial 108" ambulances services linked to a centralized call centre. Time standards have been set to guide a rapid and timely ambulance response and the initiation of hospital care. However many more ambulances are required. One must also separate patient transport services from emergency response services- so that both needs are served.

b. As of today, and there is a functional network of over 75 government hospitals equipped for trauma care and emergency medical services linked to a network- and to the ambulance services and a basic emergency response system. The role of a law is only to ensure that these arrangements are strengthened, that all areas are covered and that such services are sustained.

c. A system has to be in place by which hospitals where all emergency beds are occupied, can inform the call centre that they are "on pass" so that the patients can be taken to next nearest available emergency hospital. Time should not get wasted in seeking for an available bed- nor should the patient's family have to do it on their own.

d. Many private hospitals have contracts specifying rates of reimbursement for 48 hours free care and are empanelled with PMJAY for providing emergency care. However there are no penalties for turning away patients or double charging. Good monitoring and periodic review should ensure no misuse or unethical practices.

Tamil Nadu's progress with establishing a good emergency response system should give policy makers the confidence that they can deliver on a Right to Health care act.

18

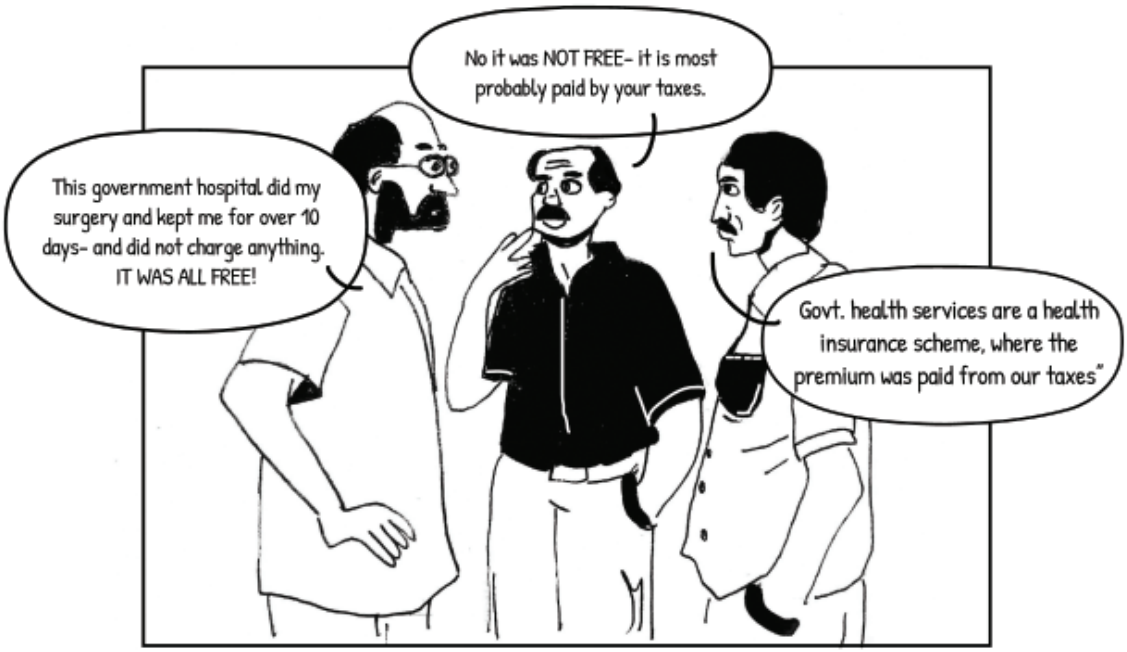
Supportive state policies for achieving Right to Healthcare

So far, we have only dealt with the organization of services. But for such a service delivery to succeed there need to be appropriate policies in many related health systems components. These are listed below and described in the following pages:

19

How do governments fund for universal healthcare?

The most effective form of financing health care for a rights - based approach is tax - based financing. Even the poor are paying taxes - indirect taxes, and in return they have a right to these services. The rich should be paying higher taxes. That assures equity in financing. The usual practice in private sector is for out-of-pocket payment, at the time of service-use, and everyone, both rich and poor, pay the same amount for the same services. This arrangement is inequitable. When people avail of "free or subsidized" services in the public sector, it is not really free, but pre-paid along with the taxes. We note that the rich in India pay far less taxes than in developed countries, especially countries with universal healthcare systems. Both state and central government should be spending at least three times more on health and education than they are doing currently. The Government's National Health Policy 2017 makes such a commitment.



There are three ways in which governments can raise these funds. One is to increase taxes in a progressive way, so that the rich who are making billions of profits pay more. One problem here is whether the state government is able to receive a fair part of the tax revenue collected.

The other approach is through social insurance schemes were employers pay a part of the premium, and employees pay a smaller part and in return the and their families get social security and health care services. The Employees Service Insurance (ESI) established in 1952 is one such scheme. The ESI was reaching only organized workforce with wages less than Rs. 16,000 per month. With expansion of the scheme to include many unorganized and contracted workers and the increase of salary cap to Rs 21,000 more per month, millions more have become beneficiaries. If the salary cap is altogether removed, even more people will benefit. And most important, if all unorganized workers are included, the funds generated would be considerable. There are many mechanisms by which inclusion of many more unorganized workers, could be done. Some of it is already taking place, but the benefits are not reaching the enrolled.

Currently the ESIC has generated a one lakh crore of surplus funds. This has led to their lowering the premium from 3.5 percent employer contribution and 1.5 percent worker contribution to a negligible level of 3.0 percent employer contribution and 0.5 percent worker contributions. But these surplus funds is largely due to poor delivery of the social security benefits. Instead of lowering premiums the focus should be on better delivery of the benefits - of which healthcare is one of the most important. The great advantage of ESI is that it is a comprehensive package of social security which not only provides a comprehensive healthcare coverage– but includes additional features like sickness benefits towards loss of wages, accident insurance, unemployment allowances and so on.

We also note that if there is full employment with good social security, then the economy would do much better. Many economists have shown that spending on health and education should be seen as investment, not as expenditure.

And the third measure to is to curb wasteful expenditure. We note that expenditure on salaries is not a waste. At this stage, salaries would be over half of what governments spend on healthcare. But there are three forms of waste we are worried about:

a. Poor-allocation of funds: The budget and human resources sanctioned for health should have a measurable relationship to the number and type of out-patients and in-patients seen and the public health functions performed- and should increase as these outputs increase. This requires good information on utilization of services and a commitment to make the budget responsive to this. TNMSC already does it for medicines. But it needs to be done for all of health care services.

b. Corruption: This usually takes place usually in four areas: contracting for infrastructure, human resource appointments, procurement of goods and equipment, contracting private sector. While catching the corrupt is necessary, it is more useful to demand systems that eliminate or sharply reduce the chances of corruption. Tamil Nadu has put in place such a transparent system for procuring drugs and equipment, which has a legal support from the Transparency Act, which ensures fair and efficient procurement and distribution. Even for recruitments, transfers and postings, systems are more transparent in Tamil Nadu. As a result, corruption in the public health sector is limited. It would be even more limited if less exceptions are allowed, and transparent systems are extended to both infrastructure and private sector contracts.

c. Poor human resource /workforce performance: When the services provided are not commensurate with human resources in place- either due to objective reasons, like lack of medicines, infrastructure etc. or due to poor motivation and performance or due to conflict of interests- like inappropriate referrals to private practice.

20

How does one improve performance of the public health workforce ?

The principles are simple:

- Ensure that the education systems and recruitment policies are such that we get the right person for the job- a person who is happy to be posted in a given situation and who has the right skills required for the job.
- When on the job, the terms of employment and the work environment should be such that the employees are able to do a good task.

We have already discussed the reforms required for health professional education. With respect to public workforce management the following policies are required:

- **Better Recruitment:** Tamil Nadu's Medical Services Board is a great strength and Tamil Nadu recruitment and posting policies are one of the most transparent and fair. The problem is really in the sanction for positions and timely notification of vacancies and quick completion of recruitment and appointment. But there are a number of other policy measures that would also be required. Where candidates are few, the Board should consider placement interviews and all India advertisements. As far as possible, subject to availability of vacancies, appointees must be posted where they are happy to be posted. For under-serviced areas, preference can be given to those who would be happy to work in such areas. Good to build in a process where aptitude and desire for public service is an important consideration.
- **Modern HR Management**: The law should call for adoption of modern human resource management strategies , that create a positive working environment enabling staff to provide their best. A mere reliance on disciplinary measures and hierarchies of reporting are inadequate to ensure accountability
- **Fair Remuneration with Social Security**: The law must call for a reasonable wage

or remuneration with job security and social security. The current approach to keeping many persons on contractual appointment for indefinite periods and paying them much less than regular staff does not help. Lack of social security provisions for such contractual staff is another major problem. The right of health workers to fair and supportive terms of employment is therefore a necessary condition for the state to fulfil its obligation to provide healthcare to the community. It will also lead to very positive outcomes for the economy.

- **Skills Upgradation:** The law and policies should ensure that the workforce have necessary skills and these are upgraded. This should be also linked to their creative development and an ability to take professional pride in the work they do. Positive supportive supervision and reviews would help. So also would mentoring by professional seniors. Opportunities for professional advancements are important. Timely promotions, along with necessary skill upgradation help.
- **Solidarity with the community**: A third important element is solidarity with the community they serve and being able to enjoy the community's respect and trust.

