Chapter 4
Health Care Jurisprudence and Health Justice: Procedural and Substantive Justice Dimensions

Abstract  The scope of the translation of health care jurisprudence into health justice is discussed in this chapter from the perspectives of procedural justice and substantive justice. The former relates to the procedural mechanisms for health care litigations, and the latter, to the outcomes of such a process, i.e. equality, dignity, and reinforced social citizenship. The empirical inputs from lawyers and judges, and the experiences of litigants on moving courts for justice in matters of health care, provide the key insights of this chapter. It will briefly delve into the challenges of the processes involved in achieving the ‘right to health care’ jurisprudence on the one hand, and, will critically analyse the contemporary juridico-legal mechanisms through which such jurisprudence is transformed into health justice for the marginalised citizens. Literature points to two key factors that stand out in understanding the processes of health care litigations. One, understanding the phenomena of health care litigations constitutive of its drivers, outcomes, and impact on health policy and programming in a given country. Two, a less explored dimension of processing health care litigations in (Indian) courts (as institutions) and the interface of judicial-administrative and socio-political processes in legalising entitlements. This chapter will reflect on the socio-political processes that impact litigations and influence the ecosystem of courts.

It is of fundamental importance that justice should not only be done, but should manifestly and undoubtedly be seen to be done.1

This book centrally places the argument that health justice is the goal of health care jurisprudence. It is conceptualised essentially as a process of establishing social citizenship of fundamental equality and dignity through health care jurisprudence and to accomplish it through SRHC. Further, it postulates such a process of engaging the institutional and procedural mechanisms with an aim of realizing substantive dignity and equality as fundamental and integral to social citizenship. In this chapter we examine the procedural justice mechanisms followed by a discussion on substantive justice employing the concepts of justiciability, enforceability, and transformability of health care jurisprudence. Structural constraints in seeking health justice are then reviewed through institutional relationships and various stages of adjudicating health

1R v Sussex Justices, ex parte McCarthy ([1924] 1 KB 256, [1923] All ER Rep 233).
care litigations, within an overarching theoretical framework of justice, including social justice.

Theories of justice consider commutative or retributive (relating to punishment of crimes), restorative (relating to compensating victims of wrongdoing) and distributive justice (relating to sharing benefits and burdens) as three key facets of justice. Aristotle considered justice as part of ethics and distinguished them as three kinds of justice (Winthrop 1978). Theories of social justice that were expounded in the second half of twentieth century refer fundamentally to the unpacking of distributive justice. Health and health care, as social goods, are considered as intrinsic components of distributive justice (Rawls 1971, 2001).

Scholars have made distinctions between social justice and legal justice. The former is related to the outcomes seen as distributive justice, and the latter is related to the legal procedures to attain such outcomes. The outcome and procedure of realizing such justice are described as ‘substantive justice’ and ‘procedural justice’, respectively. Substantive justice is the justice of outcome while procedural justice is the justice of process which brings about this outcome (Sadurski 1984:346). This book positions SRHC as an integral part of social justice in both the dimensions, i.e. substantive justice, whose final outcomes is social citizenship as well as its procedural mechanisms which are located in the fundamental right to access justice in the Indian constitutional framework.

Health care jurisprudence is a critical expression of such a substantive justice in health aimed at fair distribution of social rights. Health care jurisprudence, in a technical sense, can end up as a ‘hollow hope’ with grandiose articulations without substance, as can be seen in several court orders (Rosenberg 1991). Applying the Rawlsian principles of fairness, in this book we consider health justice to be imbued with fairness both in its outcomes (substantive justice) as well as in its procedures (legal or procedural justice). Substantive justice is navigated through the instrumentality of procedural justice, a process of adjudicating health care litigations through navigating the maze of juridico-legal institutional mechanisms. This chapter critically reviews the existing institutional mechanisms for such navigation in health care matters, and the challenges of establishing social citizenship in relation to health and justice systems.

