Contents lists available at www.innovativejournal.in

INNOVATIVE JOURNAL OF MEDICAL AND HEALTH SCIENCE

Journal homepage: http://innovativejournal.in/ijmhs/index.php/ijmhs

ISSN No. 2277-4939

# ENSURING HEALTH EQUITY THROUGH RIGHT TO HEALTH IN INDIA

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**ARTICLE INFO**

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**Key words:** right to health, public health reforms, health policy, human rights, healthcare system India

DOI:http://dx.doi.org/10.15520/ijmhs.2015.vol5.iss5.89.

**ABSTRACT**

**Abstract:** This review paper is an effort towards how the right to health is progressing in light of development health as a socially justiciable right have interacted throughout the progression of various health related policies and plans being implemented in India taking into account the preceding agendas of Indian health policies both the current and the future plans. Contribution of International health commitments in ensuing right to health in India. This paper would further deliberate right to health in the confines of Indian legal perspective. Deliberation on the bearing that right to health in accessing universal coverage programs already present in India. What paces are already covered if any and what could be done in identifying the lacunae in the health policies reform in India in terms of progress towards health equity through right to health.

**Findings:** It's high time to recognize that there is need to address the right to health in a way that is practical, realistic, and valid is crucial in the current scenario. There is a need to advocate right to health both in letter and spirit as it would expedite the process of achieving equity in healthcare. Right to health will put in force the need for policy changes in healthcare, which would be a huge leap in reconciling the legitimate plea of people for having a robust health care system that would meet their aspirations. There is significant need to establish right to health on socially just principles so as to make it valid and robust.

**Practical implications:** The outcome of this study, it is hoped, will contribute in bringing forth issues pertinent to right to health and how it will bring equity in terms of access to healthcare, which is deserved by every Indian citizen.

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## INTRODUCTION

The right to health at present been acknowledged as a fundamental human right and in foresight it will progressively be interweaved to combat against dangerous levels of poverty and starvation. A complication that comes in the enactment and implementation of economic, social, and cultural rights like the Right to health is the dearth of notional concepts and clarity. It is by no means clear precisely what individuals are entitled to under the right to health, nor is it clear what the resulting obligations are on the part of states(Toebes, 1999) .Many countries are now have initiated the process of rights-based approach in the legal system implementation and are in phase of ensuring right to health on federal and state level. Right to health has led to debates over its denial and anotherperspective advocating in its favor that it very beneficial for health care right from the inception of the concept. In light of recent rapid economic growth there is need to increase financial commitments for healthcare and it's backed by strong moral, social and economic justification for achieving equity for more than one billion Indians (Balarajan et al., 2011) .Right to health comprises of two dimensions underlying determinants like water, sanitation, food, nutrition, housing, healthy, occupational and environmental conditions, education information, etc. and healthcare(CESCR 2000).For right to health the existence of both these factors affect the society as they vary in terms of accessibility ,availability acceptability and quality in a society.

For enabling idea social justice, health equity is of having central critical importance. Health is amongst the utmost vital circumstances of human and any notion of social justice that's founded on requisite of nondiscriminatory distribution and enabling development of human capabilities cannot ignore the role of health in human life and the opportunities that persons, have to attaining good health – being devoid of avertable illnesses , preventable afflictions and untimely mortality (Sen, 2002). Poverty and hunger are the two critical hindrances of health that affect the health of millions of people will suffer irreparably can be tackled and overcome with success in the short, medium, and long-term(Schutter, 2008). Recent rapid economic growth provides for a unique opportunity to increase financial commitments to support the public health system and health systems research. In anticipation

of human rights a general consensus prevails that intention of human rights in general context is to be based upon the principle of equity and thus necessities the applicability to every human being .When consider nature of rights the "right to health" its assumed that no one has a moral human right to claim health unless everyone has one and that there is some common standard of health preservation to which everyone's human right entitles her (Sreenivasan, 2012). Intellectuals have a refined comprehension of civil and political rights but have botched up systematically to study and understand the significance of meaning and application of social and economic rights (Jamar, 1994) .In coherence with every other type of socioeconomic rights, for realizing the right to health it is essential that the current global order develops initiative in context to capacity to take constructive step the right to health .Globalization has increased the risk of exposure to an increasingly diverse types of health risks which can be averted by institutional reforms which could otherwise lead to consequentially adverse results like chronic disease, epidemics and an environment where the means of leading a dignified and healthy life are less possible (Evans, 2002).

