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# Litigating the right to heath in India:

## Can litigation fix a health system in crisis?

Photo: The World Bank

There is a healthcare crisis in India. Health indicators are dismal. 25% of the world's maternal deaths every year, occur in India. 47% of all children in India are underweight. Health rights litigation has highlighted areas of dire need and provided a discursive space for petitioners and civil society groups to engage with government on health policy issues. Yet, it has failed to improve the persistent systemic failures that plague the Indian health system and make access to health care inequitable.

**STRUCTURAL CHALLENGES**

Total health expenditure in India is 4.5% of GDP. This ranks India153 out of 193 countries with respect to total expenditure on health per capita. 75% of health expenditure is private expenditure. Government expenditure on health is only a little over 1% of GDP. This has severe consequences in a country like India where 42% of the population lives below the poverty line, and an even greater proportion of the population relies on these scarce public health facilities.

Three chief failures in India's health policy have created the current health crisis. First, absence of a political commitment to realize universal health care. Second, a decline of institutional health capacity and absence of an integrated health infrastructure in India due to budgetary and policy priorities of vertical disease eradication programmes and family planning during the 1960s and 1970s. Third, implementation of piecemeal, ill conceived and cost ineffective disease eradication programmes instead of universal health care programmes.

On the few occasions (first in 1946 following the publication of the Bhore Committee Report and later in the 1983 National Health Policy) when the central government articulated a commitment toward the provision of universal health care, international organisations like the World Bank and the WHO opposed such policies. In line with the idea championed by

the WHO and UNICEF that "poor countries" should prioritize their limited resources on specific disease eradication programmes, the government implemented vertical programmes for eradication of diseases like malaria, tuberculosis etc.These disease eradication programmes have been acknowledged by the National Health Policy, 2002 (NHP) as both ill conceived and cost ineffective. Tuberculosis and malaria have not been eradicated and the creation of separate infrastructures for each programme has proved extremely costly. Following the economic liberalisation in 1991 and the concurrent structural adjustment program imposed by the IMF, international and bilateral funding agencies introduced state level health sector reforms that advocated piecemeal strategies favouring commercialisation of healthcare: user fees in public hospitals, privatization of health services, and the promotion of public private partnerships via franchising, social marketing and contracting out of services (Duggal 2006).

## RIGHT TO LIFE AND RIGHT TO HEALTH

There is no guarantee of the right to health in the Indian Constitution. The Constitution guarantees no "substantive rights". The right to health emerged from a broader development of social rights litigation, where the Supreme Court took on liberal interpretations of its powers of review.

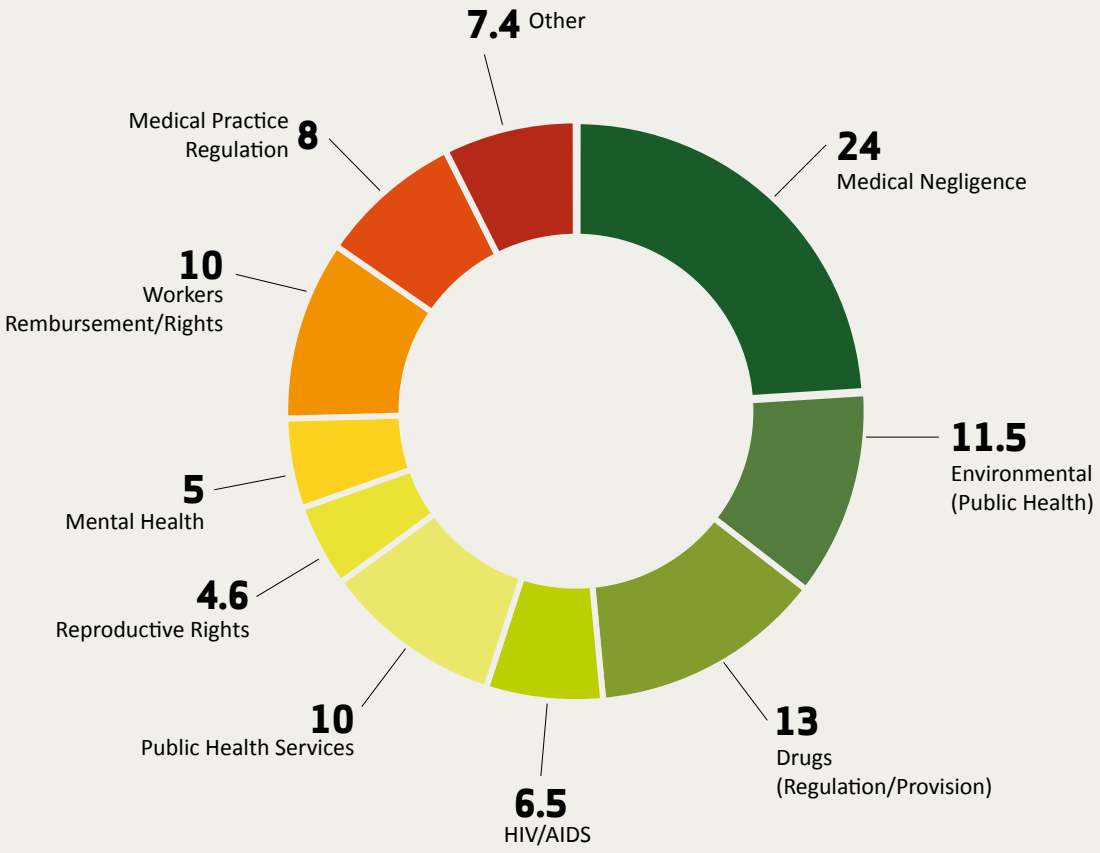
In a series of decisions from the 1980s onwards, the Supreme Court read the right to health into the "right to life" under Article 21 of the Indian Constitution, but it was only in 1996 that the right to health was made independently justiciable when the Court affirmed that "it is now settled law that right to health is integral to right to life."