This depends a lot on doctors training and orientation and even the economic class and community they belong to. It also depends on forms of engagement with the community that have been put in place.

- **Accountability:** This must ideally come from within, enabled by a positive working environment. But there will always be those who do not deliver and the system must have the means to correct it. This calls for a good system of supervision and feedbacks from the community. Accountability is much easier to establish, if the rest of the system is in place.
- **Pride in Public Services:** This requires positive feedbacks and leadership. It also requires a positive public understanding of public services by presenting the achievements and challenges faced by public providers. Private hospitals, especially corporate sector hospitals routinely do this- but public providers are in the news only for negative reasons.

We understand that many of these measures cannot be built into the law- but we call for a governance based on the above principles.

21

Why and how should health systems engage with the community?

- Being healthy is much more than having the right to health. Being healthy depends a lot on the individual, the family and the community. Healthcare - doctors, drugs, and diagnostics comes in only when illness occurs. Even in illness patients have to get healthy; the doctor and other providers are only a guide. So unlike other services where one is a provider or a consumer, here both doctor and patient are co-producers.
- Therefore, communities have to be active participants in their healthcare, not passive beneficiaries. The nature of relationships is important, and healthcare is better understood as a relationship of mutual trust and help, or in other words of solidarity.

- A paternalistic government treats the population as if they are incapable of understanding what is in their best interests. In this approach people have to be coerced or persuaded to do what is good for them. But in a right to healthcare approach, people are partners who need to be empowered.
- There are different institutions for engagement with the community. They could be listed as
    - o Institutions of Local Self-Government
    - o Village Health Committees
    - o Block and District Level Committees
    - o Hospital Development Committees etc.
- The single most important step in community participation is the involvement of institutions of local self-government- the panchayats and municipalities in health care. The Right to Health care law should make it obligatory for local self-governments to have necessary powers, personnel and finances to play a role in preventive and promotive healthcare as well as in the planning and management of health programs and facilities.

Consultative participatory committees at village, block and district level have a role in promoting community level actions that will improve health outcomes. These actions include encouraging healthier behaviors, enhancing access to all health and health-related services, and inclusion of under-served groups. It is essential to have representatives from the weaker groups in these committees. Holding regular committee meetings builds solidarity, mutual respect and trust. In the process, peripheral providers also feel more welcome and accountable.

One important requirement of the law is a provision to make it obligatory for the government, once in two to three years to hold a block and district level health assemblies where they report on progress made, and share their plans for the future and consult with communities. The feedback from the assembly is then incorporated into the plans.

22

What has been Tamil Nadu's experience with the Clinical Establishments Act (CEA)? What is required in the CEA to complement and support the Right to Healthcare Act.

Tamil Nadu has a Clinical Establishments Act since 1997. Rules were framed only in 2018. This Act is meant to ensure quality of care as also to prevent harmful and unethical practices. However the Act is very inadequate for a number of reasons.

One issue with the Act is that, contrary to its initial intent, it now encompasses both the public and private sectors. But public sector is under governments administrative control and requires a different approach from the private sector. For private sector, a separate legislation is required to identify and address gaps, to influence provider behaviour, and to penalize non-compliance. Another problem with the current law is that it provides only for registration. It requires clinical establishments to have a minimum floor space and number of qualified human resources. Currently, penalties for non-compliance are relatively small fines- and even this is seldom enforced. There is no effort in the CEA to regulate quality of care, or promote transparency and patient rights or to regulate prices. Implementation of even these limited provisions is very weak,

One reason why many medical professionals oppose a more effective law is the fear that such an Act would be used to reduce competition for large hospitals by excluding small-scale affordable providers. Also that this would give an opportunity to harass them and seek bribes etc. The larger hospitals oppose CEA because they believe that it is their right to make the level of profits they desire and to treat only those patients whom they choose to treat.

- **The main features that we want in a Clinical Establishments Regulatory (CEA) Act are:**
    - o That treatment given must be consistent with standard treatment protocols as decided by a medical board.

- Minimum standards of quality as measured by any transparent quality assurance process (e.g., NQAS, NABH) should be maintained. The focus of quality must be on the processes which ensure that treatment is effective, safe, and provided with dignity: this would mean things such as preventing medication errors, fire safety, proper discharge and referral, proper provision of health information, etc.
- While standards for infrastructure and human resources are welcome, district Clinical Establishment committees can have powers to relax these standards if other quality measures are met.
- That patient rights are respected especially with regards to privacy confidentiality, informed consent, second opinion, etc.
- That the price of services is within a specified range- as indicated by publicly funded insurance programs.
- That if empanelled for insurance services the private provider cannot deny care to patients who have that specific insurance coverage, irrespective of the ability to pay. or their social background.
- That there should be neither anti-competitive practices nor conflict of interests. Which means no kick-backs or commissions or incentives or disincentives to doctors for referrals/diagnostics/prescriptions within the hospital or with any other person or institution anywhere. Doctors serving in government cannot refer patients to clinical establishments where they do private practice, or which is owned by a close relative or where they have shares.
- There is a case for government doctors being provided a better remuneration in the form of a non-practicing allowance, and disallowing private practice.
- The private provider must be periodically attending mandatory skill upgradation and refresher programs.
- Private providers must provide all essential health data that public health system requires.

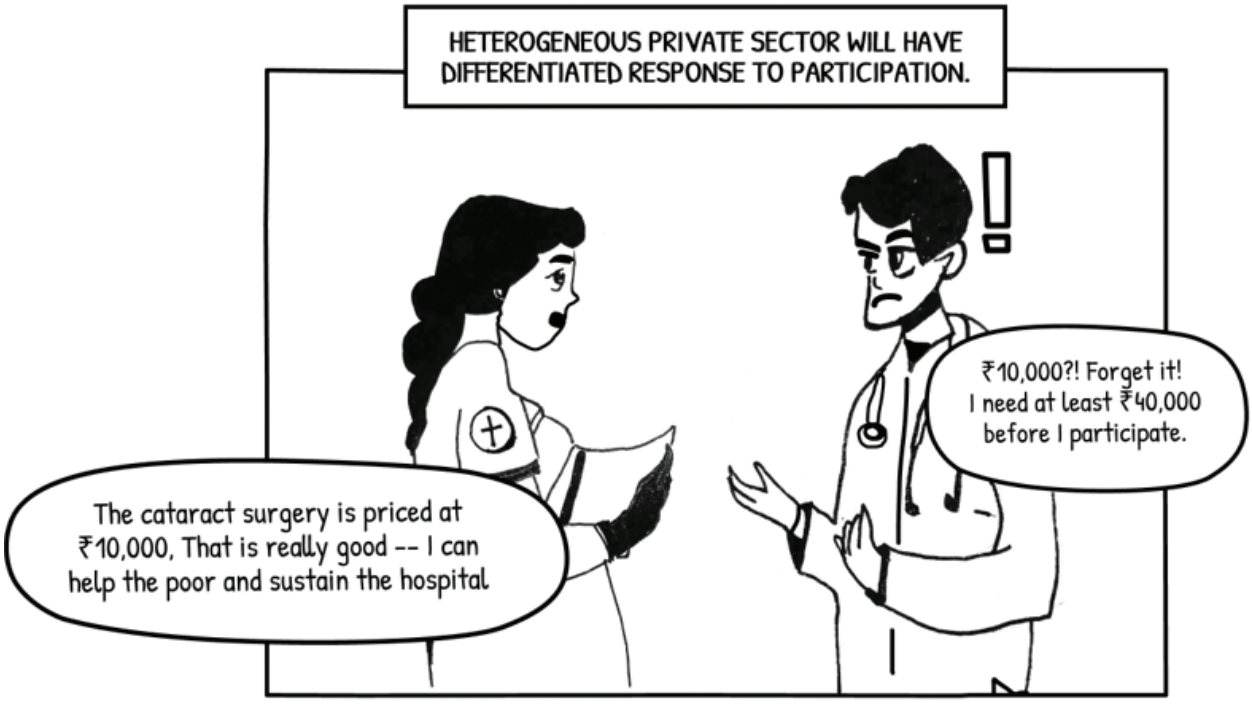
23

How else can government influence the private sector to achieve public health goals

Regulation is one form of ensuring that public health goals are served by private health sector. But there are many other ways in which governments could engage with the private sector so as to ensure better access to affordable, good quality health care. These include public private partnerships (PPPs) and Government funded health insurance programmes (like the PM-JAY)

Public Private Partnerships:

PPPs have been tried extensively over the last 20 years. But the experience with PPPs have been very poor. Most public private partnerships have been criticised as a route to privatization of health services or as a way of avoiding government expenditure in paying



a fair salary for health workers. Most often, after a few years, the PPP is declared unsuccessful and closed down.

We call for a Right to Health care law that specifies that while contracting under government insurance or through partnerships are welcome, these should be in conformity with a set of basic equity-linked principles. In effect these partnerships should be like extensions of the public services where discrimination and denial are prohibited and where patients have financial protection and assurance of quality care. These principles also guard against transfer of public funds for private profits.