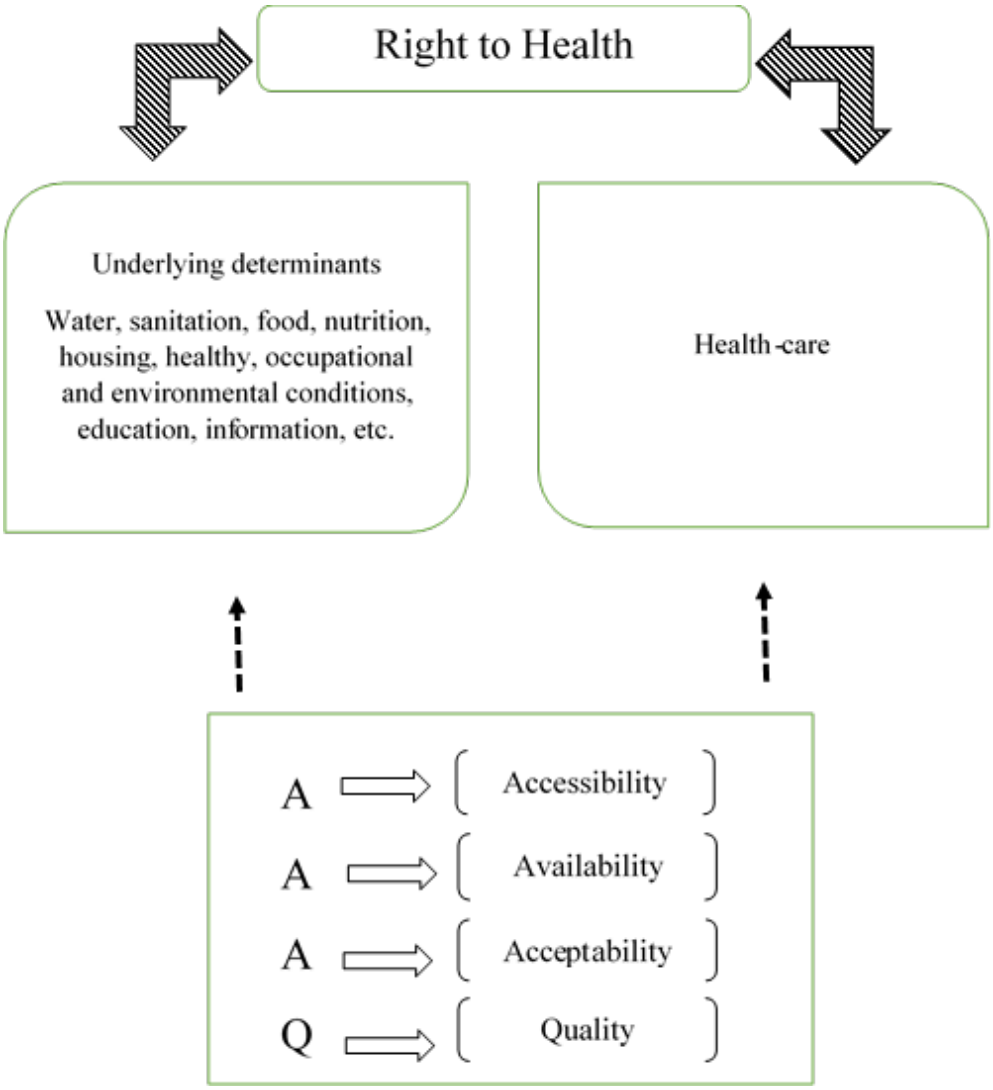


**Fig 1***Source: General Comment No.14 Committee on Economic, Social and Cultural Rights (2000)*

**Contextual Background**

Many developed and developing countries are having a national health system that entails everyone or certain segment of the population. Presently the Indian Health system is in transitory phase and its policies are being evaluated continually as it essentially influences one and all. The perceived health requirements of community have seen a dramatic increase coupled with the rising cost of health delivery system. India is unique in the aspect that it acknowledges diversity in the society which is comprised and at the same time divided by practices of castes, class-divide, social groups based on ethnicity, race gender and even on basis of belonging different states .Indian society is stratified into classes, castes and social groups based on ethnicity, race and gender. These different set of groups have associated with them various needs with regards to healthcare expectations and they concurrently aspire and compete for greater share of the allocated resources. Healthcare policy planners try their best to bring together the need of these groups and try to allocate the invariably limited resources, but this is expressed inevitably in the form of a major share for the dominant section of the society. Same can be observed at international level where in unequal power relations exist between different nations as direct consequence of which there is an unequal distribution of international health resources(Bajpai& Saraya, 2013).Different sections of the society can have different aspirations associated with healthcare system which sometime can be contradictory and competing, to remove such contradictions and ensure the principle of equity a ensuring right to health would go a long way in attempt to carrying out health for all. India is amongst the 135 countries that made Right to Education (RTE) that a

fundamental right and compulsory primary education for children between 6-14 years , this has had a dual effect in terms that parents now think it's their civil duty and also the education sector is receiving an increased attention (Mehendale, 2010), analogously Right to health could also do the same for the health sector .