Subsequently, Supreme Court and High Court decisions have outlined specific minimum obligations encompassed by the right to health. A comprehensive definition of the core content of the right to health has not been articulated. At a minimum, the right includes an individual's entitlement to adequate health care (which has been held to include emergency health care) and to "adequate medical facilities."

## POLICY IMPACT OF RIGHT TO HEALTH LITIGATION

In the project Litigating the Right to Health, we analyzed a sample of 218 cases before India's Supreme Court and High Courts that concern potential violations of the right to health, identifying ten categories of litigation claims.

**Figure 1:** Nature of health rights cases



A detailed examination of a subset comprising all Supreme Court cases (66), revealed who brought the cases to court, what and how claims were made, how the claims were adjudicated, and the litigation outcomes that followed. We also interviewed petitioners, attorneys, judges, academics, and other civil society actors working on public health and human rights issues. Finally, we researched the resulting legislative and policy responses, followed up by interviews with government health officials.

Both private and public petitioners have sought to make state actors accountable for failures to comply with existing health obligations or to highlight gaps within the relevant legal or regulatory framework. Over two-fifths of the Supreme Court cases involved social justice or public interest claims (twenty-eight). Interestingly, more than half of these claims were brought by individuals. The rest were brought by NGOs and unions (thirteen).

The Supreme Court has employed a variety of remedial techniques in adjudicating health rights cases including (i) appointing amicus curiae (friends of the court) to provide assistance on legal issues; (ii) exercising supervisory jurisdiction through the use of "continuing mandamus" over the matter; (iii) establishing commissions or expert bodies to ascertain facts or to independently verify facts presented by the parties, and asking these bodies to report to the court on the implementation of interim orders; (iv) passing mandatory orders, including preliminary and final injunctions; and (v) delivering detailed directions to public and private respondents to develop requisite policy and regulatory responses and practice.

Health rights litigation appears to have influenced the deliberation and adoption of policy in the areas of regulation of blood banks, regulation of drugs, emergency care, mental health care, medical negligence and malpractice by public entities, tobacco control laws, and reproductive rights. In each of these instances, Court guidelines have recommended the adoption of measures to fill existing policy gaps, which have in turn prompted initiatives by the government. There is no way to determine whether these policy and legislative initiatives would have been adopted in the absence of health rights litigation. But correlations between the Court's pronouncements and subsequent policy and legislative developments are clear.