The principles that should inform Public Private partnerships are:

1. The PPPs should supplement public services- and should NOT be a substitute to it.
2. The PPPs should be pro-poor. Many not-for-profit providers who have such an approach should be identified, encouraged and contracted thus becoming an additional capacity of the public services to fulfil its goals.
3. The contract should not be a form of paying employees less or denying them social security. The wages for the service providers under contract should be fixed at fair rates, well above minimum wages, with payments towards social security.
4. Some services require special experience like an emergency ambulance services, or even dietary services, laundry, security etc. These can be outsourced easier- but the employees' rights, including their social security provisions, should be safeguarded. Making them eligible for ESI Scheme is enough to start with.
5. For clinical services, the contracts should be more of reimbursing expenditures incurred at fair rates, like what happens when a hospital is empanelled on insurance, or some beds were contracted in for Covid care. But government should ensure that no irrational or unnecessary care is given. Transfers of funds to private sector to create capital assets, or transfers of capital assets like land and buildings have not worked to create the sort of partnerships that are required.

6. Reimbursements to private providers must be done on time and with dignity. Delayed payment, seeking bribes for clearance of dues etc all push out the ethical, capable private providers and discriminate against small providers who cannot sustain services if the accumulated dues run into lakhs of rupees.

7. There must be a regular grievance redressal system where complaints in care can be registered and action taken.

Government Financed Insurance Programmes (GFHIs)

- Government funded health insurance programs are another form of engaging with the private health sector. In Tamil Nadu, the Chief Ministers Comprehensive Health Insurance Scheme (CMCHIS) has played a big role in engaging private providers. This has increased access to tertiary care for a big part of the population. That is good. By reserving many simpler surgeries and treatment to government hospitals, the scheme ensures that government hospitals do not lose their skills and service users. However, there are many problems with this scheme. To list some of these:

  1 Instead of giving free care, many hospitals charge the patients considerably and then go on to take reimbursement also from government.

  2. Hospitals choose to do only those procedures under CMCHIS, where they have a good profit. For the rest, they may refuse to take the card.

  3. There are many other reasons why patients card is not used or services are denied, There is no provision that makes such denial illegal.

  4. Patients themselves have very weak awareness of their entitlements.

  5. Though government hospitals also fall under this scheme, patients may choose not to use their cards in govt hospitals, so that claims go disproportionately to private hospitals.

If these malpractices are curbed, fewer private hospitals may join, but patient rights are secured. It is difficult under Indian law to enforce right to healthcare as an entitlement with the private provider. Knowing this, the priority of the right to health movement, is therefore to ensure that all healthcare is available in public sector for those who opt for it.

24

Countering the ideological bias against strengthening public services

Public sector is portrayed as always having poor quality, that people go for, only because they cannot afford private care. The statement is often made, that given a choice most people would prefer private providers. This is not true- but this belief in the middle class and in the decision makers, especially after economic liberalization, is one reason why there is not enough pressure for universal public health services and the right to healthcare. Why does this belief exist:

- Some of those who unfairly criticise public services- have a vested interest in promoting private sector and corporate interests or are rich persons who experience and can afford private healthcare as a privilege.
- But more commonly the reason why media, academics and middle-class intellectuals are critical of public services is due to the active promotion of a public discourse that is shaped by an ideology that comes with neo-liberalism. This ideology sees everything private as good and public services as inherently bound to fail and a waste of tax payers' money. They would agree to more public expenditure on health only if this is spent in a way that it helps corporate health sector to benefit and to build their monopoly. The strategy followed is to ensure that public services are under-funded or de-funded. This leads to poor performance. This is used to justify privatization and further reduction of funds for public services.
- Many inconvenient facts are conveniently forgotten. Like India and Tamil Nadu's public health expenditure being one of the lowest in the world. Though public health expenditure is less than 30% of total health expenditure, it accounts for 30% of all outpatient care and 50 % of all in-patient care and almost 100% of all preventive and promotive healthcare services , as well as much of professional education. This neo-liberal discourse also fails to point out that public hospitals

that provide comprehensive services are highly over-crowded and some of them have reputation for the highest quality of clinical care, though patient amenities may be limited.

- Another reason for poor reputation is the design of health systems. The adoption of very selective primary healthcare gave a poor reputation to all government PHCs and SCs and pushed people to public hospitals – thus leading to over-crowding of these hospitals, which undermines the quality of care. Ideally a doctor would require to spend 10 to 15 minutes per patient. In reality they may be spending as little as one to two minutes. Further because of over-crowding many patients have to lie down on the floor or share beds. The government response should have been to increase the number of beds and staff. But instead officials and so-called experts use this as an argument to say private is better.
- In a very unregulated private health care, there is often over-charging, and provision of unnecessary care. All the evidence shows that outcomes are not better in private hospitals as compared to public ones. In the current vaccination campaign, the government reserved 25% of vaccines for private sector. Yet they could use only 4% of it. The remaining 96% of vaccinations happened in public sector. Examples like this show that where quality services are available, public services are welcomed.
- However it is true that private hospitals provide better patient convenience and comfort. In government hospitals, there is no practice of giving appointments to the patients. Patients have to spend half a day or one day on queue. Evening timings are also not given. Providers can be rude, especially when dealing with persons of lower social status. These problems, that come from both the nature of government administration, from the nature of professional education and from social and cultural differences between providers and patients, require to be addressed.

The proposed RTH Act does not address this issue directly, except in so far as it addresses quality of care and financing issues. However, understanding this issue is important to encourage the government to enact RTH.

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How to access essential health technologies?

The Right to Health care includes the rights of people to access all essential health care technologies: The proposed RTH Act must therefore also explicitly state the right to access the essential medicines, diagnostics, medical devices, vaccines, protective clothing and all other consumables necessary in health care.

Tamil Nadu has the following strengths with regard to fulfilling this obligation.

a) The Tamil Nadu Medical Services Corporation manages the procurement and distribution of medicines, and diagnostics and equipment and all other supplies to every public facility. The processes followed ensure efficient and transparent purchase of medicines and good logistics so as to ensure an uninterrupted supply at all facilities, including times when there is crisis. There are also adequate measures to ensure quality of all the medicines purchased. For implementation of these supplies as a right, it would be adequate to retain and strengthen this institution.

b) There is a clear list of essential medicines and diagnostics as required for primary and secondary and tertiary level. This list is upgraded regularly.

c) Many medicines for chronic illnesses have to be taken in continuity, and special institutional mechanisms would be required for reaching the medicines to the household or community level. The Makkal Thedia Maruthuvam, is a great start, but it has to include a wider range of medicines and be linked to the HWCs for more effectiveness.

Tamil Nadu however has the following problems that need to be addressed:

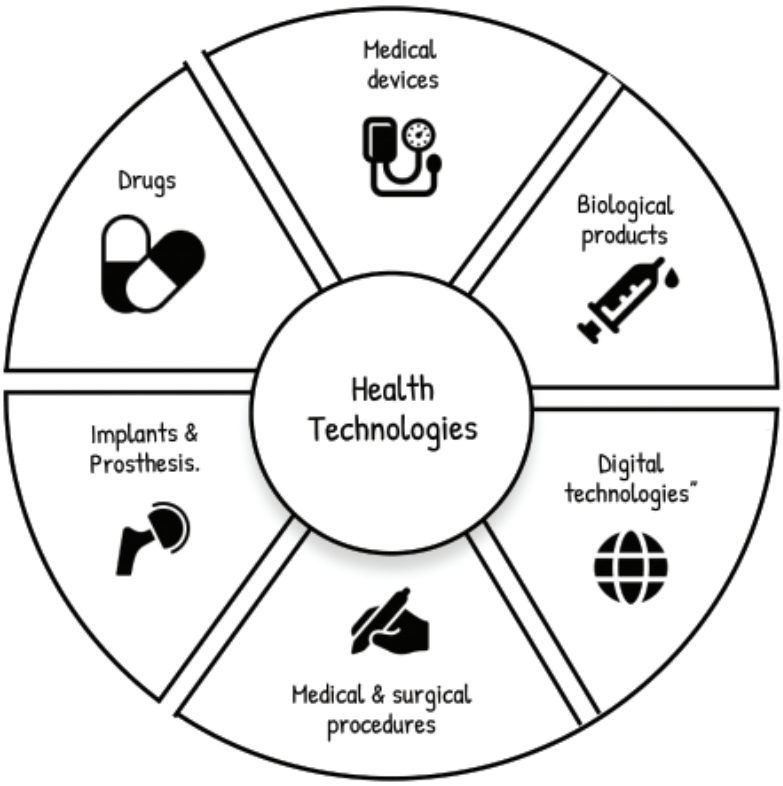
1. There is little intervention by the government in medicines and diagnostics sold in private sector. These should have price fixation along with adequate quality controls. This is currently weak. Both are almost non-existant. The recent scandal

of many Indian drugs being rejected in global markets for reasons of lack of safety is one example.

2. A large proportion of medicines prescribed in public and private sector, but much more so in the private sector are inessential or unscientific medicines or even hazardous. The efforts to curtail this are very poor, and this leads to many new public health problems like multiple anti-microbial resistance and iatrogenic disease.