Advances in medical technology have exponentially increased the average age of population globally thereby making health insurance more and more costly and this would make governments in quest for a seeking more viable cost-effective alternatives(Toebes, 2006).The WHO while framing Human rights essentially almost all of the human rights are considered negative rights, which imply that they are areas upon which society cannot interfere or restrict by political action, but right to health can be said to be a particularly distinctive and perplexing right because it's often rightly presented as a *positive right,* wherein the general public bears upon itself an onus to provide certain health resources and opportunities to the general population. India's population is estimated to be close to 1.24 billion, and it is growing at a rate of about 1.64% per year (MOSPI 2015). Contemporary Indian economy is great a capitalist with having's with huge indigenously originated multinational corporations that are in race with counterparts in developed countries, on the other hand a vast majority of Indian population is not able to earn 2$ which World Bank has defined as the minimum subsistence limit. The latest poverty estimate by India's Planning Commission puts the proportion of persons below the poverty line at 21.9%, or more than 269.3 million people (GOIPC, 2013). At the end of the day, in a country where 63 million people slip back into poverty due to catastrophic healthcare costs, it is hard not to see the logic of legally mandating health as a right, and thereby empowering the citizen to hold the state accountable for it (MOHFW, 2014).

Previous assessment is derived from a an extremely low level of monthly per capita consumption of based on Tendulkar Committee reports there was an annual average decline from 2004-05 to 2011-12 decline of 2.18% (percentage points per annum) . When we think through the fact that even after 60 years of planning 21.9% of the Indian population still lives at below subsistence level, it becomes evident that the planning has not been of much assistance to a major share population in any significant way instead of the steady decline in poverty levels. Gross national income (GNI) per capita 2011 Purchasing Power Parity was $5,150 which is comparatively low when paralleled to countries like China (PPP$ 11,477),Thailand(PPP$ 13,364) and Mexico(PPP$ 15,854) countries(UNDP, 2013). Globally India is ranked 135 in Human Development Index (HDI) and has been clubbed significantly lower amongst countries having medium developed HDI(UNDP, 2013).

| Country | Total Health Exp. per capita (USD) - 2011 | Total Health Exp. as % of GDP - 2011 | Govt. Health Exp as % of Total Health Exp.- 2011 | Life Expectancy at birth (years) 2012 |
|---|---|---|---|---|
| ***India*** | ***$62*** | ***3.9%*** | ***30.5%*** | ***66*** |
| Thailand | $214 | 4.1% | 77.7% | 75 |
| Sri Lanka | $ 93 | 3.3% | 42.1% | 75 |
| **BRIC Countries** | | | | |
| Brazil | $ 1119 | 8.9% | 45.7% | 74 |
| China | $ 274 | 5.1% | 55.9% | 75 |
| Russia | $803 | 6.1% | 59.8% | 69 |
| South Africa | $670 | 8.7% | 47.7% | 59 |
| **OECD Countries** | | | | |
| USA | $ 8,467 | 17.7% | 47.8% | 79 |
| United Kingdom | $ 3,659 | 9.4% | 82.8% | 81 |
| Germany | $ 4,996 | 11.3% | 76.5% | 81 |
| France | $ 4,968 | 11.6% | 76.8% | 82 |
| Norway | $ 9,908 | 9.9% | 85.1% | 82 |
| Sweden | $ 5,419 | 9.5% | 81.6% | 82 |
| Denmark | $ 6,521 | 10.9% | 85.3% | 80 |
| Japan | $ 4,656 | 10% | 82.1% | 84 |

**Table 1 Source:** ***Draft National Health Plan 2015, Ministry of Health and Family Welfare, Government of India, December 2015.***

India's health expenditure indicators assert the reason for being in bottom quartile of the world's countries in terms of public health expenditure. The above figures provide a grim picture of financing of Indian health sector when compared global peers or developed countries this even though the India experienced a significant economic growth in recent times . It's been observed health care needs are seldom met when health expenditure is 4% of the current Indian GDP while as globally acceptable a minimum 5 % to 6% of GDP is necessary to ensure that a bare minimum standards of healthcare are met.