The idea of health justice, therefore, is predicated on the systems perspective. (Vide. Figure 1.1) To translate the doctrines of SRHC secured through the health care jurisprudence over the last five decades, a robust health system and a well-developed procedural justice system would be quintessential prerequisites. Public health care systems are essential for the availability of health care services, whereas the justice system is a sine qua non not only for the resolution of grievances but also as a deterrent against further violations. Health justice or the systemic arrangements for realising SRHC and resolution for grievances thus form the real goal of healthcare jurisprudence that has historically evolved through the litigations in India.

From an institutional and power perspective, health rights in general or SRHC can be conceived as a balance of power between various actors through institutional rules. Young (1990:25 cited in Gauri and Brinks 2008:13) proposed that ‘rights are
not possessions but institutionally defined rules specifying what people can do in relation to one another’. Right to healthcare is not a right to a set of properties, goods, or services alone. It quintessentially entails redefining the relationships of citizenship that will govern the enjoyment of goods or services. It is also a claim to change the rules that govern the production and distribution of all goods, services, and relationships of healthcare. It means establishing institutional mechanisms and procedures by which the goods and services related to health care can be re-distributed equitably, which can be better described as health justice. The role of judicial and quasi-judicial institutions expands much beyond merely being procedural mechanisms to that of creating political space for these discourses and influencing various institutions to redefine these relationships.

This health justice seeking process, among other things, reveals the various power structures that underlie the violations and those that influence the outcomes of health justice initiatives. In the triadic relationship of actors between the State, citizens, and professions that we take into account in conceptualizing health justice, citizens seeking health care are the most powerless constituents compared to the State and the medical profession. The relationship between other two actors (State and medical profession) is characterized by varying degrees of mutual dependency and reciprocity. However, for a citizen, the dependency on professions and the State is symbolised by inequality and high dependency, with very less reciprocity. State considers a citizen as beneficiary and is a client for the medical or legal professional when s/he pays for the service. Hence the citizens who access public health care and subsequently resort to justice systems on account of violations invariably are vulnerable. They face their vulnerability vis-à-vis several actors in this process, especially the organised professions and associated institutions, viz. the medical profession and health care institutions (as health care seekers or patients), and legal profession and judicial institutions (as seekers of justice). Such vulnerability experienced by citizens tends to be acute, as both health care and justice are availed through a myriad institutions and scores of mediators, often with the anxiety over outcomes that are unpredictable.

The health care litigations illustrate the health system aspects of this vulnerability, experienced as violations of health rights by the marginalised. In addition to the marginalisation itself arising out of structural inequalities within which the underprivileged are located, an enfeebled and fragmented health care system is likely to heighten these violations further. The analysis of the factors behind health care litigations in this research showed a very close correlation with the web of these systemic factors (Fig. 4.1).

Citizens invariably have turned to justice systems in these situations and this forms the context of context of health care jurisprudence. We postulate that such a jurisprudence embeds within it the power not only to provide individual resolution but also to plug systemic holes that give rise to these violations, leading to better access to health care, and in turn effect restoration of dignity and citizenship. This assumption forms the core of the idea of health justice in this book.

The concept of health justice couched in a systems perspective evolved within the praxis of health and human rights activism of the author. Critical insights from
academic-political economy discourses and contemporary civil society debates have contributed towards shaping this concept further. It also bears an imprint of civil society and human rights thinkers that include several petitioners, victims of violations, public health experts, human rights lawyers, and judges who have subscribed to such an idea. Health justice is thus set within the overarching eco-system and political economy of the interface of justice and health care systems, seen as integral to the realisation of social citizenship both in their institutional (procedural) as well as outcome (substantive) dimensions. Accordingly, we define health justice as,

Reordering the relationship of citizens seeking health care vis-a-vis the State, health care system (including medical profession) and justice system (including legal profession), aimed at realising substantive equality and dignity for all citizens, and the social right to health care, through institutional and systemic mechanisms protected through the Constitutional framework. (Vide. Chap. 1, Fig. 1.1 and Chap. 5, Fig. 5.1)

4.1 Procedural Justice and Healthcare

The modern justice system is established on the principles of rule of law, due process, transparency and fairness. Independent judiciary or judicial independence is seen to be the hallmark of such a rule of law based judicial system. Indian justice system bears the legacy of British law known as common law practiced in commonwealth countries. The quality of justice delivered, and its perception is determined by the
ecosystem surrounding the justice system and its capacity to safeguard the rule of law. This is applicable to the Indian justice system as well.