There are also some nation-wide problems that affect Tamil Nadu, where action is required at the national level.

1. Preventing Monopoly in Manufacture and Supply: While prices of medicines procured by TNMSC are among the lowest, certain medicines remain unnecessarily high-priced due to monopolies. Other essential medicines go out-of-production because profits are low. These problems require to be



addressed by supporting increased domestic production and where necessary production through the public sector.

2. Overcoming Patent Barriers: For many new drugs, monopoly conditions exist due to patents. This means some company, usually a huge multinational corporation owns the 'Intellectual property right" and uses this right to prevent any other company from manufacturing this drug. This law is very unfair, since the drug discovery is often the work of the entire scientific community paid for with government financing. However, when there is a public health requirement, or if the products are meant for use on a non-commercial basis, there are provisions in the law that allows the Indian government to step in and give a compulsory license to another manufacturer. But governments lack the capacity and the will to do this.

3. New Drug Innovation and Discovery - Most multinational drug companies do not invest in new drugs that are a public health priority, especially for countries like India. Further new drugs for older problems also come with very strict patent restrictions. It is therefore important for Indian laboratories and universities and companies to be working on new drug discovery. This too needs government support in a major way.

- The last three items (1,2,3) taken together is what is required for health security and sovereignty of a nation.

A RTH law must make access to health technologies and health security and sovereignty a priority . The law will protect and enhance Tamil Nadu's current system of public health procurement and supply as organized through the Tamil Nadu Medical Services Corporation (TNMSC) with the assurance of uninterrupted supply of essential medicines and technologies. The Tamil Nadu RTH Act needs to make it clear that governments should not ratify any international agreements or treaties on patents, or manufacturing or trade in services or technologies that would limit the ability of the government to deliver the entitlements sanctioned under this RTH Act.

26

How are the rights enforced? What can be the penalties!!

Rights can be enforced by many mechanisms: :

Grievance Redressal System

1. One of the simplest methods is a grievance redressal system. If there is any denial of rights under the RTH Act, this can be reported into the grievance redressal system with some assurance that necessary action will be taken to correct the problem at its source. In addition the law could require payment of some level of compensation if the complainant has faced a loss.

2. Thailand has a system of what it calls no-fault liability. If a complaint related to lack of treatment or inappropriate or harmful care is found genuine, a compensation can be paid without waiting to fix responsibility for the lapse on any individual.

3. The grievance redressal system should be managed by the government, but with participation of some civil society members who are sensitive to patient rights and health rights issues.

Action by Legal Courts:

1. Individuals facing denial of services who are not satisfied with the action taken by the grievance redressal system can address the courts. This is particularly important where the denial of rights arose from a system failure.

2. Courts can take action against government authorities if some of the obligations with regard to organisation and financing of service delivery under the law have not been fulfilled. Governments could claim an inability to fulfil this obligation and the court may uphold that. That is why the law and its rules and strategies should be such that they are clearly feasible and pragmatic at the current level of development of the state.

3. The law should also make clear who is accountable. This could be the local authority or the state government or the central government. Within each of these governance structures, the office and the individual who has to be held accountable has to be clear. Also, powers, accountability and resources must go together.

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What are the governance mechanisms required by the RTH Act?

1. The principle is a participatory governance structure at state level which has policy makers, technical experts and public representatives. Their main function would be to review and guide implementation of the provisions under the Act. This structure should in no way diminish the accountability of the state government to its implementation. It should also include the central government in a way where dialogue is facilitated, and financing is negotiated but the final decision rests with the state government.
2. The current state health society and district health society structures may be examined and strengthened to play this governance role.
3. Other governance bodies required would be
    i. A health care technical board that decides on the inclusions and exclusions in the care package as also ensures appropriate treatment guidelines and care pathways.
    ii. A technical board that lays down quality policies and ensure the necessary capacity for implementation.
    iii. A financial committee that works out the norms for budgetary allocation based on the volume and variety of services delivered so that financing is responsive to requirements and reimburses providers for the costs of services delivered. Each service provider in this network would be, by law, entitled to receive the reimbursement as per norms for services provided from an appropriate source.
    iv. A board that reviews HRH policies and ensured their alignment with the obligations under the RTH Act.

28

How does the Tamil Nadu Public Health Act complement the RTH Act?

The proposed RTH Act addresses mainly the access to healthcare services. Most of the underlying determinants of health are to be addressed by the Tamil Nadu Public Health Act (TNPHA) 1939 and its amendments.

As of now the TNPHA covers the following:

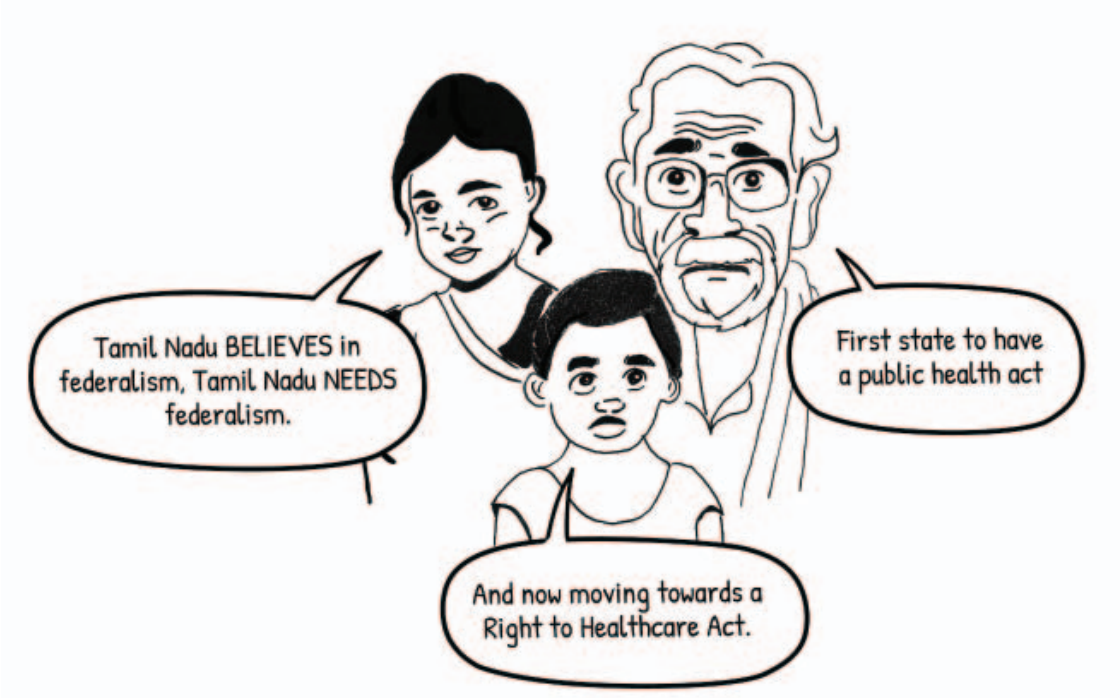
i. Creation and functions of the Public Health Board
ii. Water Supply system, including Local authority to provide potable water;
iii. Drainage and Local authority to maintain public drains, prevent freshwater pollution;
iv. Sanitary Conveniences;
v. Noise pollution and the Abatement of Nuisances- the latter includes some aspects of air pollution, animals and carcass disposal etc.;
vi. Prevention, Notification and Treatment of Diseases;
vii. Maternity and Child-Welfare;
viii. Mosquito control;
ix. Sanitation and Buildings;
x. Lodging Houses;
xi. Food Control (including the prohibition of sale of unsound food or meat not for human consumption);
xii. Fairs and Festivals;
xiii. Finance;
xiv. Offences and penalties for illegal activities.

While appreciating the role played by TNPHA, we call for further amendments to make this law more effective and rights based. Some of the suggestions include:

1. In each of these areas that the TNPHA covers, it should lay down public health

standards. These standards must be finalized by the Board and made available in the public domain.

2. Currently the TNPHA has many provisions for making the private citizen accountable for maintenance of public health. But it has none for public grievances mecahnsims for the public being able to enforce these provisions as an entitlement. The creation of public health standards for these social determinants should be followed by inclusion of provisions by which the community can advocate for and enforce their rights.
3. The TNPHA makes local governments in charge of action on these issues, but it must give them adequate powers and the capacity to do so and an assurance from the state government that it would provide financial and technical support to close the gaps and challenges that need to be addressed for the standards to be met.
4. Further the office of the Municipal Officer must be strengthened by a multi-disciplinary team which has technical understanding of the above areas, and the resources and powers required to be effective. Currently it is left to the local



authority- which neither has the resources nor the capacity to understand the needs.