There are 110 nation-states that have mentioned a reference toward right to health in their constitutions (Kinney, 2000).An assessment of constitutional rights to concerning education and health care in 187 countries revealed that out of 165 countries which had accessible written constitutional framework , 73 made a direct reference to a right to health care wherein right was guaranteed in the constitution and 29 amongst these assured of free health care and services for at the least subset of population(Gauri, 2004). This makes a compelling case for India which is proclaimed as the biggest

democracy in the world to ensure that right to health for its citizens

**An overview of India's health policies from the standpoint of right to health**

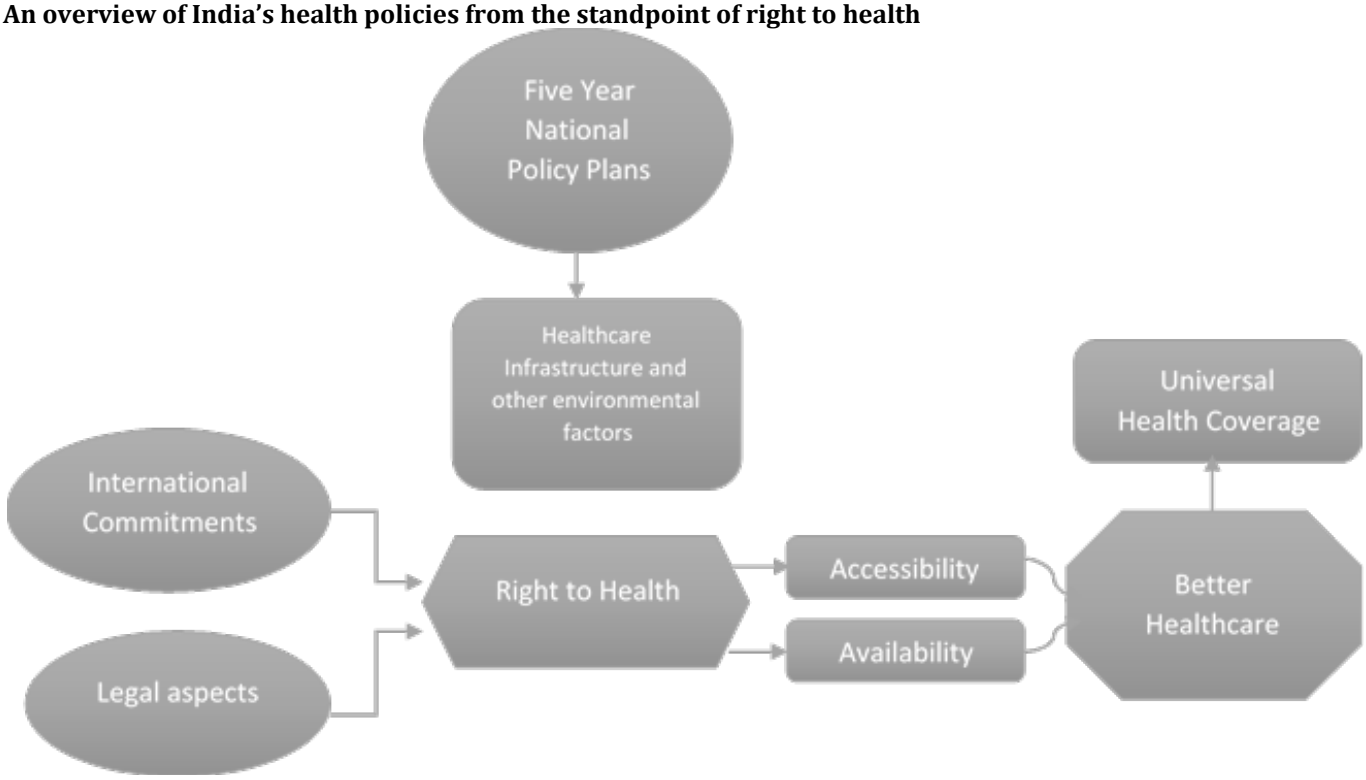


**Fig 2: Factors influencing right to health in India (Source: Developed by author)**

India's advancement en route to reduction of poverty faces a severe risk of slackening down due to the main reason - absence of apt access to healthcare due to the almost nonexistence of a well laid out public health policy(Subhashini, 2012).In order to completely understand Indian health policy a short selective discussion into the previous significant plans of India's health policy from past are to be brought forth. Effective policies are not perfected overnight, they are not one-dimensional nor can they originate in a single stint but they developed over a period as a result of direct or indirect interaction between the diverse agencies involved. They essentially need to be politically viable for execution and implementation on the intended scale. Health policies are no exception to this. It's substantially essential to trace the role of how stakeholders interact to various factors in social political context by studying them historically.Healthcare services of any country are largely impacted by the socio-economic development as well as political trends. To have a better understanding of how Indian Health Policies are shaping up towards realizing right to health its necessary to reconstruct the lessons from the preceding macroeconomic reforms in health sector and the issues that were confronted by it in achieving preferred effects and the asserts the reasons for their shortcomings .Tracing back India's health policy, the first initiative taken in India towards a broad general health framework was known as the Health Survey & Development Committee was started in pre independence India 1943 in form of Bhore Committee. In this report prominence was given to integration of curative and preventive medicine at all levels and made comprehensive suggestions for reshaping of health services in India. The report accentuated the need for a comprehensive and universal healthcare system for entire country .It was comprised of various recommendations prominently ensuring district level health scheme, provision for health organization to havea range of integrated health services that are curative, preventive, and promotive for the entire population. "Expenditure of money and effort on improving the nation's health is a gilt-edged investment which will yield not deferred dividends to be collected years later, but immediate and steady returns in substantially increased productive capacity"(Bhore, 1946). The landmark recommendations made by the Bhore Committee in 1946 continue to be relevant even today. But no steps were instigated to initiate these reforms, otherwise this could have been the essentially first and a major headway towards right to health.