The Rule of Law study has ranked India low in its rule of law index. The operational definition of the rule of law includes four universal principles derived from internationally accepted standards relating to accountability under the law, nature of the law, enforcement with fairness, delivery of justice (The World Justice Project 2015):10. Among the 126 countries assessed in 2019, India ranks 68 in the Rule of Law Index 2019, ranking at 97 for civil justice and 77 for criminal justice (Tata Trusts 2019). Indian legal-judicial system is overburdened by pendency-delay-backlog of cases, and is marked by acute vacancy of judges, low case clearance, and astonishingly low number of women judges. In general, taking into account the functioning of police, prisons, legal procedures, and judiciary, it affirms the sub-optimal performance of the justice delivery system. This resonates with the experiences of several petitioners in the primary research. Of the several problems that surround the Indian legal system, the report highlights high human resource shortages, resource misallocation, financial shortfall and structural inadequacies as needing immediate attention (Tata Trusts 2019).

An overwhelming number of 3.3 crore cases are pending in the courts of India [Ministry of Law and Justice n.d. (a)]. A sense of pessimism and cynicism prevails in people concerning the possibility of getting justice in courts due to the costs involved, slow pace, quantum of time and in the end, an unpredictability and uncertainty of outcomes of justice to the aggrieved (Dasra and Daksha 2017).

Judicial independence, which is a prerequisite to uphold rule of law, has been a subject of intense debate in India. Tension between the judiciary and the executive has come to the spotlight in recent years and it revolved around the power of judicial appointments. Since the mid-1990s, India followed the collegium system for appointing higher judiciary and was proposed to be curbed through the National Judicial Accountability Commission Act (NJAC) that was subsequently struck down by SCI as unconstitutional. Apart from this, the integrity and efficiency of courts, especially concerning the higher judiciary (i.e. HCs and SCI), have time and again been the focus of public debates. Efficiency of courts came under intense scrutiny in the backdrop of pending caseload, whereas transparency of judiciary was debated when Chief Information Commissioner under Right to Information (RTI) Act passed

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2The rule of law is a system where the following four universal principles are upheld:

1. The government and its officials and agents as well as individuals and private entities are accountable under the law.
2. The laws are clear, publicized, stable, and just; are applied evenly; and protect fundamental rights, including the security of persons and property.
3. The process by which the laws are enacted, administered, and enforced is accessible, fair, and efficient.
4. Justice is delivered timely by competent, ethical, and independent representatives and neutrals that are of sufficient number, have adequate resources, and reflect the makeup of the communities they serve.

358,029 (SCI, dt.01 Feb. 2019) 40,92,732 (HC, 05 Feb. 2019) and 2,91,73,911 cases are pending in district and subordinate courts (in total 3,33,24,672) as per the reporting of Law minister in the Rajya Sabha.
an order declaring courts as public institutions. Does the judiciary uphold the Constitution and its foundational principles impartially without fear or favour? This was debated in the contemporary socio-political circumstances of India, that included the suspension of civil and political liberties of people of Kashmir after the suppression of Article 370 of the Constitution of India, admitting review petitions against the compromise of citizenship in the Citizenship Amendment Act and police brutalities on citizens and migrant workers during the COVID19 related stringent lockdown. In addition, indiscriminate contempt proceedings against those who express opinions about the judiciary has prompted civil society and even respected legal luminaries to raise concerns over the intolerance exhibited by the judiciary towards dissent and plurality of opinions. These and such related circumstances suggest that judiciary and the justice institutions are under stress, scrutiny, and intense public gaze.