5. An equivalent health officer of public health is required in each block for rural areas also- with similar mandate. Currently it is in the purview of the district health officer- and it is not clear how they can exercise their authority at the village level. Gram panchayats of course have a role in rural areas- but the role of the health officer is distinct from this.
6. An expanded network of public health laboratories must support the office of health officers and the implementation of the TNPHA.
7. The TNPHA does not cover many aspects of air pollution and waste management, some of which come under environment laws. Nor does it cover most aspects of occupational safety and occupational health. On food, though food safety is included, access to food is not. The law(s) should be amended to be inclusive of more of such determinants. All these entitlements need not be covered under this same law- but they all need a legal framework.
8. Another major set of social determinants are to be met through better urban planning- with regards to ensuring adequate road safety, and walkable neighborhoods, with parks and recreation sites and adequate tree cover and the control of air pollution and noise pollution. These call for health standards in urban planning and can be made a part of the public health act or part of a separate health promotion act.
9. The active promotion of exercise in schools and colleges, in work-places and at home through a program for the same is also part of the right to health promotion.
10. Increasingly attention has been drawn to the commercial determinants of unhealthy life-styles and harmful health practices. The control and gradual elimination of tobacco use is most important followed by strict curbs in the use of alcohol. Substance abuse is also an increasing problem. The legal framework for tobacco, alcohol, and substance abuse control needs to be strengthened and implemented better.
11. A further set of commercial determinants relates to the promotion of unhealthy food and dietary practices, which often goes along with the lack of access to healthy food alternatives. Restrictions on these unhealthy foods and promotion

of healthy dietary alternatives is part of the right to health promotion.

12. There are also increasing health threats from the digital environment- device addiction, gaming addiction, social media perversions to name a few. There is a case for bringing all the above (from 8 to 12) into a Health promotion act.
13. Social Inequities- due to gender, caste, ethnicity, elderly status, occupation, place of residence and social status, disability, sexual orientation- are all major determinants of ill health. They act both through greater risk of disease and through decreased access to health care. Provisions against discrimination in access to healthcare forms part of the RTH Act. But provisions against discrimination with access to underlying determinants and the greater risk of disease requires provisions in the TN Public Health Act, in health promotion policies/acts and other health related acts.

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In Conclusion:

Tamil Nadu has reached a level of social and economic development where it can afford to implement a Right to Healthcare legislation. The political will to do so should flow from its belief in social justice and federalism.

Under Indian and international laws, there is an obligation for governments to ensure the Right to Health. Tamil Nadu is fortunate that it has the capacity to fulfil this obligation. Tamil Nadu already has a Public Health Act in place. Indeed it was the first state to do so. Now, thanks to its relatively robust public health

system, as well its immense technical and professional capacity it can also enact and implement a Right to Healthcare.

The Right to Healthcare means the right of every person resident in the state to access all essential healthcare services with sufficient quality and without having to face financial hardship. To be able to fulfil the obligations under the proposed Act, the state must put in place a network of facilities providing comprehensive primary level care and acting as a gateway to access secondary and tertiary care as well. Every resident would be registered with one such facility, and this helps delivery of preventive and promotive services to every household. This also helps assure necessary healthcare for the entire population with no one being left behind. Services provided by facilities within this network would be free or highly subsidised, with all providers being ensured a fair and transparent reimbursement of the costs of the services they have provided. The vast majority of providers in this network would be public providers. While private providers would be welcome, the difficulty of enforcing universal access as right with a private provider and the difficulty of finding and contracting enough private providers who are not for profit, or who are happy to work within price controls, would make the delivery of healthcare rights largely dependent on public providers.

Tamil Nadu's strengths in the public health sector are many. It has already got a large network of Health and Wellness Centers operating within very well developed district health systems. Further expansion and strengthening of this network can guarantee universal comprehensive primary health care. Tamil Nadu's network of public hospitals and medical colleges also have the capacity for universal secondary and tertiary care services. Its human resource availability is the best amongst the states. Tamil Nadu's system for procurement and distribution of essential medicines and other technologies (TNMSC), its Accident and Emergency Initiative (TAEI) and its learnings from managing the COVID 19 pandemic should give the state the confidence that it already has the systems and experience to deliver on the promise of Right to Health care.

However there are many challenges. Most important of these in the need to re-orient its entire human resources strategy, which is currently mismatched

with public health needs. It also needs to invest on expanding and staffing public health facilities better. Its financing must be responsive to the varied case loads across districts and facilities and be able to reimburse the costs of the services delivered. Most important it has to break with selective primary healthcare delivered through sub-functional front-line health centers and move to adequately staffed and fully functional health and wellness centers that deliver comprehensive primary care and serve as portals of entry to the entire range of specialist consultations and tertiary care as is required. There are also challenges in community engagement, and quality of care but we know how to address these issues and can be confident of doing so.

Tamil Nadu was a leader in achievements in reproductive and child health, but as the epidemiological and social context changes, it has not quite responded to the challenges and is in danger of falling behind. Instead of resting on its past laurels it needs a re-think of its health sector strategy for moving forward. The main barrier in achieving the Right to Healthcare at present is not so much objective circumstances or financial constraints, as it is the lethal combination of ideological prejudice and bureaucratic inertia. Only a strong public discourse in favour of such a change and political leadership's commitment to federalism, social justice and the welfare state can save the day. We also need to ask whether without investing in achieving Health for all, Education for all, and Social Security for all, is Tamil Nadu's aspiration for a one trillion economy either feasible or even desirable?

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Annexure 1

WHAT ARE THE SOURCES OF LEGAL RECOGNITION OF HEALTH RIGHTS?

Health rights are legally recognized through the following legal systems and the legal instruments created within those systems:

1. International legal system
2. National law: Constitution; Central and State legislations/Acts, Judicial Rulings

Section 1 International/ regional legal systems:

International could be a treaty (also commonly called Convention or Covenant) which is binding on, countries that become signatories to it or resolutions and declarations by the General Assembly, which have the consensus of most countries and have a persuasive value. There are also international judicial decisions and customary international law (that is in practice but not written down.

The treaties which make the Right to Health obligatory are:

1. International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12:

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Also relevant are Article 7 (family related health rights of women and children) and Article 10 (safe and healthy working conditions) of the ICESCR.

General Comment 14: This law is elaborated in General Comment 14 , adopted in year 2000 as consisting of three inter-related and partially overlapping obligations:

(a) The obligation to *respect* which requires the governments to refrain from denying or interfering, directly or indirectly, with the enjoyment of the right to health by any individual or group mentioned hereunder;

(b) The obligation to *protect* which requires the governments to take measures that prevent third parties from interfering with the health rights mentioned herein; and

(c) The obligation to *fulfill* which requires the governments to facilitate, provide and promote the health rights mentioned herein, by adopting appropriate legislative, administrative, budgetary, judicial, promotional and other measures.

This General Comment is a detailed 10 page document which requires to be studied and complied with by state and central authorities.

The case for a law on Right to Healthcare emanates from the third obligation of the General Comment. For those who believe in federalism , it is important to have a state law rather than a national law, though there are national obligations to enable states to meet their obligations. The Clinical Establishments Act and laws against commercial determinants of ill health gains legal legitimacy from the obligation to protect and respecting the right to health.

2. Convention on Elimination of All Forms of Discrimination Against Women (CEDAW), Article 12:

"1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

Also relevant are Article 10 (educational information to help to ensure the health and well-being of women and families), Article 11 (occupational safety of women and maternity

benefits) and Article 14 (health of rural women) of CEDAW.

3. Convention on the Rights of the Child (CRC), Article 24:

"1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries."

Also relevant are Article 17 (access to information aimed at the promotion of the child's well-being and physical and mental health), 23 (health of children with disabilities), Article 25 (periodic review of care, protection or treatment of physical or mental health of a child),

Article 32 (protection from occupational hazards and economic exploitation), and Article 39 (physical and psychological recovery and social reintegration of a child victim).

4. Convention on the Elimination of All Forms of Racial Discrimination (CERD) Article 5:

"In compliance with the fundamental obligations laid down in Article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: …

(iv) The right to public health, medical care, social security and social services;…"

5. Convention on Rights of Persons with Disabilities, Article 25:

"States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall: Provide persons with disabilities with the

a. same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

b. Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

c. Provide these health services as close as possible to people's own communities, including in rural areas;

d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

e. Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted

by national law, which shall be provided in a fair and reasonable manner;

f. Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability."

6. International Health Regulations 2005.

Obligations of being signatory and ratifying international law to which India is a party:

A signatory nation formally agrees, in principle, to the standards set by that treaty/ covenant/ convention. By ratification(accession) it formally confirms and agrees to 'implement' and bring into real practice, it's terms according to the series of obligations and enforcement mechanisms established therein. All conventions/treaties create a 'Committee' as a 'Treaty Monitoring Body' or an oversight body for ensuring enforcement by the ratifying nations. Countries that are members of a convention ('States Parties') are obligated to report on a periodic basis to its respective treaty monitoring body to provide information on their national compliance with the convention. For example, the reporting procedure of the CESCR (Committee under the International Convention for Economic, Social and Cultural Rights – ICESCR) requires States Parties to file an initial report within two years of the Covenant coming into force and thereafter every five years, or at any other time the Committee deems appropriate. Once a treaty monitoring body/ committee has considered a report submitted by a government and any additional information on treaty compliance brought before it also by non-governmental bodies of that country (called Shadow Report), and discussed the report with the representatives of the reporting government, it issues its 'Concluding Observations' for that country, recording the achievements of the reporting State in taking action to bring its laws, policies and practices in compliance with the obligations under the treaty. The Committee also records its concerns with lack of compliance with the treaty by that State.

To assist countries in fulfilling their obligations, treaty-monitoring bodies also develop a series of 'General Recommendations' or 'General Comments' explaining the content and meaning of duties that arise under treaty articles. For Right to Health it is General Comment 14.