Post-Independence for about first quarter-century i.e. till 1975 India's health sector was focused on managing epidemics. Large scale public campaigns were pledged by the governments to control the spread of epidemic diseases(Banerji, 1973) . Health policy planners in India conceived the development of health services combined with plans for tackling unemployment, malnutrition, social justice, housing and environmental sanitation(Banerji, 1985). Conversely, this seemed challenging to accomplish in practice.In the two decades after 1947, health planning was done by way of schemes and programmes that were formulated as part of 5-year plans. During this time several committees were formed to evaluate the achievements and failures of these programmes(Duggal, 2002).Structural outline of the Public Health delivery system in the first two Five-year plans (1951–1956) and (1956–1961) Five-Year Plans was much less the same and maintained at status quo . Urban regions were allocated more resources than rural regions but at the same time the latter received 'special attention' under the Community Development Programme (CDP). The Third Five-Year Plan (1961–1966), deliberated the complications affecting the provision of primary healthcare. With respect to health, the 5-year plans have

been high on rhetoric but have not been able to deliver on the ground. In the Fifth Five-Year Plan (1974–1979), the government recognized that the health infrastructure in urban regions was growing at the expense of the rural regions (Commision, 1974)and recognized that there was a need of social justice in terms of health. More resources were allocated to health development in rural India. A huge leap towards having a national policy for health happened on 1983 in the Sixth Five-Year Plan (1980–1984) with announcement of the first National Health Policy (NHP) which could regarded as first major step towards the transformation of India's rural health infrastructure. The signing of declaration of Alma-Ata on PHC in 1978(Alma-Ata, 1978) along with suggestions of the Indian Council of Social Science Research and Indian Council of Medical Research (ICSSR ICMR, 1980) prompted and influenced the National Health Policy. The government decided that 'an integrated, comprehensive approach towards the future development of medical education, research, and health services' was necessary(MOHFW, 1983). However no concrete plans evolved to implement the strategy of the Sixth Plan and it was only at the time of the Seventh Plan (1985–90) there was a evident policy change where in the platform for implementation of what is commonly referred to as 'Health Sector Reforms' was initiated in spirit. The Seventh Plan emphasized upon on greater efficiency, reduction of cost and improvement of quality of health services for all. It epitomized upon absorption of new technology, greater attention to economies of scale , greater competition and development of specialized care and training in super specialties in the both public and the private sectors'(Commission, 1985). Rural healthcare received special attention after NHP 1983 and in the two Five Year Plans i.e. Sixth (1980–1984) and Seventh (1985–1990) a massive programme of PHC facilities expansion was undertaken to increase the penetration level of PHC to one PHC per 20,000 to 30,000 people and one health sub-center per 2,500 to 5,000 people. It was a vital stride towards reinforcing health service accessibility for all.

Since early nineties till today the Five Years Plan are oriented towards the preventing resurrection of various communicable diseases and assessment of disease, manpower inadequacies in the health workforce, and other paucities. The Eights Plan (1992-97) started during the economic transformation, liberalization of market and was effected by economic crisis at that time. 'Health for All' as was envisaged by Bhore committee report renovated to 'Health for the Underprivileged' in the Eighth Plan in coherence of the structural adjustment policies (SAP) and Health Sector Reforms which were the vital components part of the philosophy of denationalization, globalization and orienting the health sector to market forces (Planning Commission, 1992).In coherence of SAP and new globalized economic policies in Indiaa uniform set of strategies were enforced that had been previously applied in Asia Africa and Latin America before being implemented in India and for getting international funding of health programmes through various agencies. Assessment of establishing of disease surveillance and resurgence of transmissible diseases in India in Eighth Plan .The Ninth Five-Year Plan also endorsed a of the 1983 NHP and was in consistency with the Eighth plan, with a focus not only on improving healthcare, but also on measuring and monitoring of the healthcare delivery systems and the health status of the population (Planning Commission, 2002) .Public schemes like Child Survival and Safe Motherhood (CSSM) programme transpired into the Reproductive and Child Health (RCH) programme originating from International Conference on Population and Development-Cairo agenda to which India was a party, this enabled external funding through various sources to deliver highly efficient and good quality integrated reproductive and child healthcare.The Tenth Five-Year Plan (2002–2007) concurred with simultaneously National Health Policy of 2002 which has distinction for being formulated after feedback from the public . The 2002 NHP endeavored into regulation of the private health sector through legislative licensing requirements and recommended incorporating of a referral system into along with stress on improving the various key health statistics. The Eleventh Five-Year Plan (2007–2012) following the trend of prior national plans put forth the need for generating investment for primary health care services. The Eleventh Five-Year Plan was piloted by National Rural Health Mission (NRHM), which was launched with the 2005/2006 budget in order 'to provide effective healthcare to the poor, the vulnerable and to marginalize sections of society throughout the country. In 2003 under the Jan SwasthyaAbhiyanpledged that Right to health should made a constitutional right for all the countrymen and women as it would be essential to attaining the goal of health for all(Phadke, 2003). The National Health Policies of 1983 was subsequently revised in 2002 and aimed at achieving an acceptable standard of good health by the year 2015 and strive to reach "Health for All" concept by 2020 by having it as "Vision 2020".