The mechanisms employed for seeking health justice and their capability to deliver justice are contingent on the functioning of legal system of justice dispensation, threshold of access, and opportunity structures available for citizens to mediate their use (Yamin and Gloppen 2011; Gauri and Brinks 2008). Most importantly, the procedural mechanisms which are laid down and are supposed to uphold the rule of law hold the key to meet the ends of justice, i.e. substantive justice. Such mechanisms are required for grievance redressal in the instances of healthcare violations to an individual or to a community. How do these mechanisms work and what is the politics that defines their functionality and their ability to convert healthcare litigation into health justice for the aggrieved?

The legal literature denotes three ways of seeking redressal for health care related grievances in India, viz. engaging Consumer Redressal System (Consumer Redressal Forum at the district and Commissions at the State and National level) for negligence or deficiency of service, considered civil wrong under tort law; accessing the criminal justice system for criminal negligence; and, employing medical councils for confronting professional misconduct of medical personnel in matters of medical negligence and violation of the code of medical ethics (Desai and Chand 2007). The first two procedures are based on substantive law—i.e. Civil Procedure Code (CPC) and Criminal Procedure Code (CRPC) and could be concurrent redressals. In the CPA 1986 based consumer redressal fora/commissions have emerged as the quasi-judicial forums for redressing civil litigations (complaints) on deficiency of service or in products, which includes medical negligence cases. Adjudicating on professional misconduct by the medical councils is considered as the self-regulatory exercise of the medical profession for which the legal framework is provided by the Indian Medical Council Act 1956 (recently replaced by the National Medical Commission Act 2019).

The research process led to documenting additional four pathways engaged by citizens for seeking justice in the matters of health care. They are classified under healthcare system based institutional complaints mechanisms, specific statute-based redressal, oversight quasi-judicial institution-based redressal, and Constitution based
writ petitions. The quasi-judicial institutions such as medical councils or statutory commissions referred here, enjoy the power of civil courts for procedural matters, that include powers to admit evidence, to summon witnesses and to provide orders or recommendations. Table 4.1 provides an analysis of the various procedural mechanisms of seeking redressal for grievances in health care that are currently engaged by citizens.

4.1.1 Consumer Protection and Civil Remedy

Accessing consumer fora at the district level or the commissions at the state or the central level depend on the quantum of compensation for the medical negligence that is prayed for. Only the aggrieved persons who are seeking care in private health care facilities can arguably access this remedy as the SCI has defined the doctor—patient relationship only in terms of consideration (fees) paid. Although the public health care services are managed on tax-based revenues allocated by the government, they are apparently considered free at the point of delivery, and hence are excluded from this remedy. The blurring boundaries between the private and public health care services and several grey areas of such a demarcation, are seen to be subjecting citizens into serious disadvantage. In most of the public hospitals, patients are made to pay user fees for several services. Additionally, under the Public Private Partnerships (PPPS), an approach that the governments have increasingly adopted, health care centres/hospitals and often significant services are outsourced to private parties. However, it is challenging for patients to differentiate between these services provided in the same institution. In addition, as government of India has launched public insurance-based health care (Rastriya Swasthya Bima Yojana-RSBY or Pradhan Mantri Jan Arogya Yojana-PMJAY), patients are prompted to avail services from the empanelled private health care institutions. If these publicly funded and privately provided services come under the definition of ‘service’ is a matter that has no clarity in the prevailing jurisprudence.

The complaints filed in the redressal fora are potentially subject to a protracted legal battle, as the dissatisfied party can move up to the National Commission and then to SCI in appeal for the final remedy. A vulnerable patient can lose out or give up at any stage, starting from consumer redressal forums at the district level.