A signatory country's obligation under the law require it to fill the gaps in its legal system so that all the standards in the treaty/ covenant/ convention are effectively in place and practice and are not breached in omission. This would mean reviewing all laws and policies of the country to bring them in line with the treaty/ covenant/ convention and amending or bringing in new laws as needed and taking measures against any action or practice that

contravenes it.

7. International Declarations with relevance to Health Rights:

The most important declarations are the Universal Declaration of Human Rights (1948) the Declaration of Alma Ata (1978), Declaration on the rights of mentally retarded persons (1971), Declaration on the Rights of Disabled Persons (1975), Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991), Declaration on the Elimination of Violence against Women (1993), Declaration on the Right to Development (Vienna Declaration and Programme of Action) (1993), Programme of Action the International Conference on Population and Development (ICPD, 1994, Cairo),International guidelines on HIV and human rights, 1997,Millennium Development Goals (MDGs 2000), Declaration of Commitment on HIV/AIDS, 'Global Crisis-Global Action' (2001). There are many others.

While declarations are not legally binding, they do form a commitment of the government and can be used to persuade governments. National Courts and executive can also use it frame or interpret laws.

Section 2. National/Domestic legal system for recognition of health rights in India:

There are three sources of legal recognition of health rights within India- the Constitution, Acts passed by legislatures of central or state government and judgments of Supreme Court and High Court, that have the same status as an Act.

A. Constitution:

The Constitution does not make healthcare a fundamental right. However, they are part of the Directive Principles. These are not enforceable by any court, but the principles are fundamental to governance and it was to be the duty of the State to apply these principles in making laws.The founders of the Constitution expected these to become legally enforced rights within 10 years of adoption of the Constitution, but till today, they remain more of a guiding principle.

All the relevant Directive Principles have relevance for Right to Health through the principle of social justice. For the Right to Healthcare the most relevant are:

- 47: Duty of the State to raise the level of nutrition and the standard of living and to improve public health,
- 48. Provision for just and humane conditions of work and maternity relief: The State shall make for securing just and humane conditions of work and for maternity relief,

- 49. provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement.

B. Central and State Acts:

There is no central or state right to health Act. However, there are many Indian laws covering selective aspects of right to health and health care. To list:

Epidemic Diseases Act, 1897; Drugs and Cosmetics Act, 1940; Drugs (Control) Act, 1950; Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954; Maternity Benefit Act, 1961, Registration of Births and Deaths Act, 1969; Medical Termination of Pregnancy Act, 1971; Water (Prevention and Control of Pollution) Act, 1974; Narcotic Drugs and Psychotropic Substances Act, 1985; Air (Prevention and Control of Pollution) Amendment Act, 1987; Mental Health Act, 1987; Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988; Transplantation of Human Organs Act 1994; Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994; National Environment Tribunal Act, 1995; Persons With Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995; National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999; Cigarettes and Other Tobacco Products Act, 2003, Food Safety and Standards Act, 2006, Clincial Establishments Act (2010), Rights of Persons with Disabilities Act, 2016, Mental Healthcare Act, 2017, National Medical Commissions Act 2019, National Commission for Allied Healthcare Professions Act, 2021, National Nursing and Midwifery Commission Bill, 2022, (List- not exhaustive)

In addition there are Public Health Acts in 6 states: Tamil Nadu (1939),Andhra Pradesh (1939), Madhya Pradesh(1948), Goa (1985) Uttar Pradesh(2020), and Hospital and Clinical Establishment Registration and Regulation Acts in different states; laws to deal with negligence like Consumer Protection Act also relate to healthcare.

C. Court Judgements:

Many Supreme Court Judgements that provide for a Right to Health and Healthcare. These are largely based on article 21 or article 14.

1. Article 21 of the Indian Constitution states:***" Protection of life and personal liberty: No person shall be deprived of his life or personal liberty except according to procedure established by law."***Through several judgments Supreme Court has expanded the

fundamental right to life guaranteed under Article 21 of the Constitution into an overarching right under which several other positive rights are subsumed as necessary components of life. The Right to health care is one of these. Some landmark judgements in this regard are:

Francis Coralie v. Union Territory of Delhi (1981) I SCC 608: (AIR 1981 SC 746) that the right to life includes the right to live with human dignity and all that goes along with it namely, the bare necessities of life such as adequate nutrition, clothing and shelter over the head and facilities for reading, writing and expressing oneself in diverse forms, free movement and commingling with fellow human begins.

Chameli Singh v. State of U.P. (1996) 2 SCC 549: "Right to life guaranteed in any civilized society implies the right to food, water, decent environment, education, medical care and shelter… All civil, political, social and cultural rights enshrined in the Universal Declaration of Human Rights or under the Constitution of India cannot be exercised without these basic human rights."

Paschim Banga Khet Mazdoor Samity and others v. State of West Bengal and another, 1996): "Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. … Article 21 imposes an obligation on the State to safeguard the right to life of every person. … The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in a violation of his right to life guaranteed under Article 21."

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

Other relevant rulings are:

- R**ight to health is a fundamental right** was held in CESC Ltd. vs. Subash Chandra Bose, (AIR 1992 SC 573, 585);
- **Everyone is entitled to adequate health care** was held in Mahendra Pratap Singh vs. Orissa State AIR 1997 Ori 37;
- **Health and health care of workers is an essential component of right to life** was held in CERC vs. Union of India, (1995) 3 SCC 42 and Kirloskar Brothers Ltd. vs. Employees' State Insurance Corporation, (1996) 2 SCC 682, and in State of Punjab and others v. Mohinder Singh Chawla and Ors 1997 (2) SCC 83;

- **Right to health care of government employees is integral to right to life** was held in State of Punjab vs. Mohinder Singh Chawla 1997 2 SCC 83;
- **Emergency health care as fundamental right to life** was held in Paschim Banga Khet Mazdoor Samiti vs. State of W.B. (1996) 4 SCC 37.

2. **Article 14 of the Indian constitution states that *"The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India." This provides a special space for social justice to address health inequities.*** There is a duty of the state to ensure that deprived and marginalized sections also have an equitable access to quality health care. Judicial pronouncements from the Supreme Court as well as the High Courts of the country have left no doubt that it is not merely "formal" equality that the Constitution guarantees. Mere formal equality would mean that the society would simply reflect its extant hierarchy and order in the distribution of resources and would oblige the state to only be responsible for treating all persons in the same manner, based on objective standards. Social justice requires "substantive" equality which calls for affirmative action, positive discrimination when dealing with unequals. This makes it the government's responsibility to ensure that the systemic, socio-economic vulnerabilities, e.g., of women, children, rural populations; and historical conditions of disadvantaged classes of persons, e.g., scheduled classes and tribes have substantive access to health care and similar health outcomes. Therefore Article 14 must be interpreted to ensure access to healthcare even where due to problems of lack of information, affordability or social exclusions, marginalized sections are unable to access care. This principle also flows from Article 15 (right to non-discrimination), Article 17 (abolition of untouchability); Article 23 (prohibition of traffic in human beings and forced labour); and Article 24 (prohibition of employment of children in factories, etc.).

   Court rulings in this regard are many and often relate to special groups like those with mental illness or disability.

Justiciability of government and of private sector:

Any violation of a fundamental right, which can be attributed to the government's action or inaction, can be taken to the constitutional courts (Supreme Court and High Courts) through Writ Petitions under Article 32 and 226 of the Constitution respectively. However, the fundamental rights cannot be ordinarily invoked against a private person or body. This makes it possible to address denial of care by an public institution, but it makes it difficult to invoke this against a private provider.

Annexure 2

How Thailand Achieved the Right to Health Care

(while Tamil Nadu did not!)

In the nineties, the achievements of Tamil Nadu state and of the Thailand nation were similar. Both have a similar population size (In 2022- Tamil Nadu 7.65 crores & Thailand 7.17 crores) Both had continued to invest in public health services, both had not gone by the advice of the World Bank and its structural adjustment program. Both had a commendable network of primary health care services. Both had a Public Health Act in place. In fact Thailand health authorities were quoted as saying that they had learnt from Tamil Nadu and Kerala about strengthening public health services. Both benefitted from increased government investment in the first decade of the 21st century, with the NHM in India helping Tamil Nadu health sector. But here the comparison ends. Whereas Tamil Nadu opted for a World Bank loan, a selective primary healthcare approach and a market based insurance, Thailand opted for a National Health Security Act , built a non-market, public provider centered, comprehensive health care approach. Thailand today is the world's most successful universal healthcare system and achiever of health care rights not only in the third world but in the entire world.

Much of the reason lies in the National Health Security Act that Thailand adopted in 2002, and as part of this put in place its Universal Coverage Scheme. In the first few years, each person had to pay about 30 Baht (about Rs 60) for treatment for each illness, and for registering with a primary health centre - with the slogan was - "30 Baht pays for everything." This meant that if a family paid 30 Baht (about Rs 50) they become part of the Universal Coverage Scheme and gain access to ALL healthcare services- ranging from a common cold to a kidney transplantation surgery. When the next government came, they removed even this minor payment of 30 Baht. But people are fond of that slogan - because from that day they began to enjoy universal healthcare as a right.