Policy of present Indian government in the National Health Policy Draft (MOHFW, 2014) envisages significant weightage to right to health .It goes to fully understand the implications of establishing right to health by emphasizing its significance in current scenario of the country. It's important to provide right to health while trying to achieve universal health coverage is being attempted via public or community health insurance because their premise is limited to "basic packages" that translate into limited and unequal access to and use. And this problem is compounded by the unfair distribution of social and geographical resources. Government have a tentative proposed framework which is envisioned to deliver policy commitments through right to health. It plans to introduce a National Health Rights Act which will make health a fundamental right and ensure that denial of access to healthcare will be justiciable.

A policy is only as good as its implementation. Past policies, have faced innumerable restraints in implementation but a unifying underlying agenda in all the health policies is that to have a health delivery system in which the entire population would have equal opportunity for public health resources. It can be assessed from the preceding discussion that right to health is in consistency with the core Indian health policy for health equity for everyone.

**Universal Health Coverage role towards right to health.**

Universal health coverage (UHC) through health insurance could be expedited and amplified from the implementation of right to health. The WHO (2012) excogitates that UHC is a pragmatic manifestation of the concern for health equity and the right to health .In India there are a number of publicly financed health insurance schemes that were introduced to improve access to hospitalization services and to protect households from

high medical expenses. Eight states in India have already introduced health insurance programmes for covering tertiary care need and over time as expenditures increased, many of these States (Andhra Pradesh, Karnataka, Tamilnadu, Maharashtra, etc.) moved to direct purchasing of care through Trusts and reserving some services to be delivered only through public hospitals. Insurance coverage The Central Government under the Ministry of Labour& Employment, launched the RashtriyaSwasthyaBimaYojana (RSBY) in 2008. The population coverage under these various is about 370 million in 2014(almost one-fourth of the population). Nearly two thirds (180 million) of this population are those in the Below Poverty Line (BPL) category. Evaluations reveal that public health insurance schemes such as the RSBY, have improved utilization of hospital services, especially in private sector and among the poorest 20% of households and SC/ST households .However there problem is information asymmetry among the beneficiaries about the entitlement, right to health would help them in recognizing these benefits and thereby filliping them towards better utilization of health services provided under health coverage.

Under right to health people expect health facilities same as in under UHC that provide the services they may need by to ending to the discrimination originating from direct payments affirming to the principle of equity(Ooms et al., 2014). It could be reasoned that large user base of publicly financed health insurance schemes enhances the protagonism for right to health in India. From a different angle right to health will strengthen the case of universal coverage for the society as it also would facilitate plummeting the burden on various public health insurance schemes by a putting all under a single umbrella of universal coverage scheme consequently reducing number of concurrent public schemes that are currently being implemented in Indian society which would lead to a reduction in state reduction of unnecessary burden on state health exchequer. Thereby it could be contended that right to health and universal coverage share a synergetic relationship.

**Global Commitments of India in perspective of Right to health**

In recent years there some remarkable developments in the field of progression of international human rights and the international community which was focused on classic political and civil rights like right to a fair trial, freedom of speech, etc. is since the late 1990s instigated towards giving more attention to economic, social and cultural rights – the rights to education, food and shelter, as well as the right to the highest attainable standard of physical and mental health (Yamin, 2005a). India being a country of global significance can't remain unswayed to these significant developments and is doing its part to considerable extent. Right to health is amongst falls in an array of socioeconomic rights which nations assent to under obligation of international laws ,but due to the nature of politics of rights the socioeconomic rights are seldom given treated on par with liberal freedoms that are associated with civil and political rights (Evans, 2002) . International aiding agencies with their funding have an impacted healthcare ideology in India and influence policymaking and program design right from the First five year plan(Duggal, 2002).Earlier it used to be through small quantum of money but now it's coming mostly in the form of soft loans .