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4 The health care system based institutional complaints mechanism such as complaining to higher authorities in the health care system or through the help lines established for the purpose forms other usual mechanisms. The specific issue-based statute defined redressal mechanism provides for another mechanism illustrated by PCPNDT Act, Lokayukta Act, Clinical establishment Act etc. Quasi-judicial bodies instituted oversight institutions and commissions through specific or general statutes supposed to provide easy access to citizens—medical councils under MCI Act, NHRC, Women’s Commission. Constitution based system of writ-based redressal mainly through PILs (Constitution 32 and 226 of the Constitution of India) forms the forum of original jurisdiction or an appellate institution for all the above is the most significant and most authoritative redressal authority.
| Type           | Legal platform       | Legal system                                      | Scope                                      | Patient rights protection? | Regulation of establishments? | Kinds of actions available for patients | Limitations                                      | Challenges for patients                  |
|---------------|----------------------|---------------------------------------------------|--------------------------------------------|-----------------------------|------------------------------|----------------------------------------|---------------------------------------------|------------------------------------------|
| Civil remedy  | Civil procedure code | The court system from JMFC to appellate courts     | Disputes between two individuals considered private or civil wrong | NO                          | NO                           | Civil suit for various kinds of damages and injunctions. This function is currently delegated to consumer disputes forums and CPA | Time consuming; subject to further appeal | Time consuming, requires financial and legal resources |
| Criminal law  | Criminal procedure code | The courts from the lowest level to appellate courts at higher levels | Offences defined as criminal offences, i.e. offence against the State | Deterrent in general        | No                           | Patient can file criminal complaints against gross criminal negligence in health care services | Expert medical opinion by a medical doctor/board is required for criminal prosecution | Obtaining medical opinion against doctors is challenging; Police resist filing FIRs against hospitals and doctors; Outcomes are contingent on the public prosecutor and investigating officers to produce evidence; Outcome is punishment—does not enhance health justice positively for the suffering patient even if prosecuted successfully |
| Type | Legal platform | Legal system | Scope | Patient rights protection? | Regulation of establishments? | Kinds of actions available for patients | Limitations | Challenges for patients |
|------|----------------|--------------|-------|----------------------------|-----------------------------|---------------------------------------|------------|------------------------|
| Specific statute based avenues (Criminal or Civil) | PCPNDT, TOHO, MTP, Nursing homes Acts; Clinical Establishment or relevant state level Acts etc. | Sessions courts (for Criminal matters) Designated Appropriate Authority (Civil matters) | Specific offences or issues as defined in Acts | Criminal Procedures—Serve as deterrent in general Civil issues such as those in CEA—Generally ineffective | Regulation of specific services (Ultra Sound) | Complaint with designated/appropriate authorities | Outcomes subject to criminal prosecution; Collateral adverse impacts (Victimising women seeking abortion; harassment of doctors on administrative matters, e.g. keeping records etc.) | The outcome is punishment of the accused; It depends on the court proceedings and the prosecution. The victims need to other legal avenues for compensation |
| Lokayukta | Lokayukta courts | Corruption and mal-administration | NO | Yes (limited to corruption) | Complaints with Lokayukta for specific acts of corruption, irregularity and maladministration | Lokayukta is not very proactive; Many states have not appointed Lokayuktas; There are inherent limitations—Lokayukta needs an upalokayukta to focus on specific issues such as health | The complainants are rendered as witnesses as the matter is between the State and the accused; the challenge is to attend the courts, to be present at hearings. The outcome, even if it is positive, is punishment. It has no personal gain for the patient |

Table 4.1 (continued)
| Type                     | Legal platform                      | Scope                        | Patient rights protection? | Regulation of establishments? | Kinds of actions available for patients | Limitations | Challenges for patients                                                                 |
|-------------------------|------------------------------------|------------------------------|-----------------------------|-------------------------------|----------------------------------------|-------------|--------------------------------------------------------------------------------------------|
| Consumer protection Act | Consumer forums and commissions    | Deficiency of service and negligence | Yes, in terms of awarding damages/compensation | NO                            | Pray for compensation                   | Orders are recommendatory, appealable; Time consuming and financial resources are required; the complaints are admitted in relation to the value of compensation sought for the goods and services which is problematic in health care matters; the district forum is ill-equipped to deal with the technical matters of health care services whose deficiency is construed as negligence by patients. | Patients need medical records and documents; Need legal counsels to follow up; Patients give up almost after the district level orders; Generally, if it is pro-patient, the doctors and hospitals appeal to the State commissions; health care as service is not included in the CPA 2019 and will face legal challenges to bring health care matters to the consumer disputes redressal fora. |