Thailand delivers the persons' right to healthcare services through 9762 public primary health centres and 918 public hospitals all of which provide comprehensive health care. A public primary health centre (much like Tamil Nadu's health and wellness center) would be having three to four nurses or mid-level care providers with three years training and be catering to about 5000 population. This is supplemented by a small number of private

hospitals - most of which are contracted for a few select high end services. If the health condition cannot be treated at the primary health center, they would be referred to the district hospital, but even at higher hospitals, the treatment would be assured and free.

There are three insurance schemes that "reimburse" pay these healthcare providers centres. Of these the Universal Coverage Scheme is the largest and covers 72 percent of the population. The others are an ESI like insurance scheme for organized workers which covers 18 percent of population and an insurance scheme for government employees which covers 8 percent of the population.

The National Health Security Act has five features that make this possible.

1. *Coverage:* Firstly under its clauses 5 to 7 of the Act, every resident not covered by other insurance schemes is considered eligible for universal coverage scheme and has to be registered in the neighbouring primary health center to be entitled to its benefits. In case a patient comes who is not eligible and registered, that registration becomes the responsibility of the health team. There is no area without a PHC offering coverage.

2. *Range of Services*: Secondly the PHC provides comprehensive healthcare services, and this includes referral to district hospital if they do not have the medicines or skills for the care. The referrals to district hospital and from district hospital to the higher facilities are free. The act provides that the services to be made available and the costs and quality of such services are to be defined by a Board. All services are considered included, but exclusion can be defined along with justifications. The composition of the Board is also defined by the Act.

3. *Financing:* To ensure zero out of pocket expenditure, every provider, whether public or private who is part of this scheme is *entitled by law* to be reimbursed the costs of care as decided on a fair and transparent basis.

    a. Reimbursement of care is based on three pathways:

        i. For high value technology intensive services it is on a fee for service basis.

        ii. For in-patient care the current years budget is based on the basis of last years caseload- numbers and category of cases.

        iii. For outpatient care the budget is based on the population served as adjusted for the age of the population and the prevalence of

some chronic illnesses that cost more to treat.

b. Global budgets: These are the basis for calculating the budget, but the budget is given as a lumpsum and this allows the facility managers to decide on how best to use it. Medicines are procured from a government outlet and human resources part of the budget flows through the treasury. There is some incentive for collective achievements- but no pay for performance approach.

c. National level Financing : On a similar basis districts are allocated funds by the NHSO and the NHSO is allocated funds by the Finance ministry. Therefore financing is very responsive to needs and there is neither excess allocation in some place, nor wastage in the other places. At a public health expenditure of 3% of the GDP and a public share of total health expenditure at 75% this is one of the world most efficient achievements of universal healthcare.

d. Private sector participation: Any private sector unit willing to participate at these costs and conditions are welcome. About 5 percent of primary care providers are private, mostly not for profit. In the high value services many corporates also participate. Most private sector units keep out, but these cater mainly to medical tourism and to very well to do patients.

e. Linkages with other insurance schemes: It is worth noting that patients of the other two insurance schemes (for government employees and for organized workers) can also seek care at these centers. The care will be free for the service users but the bill will be sent to respective insurance schemes. If the service user is a non-Thai migrant worker, the bill is sent to the insurance scheme for such workers which is managed by the department.

4. *Grievance redressal:* There is a grievance redressal system which is very active- and any denial or excess charging can be reported and this will be looked to. If found valid, then even without attributing blame to anyone a compensation is paid. 1 percent of the budget allocation is for such compensation. Though the sum may not be much, the process and acknowledgement of the denial helps keep the system efficient and accountable. This is also popularly known as article 41- the no-fault liability clause.

Community and Civil Society Involvement: There is active involvement of civil society in the national boards and in the district level committees and in facilitating local grievance redressal and service delivery. Community feedback is sought through district, provincial and national health assemblies.

End Notes:

Chapter 2

1. For more on country status internationally with respect to Right to Health and Healthcare refer to a study by: University of California - Los Angeles. (2013, July 19). A constitutional right to health care: Many countries have it, but not the U.S.. ScienceDaily. Retrieved November 21, 2022 from www.sciencedaily.com/releases/2013/07/130719104927.htm. The study found that 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 countries (11 percent) aspired to it.

2. Over the past decades, the international legal community has established a legal obligation for states to provide their citizens with access to health care and medicines through three legally binding treaties and conventions. These obligations were first established through the 1946 Constitution of the World Health Organization, the 1948 Universal Declaration of Human Rights, and the 1966 International Covenant on Economic, Social and Cultural Rights. For more on these obligations under international law to have a Right to Health refer to the document by: OHCHR, The Right to Health, 1, Retrieved November 21, 2022 from https://www.ohchr.org/documents/publications/factsheet31.pdf.

See also annexure 1.

3. For obligations under national law in India to have a Right to Health Act refer to the National Health Systems Resource Centre document, which examines the current Constitutional provisions concerning health and prior supreme court rulings to make the case for a right to health act, for the requirements under Indian national law to have such a law. Retrieved November 21, 2022 from http://qi.nhsrcindia.org/sites/default/files/Chapter%205 Right%20to%20Health%20Indian%20Legislations%20%26%20International%20Documents.pdf

See also annexure 1.

Chapter 3

4. Read the General Comment 14 of the ICESCR- which elaborates in full the meaning of

Right to Health as understood under this binding International Treaty with a commentary, 70 The Right to Health CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) CESCR (Committee on Economic, Social, and Cultural Rights). 2000.). 11 August. Doc. E/C.12/2000/4. Retrieved November 21, 2022 from https://www.ohchr.org/en/ resources/educators/human-rights-education-training/e-general-comment-no-14-righthighest-attainable-standard-health-article-12-2000

See also annexure 1

Chapter 4

5. The first public health law passed in India during colonial rule was the Tamil Nadu Public Health Act of 1939, which was intended to promote the health of those living in Madras province. This law has undergone numerous revisions to better it and take into account societal advancements. This ground-breaking Public Health Act has tremendously aided in the development of the current infrastructure and success of public health care provisioning in Tamil Nadu. Retrieved November 21, 2022 from https:// www.indiacode.nic.in/bitstream/123456789/13300/1/ the_tamil_nadu_public_health_act_ 1939.pd

Andhra Pradesh has also the same law in place, but amended by the state and different times. Since then Goa, Madhya Pradesh and Uttar Pradesh have also passed public health acts.

See annexure 1.

For a summary of Thailand's system one could refer to

1. Health systems development in Thailand: a solid platform for successful implementation of universal health coverage: Viroj Tangcharoensathien, Woranan Witthayapipopsakul, Warisa Panichkriangkrai, : Walaiporn Patcharanarumol, Anne Mills, www.thelancet.com Published online January 31, 2018 http://dx.doi.org/10.1016/S0140-6736(18)30198-3

2. The Kingdom of Thailand health system review; Health Systems in Transition, Vol. 5 No. 5 2015; Asia Pacific Observatory on Health Systems and Policies; World Health Organization Regional Office for the Western Pacific; World Health Organization 2015

For Costa Rica's health system a very useful description is in

1. Pesec M, Ratcliffe H, Bitton A. "Building a Thriving Primary Health Care System: The Story of Costa Rica." Case Study, Ariadne Labs, 2017

2. Amelia VanderZanden, Madeline Pesec, Melinda K. Abrams, Asaf Bitton, et al,

What Does Community-Oriented Primary Health Care Look Like? Lessons from Costa Rica; Case Study, March 21, 2021; https://www.commonwealthfund.org/publications/case-study/2021/mar/community-oriented-primary-care-lessons-costa-rica

For Cuban health system refer to:

1. Ronn Pineo: Cuban Public Healthcare: A Model of Success for Developing Nations; Journal of Developing Societies 2019 35:1, 16-61

For all of the above – another good source is "Good Health at Low Costs" Halstead SB et al, Rockefeller Foundation, 1985. and "Good Health at Low Costs- 25 years on" What makes a successful health system? London: School of Hygiene and Tropical Medicine, 2011,

Chapter 5

For more on these aspects of the Political Economy of Health Care, two essential readings that express it best are:

1. Arrow, K.J." Uncertainty and the welfare economics of medical care' American Economic Review, 1963.. (this paper is widely cited and re-printed by many other journal and publications)

2. Julian Tudor Hart, Political Economy of Health Care, Policy Press, 2010, University of Bristol, Bristol.

Chapter 6

1.The international and national legal basis for calling for legislation is given in some detail in annexure 1.

2. The issue of whether a right to healthcare law should be a state law or a central law has been the object of much debate since the first draft bill was put up in 2009. Subjects under the central list and the concurrent list can come under a central law. However subjects on the state list should not. One way to get around this, is for a central law that is in fulfilment of India's international obligations under the treaties it has signed, notably the ICESCR Many nations have acceded to the ICESCR with the reservation that due to its federal system it cannot enforce this across states. India's accession to this convention did not make such a reservation. India also has the option of a constitutional amendment to bring healthcare under the concurrent list and then legislate a law on healthcare. However democratic opinion hesitates at giving the central government such powers.