WHO had conceived a concept of "Health for all" in 1946 constitution of the World Health Organization and was successively endorsed in 1978 at International conference on Primary Health care in Alma Ata. The right to health was enacted under the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights to become formally an international law 1976 (Wolff, 2012).The Alma-Ata declaration which was discussed earlier under Indian health policy requires states "people have the right and duty to participate in individually and collectively in the planning and implementation of their health care"(Alma-Ata, 1978, p. 1). This essentially advocates and transpires to a component of right to health by means of "health information" and "human rights information". India pledged itself for successfully putting into practice the resolutions arrived in the Alma-Ata Declaration by 2000 AD. India failed to reach the Vision Health for All by the year 2000 which was its target(Tarafdar, 2008). Besides this India is a joint party to a various international covenants wherein it would give it right to enact a national law ensuring right to health.

These core right to health obligations affect the "survival kit" or "existential minimum" which every person needs for survival and for leading a life in dignity and are listed in Article 38(1) (c) of the Statute of the International Court of Justice (ICJ). "(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups, (b) to ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone, (c) to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water, (d) to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs, (e) to ensure equitable distribution of all health facilities, goods and services, and (f) to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population" There are core basic but essential number of core obligations that are to be made out by all states, whether rich or poor. States parties cannot justify their non-compliance with the core-obligations set out, which are non-negotiable which consequentially transpires into Indian context by presenting a strong motivation for right to health.

**Legal Framework for the Right to Health:**

Having rights orientates and provides a solid-ground for an individuals to acquire information, benefit from of various public service delivery options, bring together local institutions and civil societies, and to take a legal recourse in domestic courts whenever necessary (Gauri, 2004).

Many nation-states, predominantly democracies of the west along with some developing nations, have setup in their constitutions an unequivocal right to health. Laws that govern health policy and its execution are present in India are already enacted in the constitution of the country. But with changing time and milieu, some laws have become have obsolete and need reviewing alongside enactment and evolution of new laws. It's sensed that there should process of aligning many of health sector related laws for

fulfillment of lacunae of comprehensive laws that encompass the various issues of healthcare for every citizen of India. Right to health will not only be in compliance of already present provisions in Indian Constitutions but will also reinforce the implementation of various healthcare policies. Making of right to health as a fundamental right by passing a legislation for right to health is a pivotal agenda on government health reforms. Enactment of right to health has been a primary enabling factor for economically comparable nations like Brazil, Thailand for progressing towards universal health coverage.

Indian courts have conceded in through several rulings that have a proclivity to proponent right to health as a fundamental right- and a constitutional obligation flowing out of the right to life. Having a right to health implies inducing in an individual a right to participate in choices influencing his or her own health and thereby associates health issues with an active participative social-citizenship. Besides this national acknowledgement of a right to health in case of the state will lay forth a binding guideline in ensuring equity in access to care and the necessities for health and while simultaneously ensuring the elimination of discrimination(Yamin, 2005b). The proposed National Health Rights Act is bound to guarantee health as a fundamental right, whose denial will be justiciable. States would voluntarily opt to adopt this by a resolution of their Legislative Assembly given their fiscal conditions.

**Criticism**

Detractors of right to health have a conventional perception with regards to right to health being impossible to be judiciable right since health is a natural process and thereby is an uncontrollable factor. They need to shun the approach of indefiniteness and relate right to healthcare, services or conditions as a socio-economic right the execution of which predominantly involves resource (re)distribution (Greco, 2004). The health policy planners : economists, administrators and elected representatives of the people need to commit predominantly to represent the welfare of society and only secondarily the interests of individuals (Curtin, 1980).

It's important to recognize that accessibility to healthcare is and must necessarily be a public service from which no person can be excluded as a matter of right(Halabi, 2009). 'Right to Health places a legal obligation upon the government and brings into focus the elements of responsibility and accountability' (Srivastava, 2015, p. 18).Right to health must be understood in the context of shared susceptibility of humans wherein everyone can develop illness or become injured or get infected by a contagious disease – it's a struggle to enable various elements that would enable a specific individual or a group to attain a fully one needs to and in the specific struggles for recognition of the plural ways of acting and being treated that enable individuals and groups to attain fully human status(Hayden, 2012) .Problems with implementation of right to health is aggravated by overall botch-up of socially mediated human rights where in Human right to health is relies on political framing that are inadequate due to being either catchall and even-handed or social stratum based and disbarring.