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### Table 4.1 (continued)

| Type                  | Legal platform                  | Legal system | Scope                                                                       | Patient rights protection? | Regulation of establishments? | Kinds of actions available for patients | Limitations                                                                 | Challenges for patients                                      |
|-----------------------|---------------------------------|--------------|----------------------------------------------------------------------------|---------------------------|------------------------------|---------------------------------------|---------------------------------------------------------------------------|------------------------------------------------------------------|
| Professional regulation | MCI Act (Now replaced by NMCA)  | Medical councils | The ethical-professional conduct of ‘doctors’ alone | No                        | No                           | Patients can complain—demand suspension or cancellation of license | Conflict of interest—doctors body judges doctors; MCI/State bodies do not follow open court procedure in conducting hearings; Non transparent; Medical Councils admit complaints only against doctors and not other health care professionals; MCI is limited only to allopathic doctors; Allegations of nexus and corruption in medical councils | The suspension and revocation of licenses are not enforced; Appeals from state councils to MCI—challenging for patients to follow up; Medical councils are hostile to patients |

(continued)
| Type                          | Legal platform                                                                 | Legal system                                                                 | Scope                                                                 | Patient rights protection? | Regulation of establishments? | Kinds of actions available for patients | Limitations                                                                 | Challenges for patients                                                                 |
|------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------|-------------------------------|-------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Statutory Commissions        | Central Act of the Parliament                                                  | Commission is established at the National and State levels                    | Sectoral complaints; have suo-moto powers to take cognisance; enjoy the power of civil court. | No                          | No                            | Enquiry reports and recommendations | Recommendatory in nature; Chairpersons are political appointees—do not take a stand against the ruling governments; Very few health care related matters addressed; | Generally, commissions are inactive; Needs strong media Mobilisation and opinion building to move them; The onus is on patients to mobilise them |
| Writ jurisdiction            | Under the Constitution Articles 32 and 226                                   | HC and SC                                                                     | Can take suo-moto cognizance, receive appeals, use powers under different writs (e.g. injunction) | Yes, All encompassing powers | Yes, All encompassing powers | File writ petitions; Force the State to act or refrain. | Challenging to get specific reliefs of health care; Time-consuming. | Very sympathetic and lenient towards doctors; Need experienced lawyer to represent; Unaffordable and inaccessible to individual patients; Can have adverse policy setbacks and outcomes |

*Source* Author
At what level and under what circumstances does a patient give up? This needs further investigation. A few known cases indicate that it is a time-consuming process, requiring enormous resources, time, legal support to sail through this hierarchy. The proceedings in the consumer forum or commissions are based solely on documentary evidence. As gathered from interviews, since the right to medical records is not a legislated right so far, it is a great ordeal for patients to secure medical records from private-commercial health care institutions. Private hospitals are not covered under the jurisdiction of RTI, and hence, getting required documents was an uphill task for several patients.

Unlike a patient challenging the hospitals or doctors in the district fora as an isolated individual, the available studies suggest that doctors are well organised through their networks at the district level to offer mutual support in cases of medical negligence. Hence, it becomes cumbersome for patients to face such an organised force. Besides, as the redressal forums are ill-equipped to deal with and to understand the technical matters in these issues, the respondent hospitals are better equipped to confuse and circumvent the officials. In addition, unlike some countries such as the USA where the law of tort is well evolved to settle matters such as medical negligence, patients face disadvantage in India as the discipline of tort is under-developed. Lawyers are not oriented to the basics of health care discipline to understand the health systems and hence are ill-equipped to deal with the legal aspects of healthcare and medical negligence.

The jurisprudence of SCI on matters of criminal prosecution of doctors has a negative cascading impact on the consumer redressals as well. The twin judgements, viz. Jacob Mathew case and Martin F. D’Souza v Mohd. Ishfaq, cumulatively, have dealt a severe blow to the consumer protection remedy as the fora are now demanding a medical opinion to even admit the complaints on medical negligence. It is virtually impossible for a patient to get such an opinion from the medical fraternity. Though such a reading has been reversed in the subsequent judgments, the practice of demanding medical opinion, is still in practice in several districts. In the consumer redressal forum, the only easily accessible remedy, majority of the decided cases are in favour of doctors. Several complaints are dismissed due to lack of evidence for negligence and quite several cases the orders cite medical opinion not substantiating medical negligence (Institute of Public Health 2012).