| CASE | LITIGATION OUTCOME | POLICY OUTCOME |
|---|---|---|
| Blood banks (1998) | Licensing system outlined for blood banks | Blood bank legislation extensively revised in 1999 to include good manufacturing practices, standard operating procedures, and validation of equipment (Blood Index 2007)a |
| Drugs and vaccines (1995, 1996) | Specific orders issued banning the drug Analgin | Directives issued by central government in 1996 banning the manufacture, sale, and distribution of fixed-dose combinations of Analgin and antispasmodics (Pharmainfo.net 2009) Mashelkar Committee appointed by Ministry of Health to comprehensively review the drug regulatory system to prevent the manufacture and sale of substandard and spurious drugs |
| Emergency care (1996) | Committee appointed to investigate the provision of emergency medical care State governments ordered to formulate time-bound plans for implementing measures recommended by the committee and the Supreme Court | Expert group appointed by National Human Rights Commission recommended national accident policy and the establishment of centralized accident and trauma services in all districts (2004) (National Human Rights Commission 2006) Proposed legislation and regulations by Law Reform Commission (2006) |
| Mental health care (1991) | Government ordered to improve mental health institutions and integrate mental health into primary care | National Human Rights Commission delegated oversight of three mental institutions (National Human Rights Commission 2006, 2), which later reported progress in practiceb |
| Medical negligence (2001) | Guidelines framed under which a doctor could be held criminally liable for professional negligence or deficiency of service Medical Council of India ordered to institute a formalized mechanism for hearing complaints | In 2002, regulations on professional conduct, etiquette, and ethics adopted by Medical Council of India; chapter 8 concerns punishment and disciplinary action (Medical Council of India Notification 2002) |
| Tobacco control laws (2001) | In the absence of statutory provisions, smoking prohibited in public places (e.g., hospitals, health institutions, educational institutions) All levels of government directed to take necessary action to implement the ban | Tobacco-control legislation passedd |
| Reproductive rights (2003) | Guidelines issued for regulating the performance of sterilizations; negligence standards and compensation scheme established | Family Planning Insurance Scheme adopted in 2005e |

This CMI Brief is based on Parmar, Sharanjeet and Wahi, Namita (2011)"India, Citizens, Courts and the Right to Health: Between Promise and Progress?" in Yamin, Alicia Ely and Gloppen, Siri (eds) Litigating Health Rights. Can Courts Bring More Justice to Health? Harvard University Press, 2011.

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The persistence of India's executive and legislative health failures renders the enforcement of a right to health an important tool. Citizens can hold the state accountable for its constitutionally mandated obligations and seek concrete relief. Health rights litigation has highlighted areas of dire need, including basic necessities like food, water, and essential medicines. It has opened a discursive space that has forced the government to defend its record on certain health rights issues and negotiate with petitioners and civil society groups before adopting policies. This latter dynamic is particularly important for petitioners from marginalized and vulnerable groups who lack the means to influence government policy.

At the same time, health rights litigation has serious limitations. Specifically, the record on implementation of Supreme Court orders has been mixed, making it difficult to assess the overall effectiveness of judicial accountability on the health system. We find that because the Court's remedies are not backed by serious penalties for noncompliance, enforcement challenges, particularly in cases of structural reform, continue to abound—notwithstanding the use of oversight mechanisms. Litigation is neither necessary nor sufficient to achieve structural reform on a particular issue. Cases considered relatively successful, such as the right-to-food and access-to-treatment cases, have employed litigation within a broader public advocacy campaign. Civil society networks have also been actively involved in followingup the implementation of the Court's remedies.

## CONCLUSION

Health rights litigation does not appear to be worsening health inequities in India. Yet, health rights litigation by itself cannot bring about the structural and systemic changes necessary for improving access to health care for the vast majority of the Indian population.

Health rights litigation in India has in some cases made government more accountable to the people. By highlighting areas of dire need including food, water, essential drugs and reproductive care, it has supported access to basic necessities for marginalized and vulnerable sections of the population. Litigation has opened a discursive space that has forced the government to defend its record on certain health rights issues and to negotiate with petitioners and civil society groups before adopting policies. This has produced equitable outcomes. Thus, health rights litigation has played an important role in improving health service delivery for the poorest and most marginalized people and thereby made health service delivery somewhat more equitable.

Yet, context matters greatly. Health rights litigation in India may represent a more promising subset of cases regarding the potential of litigation to bring about social change. However, given the gravity of the health-care crisis in India, any improvements in health outcomes through litigation are noteworthy deserving complete and detailed consideration by lawyers, academics, and health practitioners.

## FURTHER READING

**Litigating Health Rights** examines the potential of litigation as a strategy to advance the right to health by holding governments accountable for these obligations.

The book presents cases studies from Costa Rica, South Africa, India, Brazil, Argentina and Colombia, as well as chapters that address cross-cutting themes.


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