Some critics of right to health care advocate that right to health should not be considered a human right because of the ambiguity of defining what are the various elements it entails and how would one establish the minimum qualifying standard of prerogatives under the right to health .Barlow(1999) fosters this by deliberating that rights confer duties upon other people or agencies to shield or assure, and that it is unclear who's having the societal obligation for the right to health. Another fervid argument contradicting the making of healthcare a right as a policy one must consider that by doing so, rights are turned into entitlements .More stress should be laid on exerting in finding new policies that will lead to a healthier society rather than expecting healthcare system to do everything beneficial for the society(Lamm, 1998) . Right to health as it would require government to devote a large quota of its wealth to provide its citizens with it the healthcare that is established by right to health which is not possible in the current socio-economic order of socialism and capitalism. Its further asserted upon the universal healthcare is unachievable and we should strive for better health but right to healthcare is not the sole element that affect it other issues like restoration of family, peace, new economic order are also needed and they can't be classified under the right to healthcare (Loefler, 1999).

This criticism is denounced when health is contextualized in an equalitarian perspective on the basic premise responsible for inequality in health is caused by exposure to unhealthy living habitats, lack of accessibility to healthcare and other elements of public amenities or social mobility related to healthcare its unmistakably partial, this inequity controverts the fact that all human beings are of equal worth and that dominance, abuse and ostracism needs to be obliterated. It might be argued that health is personal responsibility for instance one can do damaging behavior due one's of lifestyle choices its more often then or not a result of marginalization and poverty that one might be forced to live with such life style choices.

There is a strong sense approving the right to healthcare for everyone but there needs to be a rationale on for claiming right to health as there are various circumstances where in there are other contributing factors that affect health of an individual. It would be unjust to practice the principle of equity if an individual's willful actions such as smoking, alcoholism to name a few result in ill health. There is need to limit the right to health and prevent the exploitation of the limited public resources thereby also making it more equitable in a just society. This could be achieved by categorizing the source of these health differences that would be a more equitable approach towards ensuring right to health. It makes sense to recognize these health disparities and classify them to determine the eligibility of right to health any ambiguity in recognizing them could lead to misappropriation of resources (Paula Braveman, 2014).

Health inequity has moral and ethical dimensions wherein there are some differences that are avoidable and unnecessary while others are unjust and unfair these need to be identified and judged in fair context of remaining population(Whitehead, 1991). The unavoidable unjust differences can be identified based on "1. Natural, biological variation.2. Health-damaging behaviour if freely chosen, such as participation in certain sports and pastimes. 3. The transient health advantage of one group over another when that group is first to adopt a health-promoting behaviour (as long as other groups have the means to catch up fairly soon).4. Health-damaging behaviour where the degree of choice of lifestyles is severely restricted.5. Exposure to

unhealthy, stressful living and working conditions.6. Inadequate access to essential health and other public services.7. Natural selection or health-related social mobility involving the tendency for sick people to move down the social scale."(Whitehead, 1991, p. 5). These could serve as a basis for eligibility of right to health. Implication of equity in health would necessitates a design of distribution of resources in ways that are consequentially more likely to even-out the healthcare for underprivileged social groups when compared to advantaged counterparts(P Braveman & Gruskin, 2003).

**Conclusion: Consensus or Symbiosis?**

Backing the promotion of the right to health in veracity is a contributing towards part of a globalized struggle for combating social injustices in form of unequal healthcare. Questionable health inequity and lack of accessibility to adequate healthcare services: essential medicines, diagnostic tests are perturbing annoyances that could affect everyone in all countries. The requirement of public resources by productive sectors of the economy is more urgent from the business perspective than the social sectors, hence healthcare sector gets only a residual attention by the state. By recognizing health as a basic of human right would likely do for what right to education did for education .If its realized a national goal It would also ensure that a right push towards increase spending on public health expenditure with is very essential for realization of proper healthcare infrastructure which will be a key in delivering health equity through availability, accessibility to quality healthcare. Various core issues that emasculate right to health are needed to be addressed by the state on priority basis so that all the segments of the population of a state are able to exercise the right to health for wellbeing (Wilson, 2009). For right to health to be a just and ensure that resources are distributed in an equitable modus one there is a need of understanding and defining health disparities and recognizing their sources for classification, which would eventually lead to an enhanced practical implementation of right to health rather than a blanket cover with no real value added to healthcare as proponed by some critics of right to health. From discussions on the various factors one can fairly ascertain that shape healthcare in India is still in considerably a dismal state and there is opportunities for lot of improvement achieve healthcare goals both in terms on national level and global commitments. Ahuman right to health will act as a fulcrum facilitating sustainability in ensuring healthcare equity if right is established.

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**How to cite this article:** Farooq Ahmad Khan, Ahmed Tauqeer Zahid. Ensuring Health equity through Right to Health in India. **Innovative Journal of Medical and Health Science**, [S.l.], v. 5, n. 5, nov. 2015. ISSN 2277-4939. Available at: <http://innovativejournal.in/ijmhs/index.php/ijmhs/article/view/89>. Date accessed: 17 Nov. 2015. doi:10.15520/ijmhs.2015.vol5.iss5.89.