Although the consumer redressal fora are touted to be cost-effective and easily accessible to people, they are still out of reach in health care matters. They serve as the first point of demanding justice at least in some aspects of health care. However, the issues of deficiency of service and medical negligence, often are fiercely contested in the hierarchy of appeals, and the finality of outcomes depends on several factors that are associated with pursuing litigations in the higher domains of judicial or quasi-judicial institutions. Bringing health care under the jurisdiction of CPA 1986 was itself a long-drawn court battle which the medical associations waged. Defining medical care as ‘service’ was done in 1995, ten years after the promulgation of CPA,

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5V. P. Shanta v. Indian Medical Association, Kunal Saha versus. AMRI, P. C. Singhi versus. Dr. P. D. Desai.
in the *IMA v. V. P. Shantha case* in 1995. In the newly promulgated a Consumer Protection Act 2019 that repealed the CPA 1986, ‘health’ does not find a mention as one of the services listed or covered. This has again added uncertainty and ambiguity to the existing perplexities in availing this procedural remedy for health care matters.

### 4.1.2 Criminal Law Remedy

For gross negligence of criminal nature (criminal negligence), patients have the option of resorting to Indian Penal Code (IPC) 304B (death caused by negligent act)\(^6\) and section 319–322 (causing hurt, grievous hurt) to pursue criminal prosecution. However, SCI judgments have imposed restraints on the criminal prosecution of doctors.\(^7\) (Vide: Sec. 3.3) This has stifled the options available for patients to prosecute medical professionals for professional misconduct or for criminal negligence. On the other hand, it is seen in some instances that the government is swift to arrest whistleblower doctors who speak out against its unaccountability and inaction.\(^8\)

In recent years, rather than the criminal law offering a remedy for aggrieved patients, the practice of medical professionals using criminal law against patients has seen an upward trend. Several states have passed legislations for protecting doctors in the backdrop of assaults on doctors and a synchronised protest by doctors across India demanding such a legislation.\(^9\) While the demand for a central act is pending, the central government has promulgated an ordinance to make violence against health care workers deployed to combat COVID19, a non-bailable offence. The Ordinance moots six months to seven years of imprisonment as punishment along with fine that

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\(^6\)Sec. 304-A: Deals with death caused by a negligent act: Causing death by negligence: Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.\]

\(^7\)In the Jacob Mathew case police were ordered not to file FIR without a favourable medical opinion on negligence. In civil appeal to the SCI, Martin F. D’Souza (appellant) v Mohd. Ishfaq (respondent), Civil Appeal No. 3541 of 2002 decided on February 17, 2009 justice Markandey Katju and Justice M. Lodha restrained police cannot arrest doctors over complaints of medical negligence without prima facie evidence and restrained courts, including consumer fora, from issuing notices to doctors for alleged medical negligence without seeking an opinion from experts. [Martin F. D’Souza (appellant) v Mohd. Ishfaq (respondent), Civil Appeal No. 3541 of 2002 decided on February 17, 2009].

\(^8\)In August 2017, 63 children died at the Gorakhpur hospital in Uttar Pradesh after the hospital’s piped oxygen supply ran out which was a lapse in administration. However, Dr. Kafeel who saved many lives was arrested. He was cleared of all allegations after several months in Jail. He was arrested again for speaking out against the government.

\(^9\)At least 19 states—including West Bengal, the epicentre of the protests—have passed what is called the Protection of Medicare Service Persons And Medicare Service Institutions (Prevention Of Violence And Damage To Property) Act, also known as the Medical Protection Act (MPA).
4.1 Procedural Justice and Healthcare

can range from Rs.50,000/— to two lakhs and is enacted by bringing an amendment to the Epidemic Diseases Act 1897 (The Wire 2020).