Another approach is for a central law that is drafted because 4 or more states requested

the central government to do so on their behalf. If this is done, then state governments who want to adopt this law can join by passing a resolution in the state legislature, and those who do not want to do so can make their own law or not have any law at all. The Central Clinical Establishments Act of 2010 has followed this route. Implementation by the centre, and by the states who have acceded to it has been very poor. But states who have made their own law or not made a law have not done any better.

A third is to make a model law and leave it to states to adapt and adopt it. In today's context this would be an useless gesture. However if High Courts or Supreme Court steps in to make its judgement to enforce provisions of this law or call for state legislation or is state human rights commissions does so, it could be useful. A state like Tamil Nadu making a legislation which is successfully implemented can have the same effect.

Chapter 8

Each of these rights listed in this chapter is important on its own merits- and does not need to be linked to other rights under the Act. In legal literature and in health policy and systems studies there are many useful definitions of each of these rights and considerable elaboration of the legal provisions that would be required, a number of national and international legal precedents. For reasons of brevity, we have not given these references, but could be made available on request.

Do note that in Thailand, most of these "human rights aspects" of health rights are part of a Right to Health Act of 2009 which is distinct from the National Health Security Act of 2002 (NHSA, 2002). The latter, NHSA, 2002 pertains only to issues of access to healthcare.

Chapter 9

The approach to making a law such that it lends itself to actual realisation of the rights is based on the Thailand experience and Thailand's National Health Security Act of 2002. It is worth noting that the law itself does not talk of whether it would be public or private sector and what would be the organization of services. The legal position is that the law is equally open to it being a public or a private provider. However in practice, because of the conditions for getting empanelled, the insistence on preventive and promotive care being included in the package, the insistence on all care being free but against the promise of reimbursement, and the fairness of costs of care reimbursed combine to make it attractive to only the government provider and the not-for-profits. Further the act of registration with the local primary care provider, becomes the guarantor of realization of healthcare rights. In some way or other most countries which have ensured right to healthcare whether it is

Cuba or Costa Rica or the UK, or most European nations- all have a similar organization of care and delivery of the entitlement

Chapter 10

The definition of primary health care is from WHO's "World Health Report 2008- titled Primary Health Care- Now more than Ever."

For more on Health and Wellness Centers read the details of the Ayushman Bharat Health and Wellness Center program as available on the websites of NHSRC, NHM and the National Health Portal. For a policy level and evidence based understanding of its design read the report of the Ministry of Health and Family Welfares "Report of the Task Force for Roll out of the Comprehensive Primary Health Care" 2016 and the "National Health Policy, 2017."

For a report of the subversion of comprehensive primary health care by selective healthcare there are many sources. As a sample of such work, one could read:

1. M. Cueto, The origins of Primary Health Care and Selective Primary Health Care: American Journal of Public Health | November 2004, Vol 94, No. 11

2. There is also a Lancet's special issue in the 30th anniversary of Alma Ata Declaration- Volume 372, Number 9624, September 13th, 2008, especially article, 1, 4 and 8 in the series.

For an evaluation report on Tamil Nadu's early and very positive experiences with Health and Wellness Centers read VR Muraleedharan's Report:

Chapter 11 and 12

Tamil Nadu has formally agreed to upgrade all its existing sub-centres and PHCs to become Health and Wellness Centres. However this has happened only in name. There is no effort to meet the standards in terms of both range of services and the staff that HWCs should have. Moreover, Tamil Nadu already had a shortage of staff at the frontline level and had failed to expand the number of its sub-centers and PHC in line with the growing population and needs. Part of the problem is that the rapidly growing urban areas do not have matching primary healthcare development. Often urbanization is by incorporation of rural areas, but the health infrastructure may not come along with it. All of these factors have led to a growing gap.

For many decades, Tamil Nadu along with Kerala, has been considered the leader in health sector achievement. The public health cadre and the directorate of public health remains

largely focussed on reproductive and child health, and within this care in pregnancy and has been reluctant to learn and move into universal access to NCD care. Though a good start has been made for diabetes, hypertension and a few cancers this is far from enough. Thus in a number of areas, Tamil Nadu is no longer considered the leader in healthcare achievements, and its rank has been dropping. Mortality in the 15 to 60 age group, especially among males is now very high and the costs of healthcare and impoverishment due to healthcare are also rising.

Chapter 13

The suggestions in this chapter are all practical measures to expand the range of services provided in the HWCs. One of the bottlenecks to achieving this, is the need for a greater understanding and coordination between the directorates of public health and the directorate of medical services. There is considerable inertia in this level with the directorate of public health, preferring to remain in a selective care mode.

Chapter 14

In most states there is insufficient number of specialists. Tamil Nadu must be congratulated for having relatively solved this problem, at least at the level of district hospitals and medical colleges, through very state-specific policies in post-graduate education and postings. However the efforts to take advantage of this positive situation and make such specialists part of a continuum of care with the primary care provider remains very weak.

We also note that serious imbalances of staffing in the public hospitals, especially a lack of nurses and support staff and general duty medical officers leads to problems in quality of care and in their ability to provide support and lead the district health system as a whole.

Chapter 15

There are many options for quality accreditation available in India. In private sector, the NABH is the most commonly used. However this is costly and not transparent, and there are institutional challenges with the QCI. The much better option is the National Quality Assurance Scheme, launched by NHSRC, under NHM. However we caution that accreditation as such could have limited gains. What is more relevant is the understanding of quality in healthcare that it brings about, and how the quality dimension of healthcare becomes visible and actionable. Tamil Nadu has made some very good initial steps in it. But to take it to scale it has to build up a much larger team of quality auditors, management support for quality improvement and a state level institution that ensures that all government

health care facilities are scored for quality and constantly participating in quality improvement. Legislation would help achieve this. This quality accreditation process can also be used skilfully to ensure that patient care in the public hospital is more patient centred and patient-friendly.

Chapter 16

Tamil Nadu has built up a large network of government medical colleges, which is already adequate for its needs. Its state policies have also led to a situation where there is no shortage of qualified persons available for recruitment in government services. It also has a large and growing number of private medical colleges which charge exorbitant fees. Many of the graduates of these colleges are struggling to establish a successful practice or get employment. The frontier of reform in Tamil Nadu is not increase in numbers but ensuring that the graduates have the necessary competence, professional ethics, and the spirit of public services. Because of excessive commercialization and centralization of policies, this has become difficult. These issues have been touched upon, but need to be discussed in more detail. (A useful reference is the article in Frontline : Skewed vision- Healthcare education in the New Education Policy. Sundararaman, Frontline July 19th, 2019)

The nursing and paramedical workforce has problems similar to that of doctors and specialists. There is an excessive production and not enough scope for public employment. The private sector systematically under-pays nursing and paramedical workforce.

Chapter 22

The strategy suggested by the policy brief, is to keep the Tamil Nadu Clinical Establishments (Regulations) Act (TNCEA) out of the Right to Healthcare Act and restrict its (TNCEA) scope to the private sector. The discussions on the possible amendments to the current TNCEA have been touched upon, but these need to be taken up for discussion and negotiations separately with the concerned stakeholders. However we do note that the General Comment 14, of the International Covenant specifically makes it an obligation of the government to protect people's health from excessive charges or unethical practices or poor quality of care in the private sector.

Chapter 23

This policy brief takes the position that while the participation of the private sector in health care delivery is welcome and the Act should provide space for private sector joining in, it is neither feasible nor desirable to force this through legislation. Current forms of securing private sector participation (public private partnerships and health insurance)

have not performed well. Further, our current understanding is that while one can demand judicial action against a public institution that denies health services to any person, the same demand is not possible private citizens or organizations. Or in other words the right to healthcare is enforceable only with public institutions.

Chapter 24

this ideological bias against public services is a feature of the neo-liberal discourse, and often a ploy to promote privatization. Over three decades of neo-liberalism, such thinking is widespread even in the middle class. This has to be countered with facts. But while doing so, one has to be alert to many valid reasons why private services are opted for and address these barriers. Jan Swasthya Abhiyan (Makkal Nalvazhvu Iyyakkam) has a number of publications detailing the problems of public services and how these are to be addressed.

Chapter 25

The Right to Healthcare deals only with procurement and distribution and access to essential technologies within the public health sector. Policies related to innovation and manufacture of drugs or to pricing and quality in private sector are/should be covered by separate legislation. However some of the key issues in these areas have been flagged in this policy brief.

Chapter 26 & 27

This policy brief has not gone into great detail into the different governance and enforcement mechanisms that are needed and the composition of the institutions to be put in place. It has only outlined some key principles for public discussion. The actual drafting of the Bill will have to convert these principles into suitable text. The focus of this Bill is in the organization of services that can delivery.

Chapter 28

The Right to underlying determinants of health are mostly in the Tamil Nadu Public Health Act of 1939 and its many subsequent amendments. Though this is not the main focus on this Policy Brief, we briefly touch on some of the issues therein so as to provide space for a parallel discussion on these determinants of the Right to Health.

Conclusion

The conclusion is also a summary. A very useful reference point for the philosophical understanding of the relationship of health to development, of its relationship to equity and social justice and the question of affordability at the current stage of development we

would refer readers to Prof. Amartya Sen's , the eminent Nobel Laureate's Keynote Address "Health in Development" , delivered to the 52nd World Health Assembly in Geneva, on 18th May 1990.

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