4.1.3 Health System Based Institutional Mechanisms

The avenues of departmental inquiries and access to higher authorities on the grievances with a personal representation or helplines is an accountability mechanism that is feasible for people to access. However, experiences of civil society engaging such measures indicate that they effectively elicit response only when media is mobilised or when pressure is exerted through influential people such as elected representatives. Such responses are short lived and might result in commissioning internal inquiry (such as in the matters of individual maternal deaths) or judicial inquiries (owing to the public pressure as in the case of Chattisgarh sterilisation deaths). Excepting some rare cases, such inquiries are conducted secretly and are seen to invariably exonerate doctors or hospital authorities, shifting the blame squarely on the deceased or their families. In cases where civil society is persistent, at the most such blame shifts to the lowest frontline health care functionary such as ANM or an ASHA (Singh 2016).11

4.1.4 Statute Based Mechanisms

Individual legislations enacted on specific health care issues provide for complaint mechanisms for both civil and criminal remedies. The following legislations are a few illustrations:

- Consumer Protection Act 1986, for example, provided for the consumer redressal forums.
- The Clinical Establishment Act 2010 and its state counterparts such as Karnataka Private Medical Establishment [KPME] Act 2007 (and its amendment in 2016) incorporate civil remedy mechanisms for redressal.

10 In the case of unwarranted hysterectomies in Karnataka, civil society mobilisation was so strong that the women commission instituted a thorough inquiry which became a significant piece of evidence in the litigation filed in the SCI.

11 Fact finding report accessed the maternal death of Vandana, a young woman who was made to run from one public hospital to the other without providing treatment, in Satna District of Madhya Pradesh, finally the blame was put on the dead patient. Similarly, in the death of an infant in Sidhi District, a complaint and then an inquiry was enforced. Finally, the ANM and ASHA and dayi were blamed for the mishap, though the doctor never attended the PHC. A follow up discussion with a community activist revealed that ASHA got restored to her work by paying Rs. 2000 to ANM and in turn ANM escaped any penalty by using her influence and perhaps even money. But a dayi (traditional birth attendant) who used to earn some livelihood by conducting deliveries in PHC was penalised by being barred from the work.
The Lokayukta Act covers public health establishments under its overarching mandate of reforming administration (includes corruption and maladministration).

The Pre-conception and Pre-natal Diagnostics Technologies (Regulation) Act [PCPNDT Act] 1996 provides for inspection of clinics and criminal prosecution when procedures are not followed.

The Medical Termination of Pregnancy Act 1971 provides for safe abortions under some conditions up to the period of 20 weeks of gestation. Those who violate the provisions are prosecuted under IPC 312, 313 and 314 (Causing miscarriage and abortion).

The Transplantation of Human Organs Act [TOHO] 1994 provides for prosecution in violation of the provisions of the Act.

The National Medical Commission Act 2019 has proposed to establish National Medical Council and Autonomous Boards. [However, it is silent on the adjudicatory functions of the Boards for grievance redressal].

The statute-based mechanisms vary in their effectiveness of providing relief to the aggrieved patients. The redressal under CEA 2010 is generally deemed to be quite toothless. The two cases of Lokayukta case in Karnataka (Haveri District) that were analysed as part of this research indicate the possibility of using Lokayukta for systemic issues in healthcare. However, it is contingent on any local leader to pursue the case. Lokayukta legislation provides for addressing administrative reforms, but it is hardly used to address healthcare issues. The complaints to Lokayukta, by nature of the law, are treated as criminal matters and are prosecuted using CRPC. More importantly, the individual leadership and the personality of the appointed Lokayukta appears to have made a great difference in a few cases as in the case of Karnataka. Lokayukta in Karnataka when it was headed by (Retd.) Justice Venkatachala (2004–06), appointed a Uplokayukta for health who focussed on corruption in public health hospitals (Sudarshan and Prashanth 2011). Similarly, Santosh Hegde, J. (Retd.) when headed the same office, also wider issues of corruption that included hospitals were taken up. The influence of this office has seen steady decline in recent years.

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12Section 312. Causing miscarriage: Whoever voluntarily causes a woman with child to miscarry, shall if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

Section 313. Causing miscarriage without woman’s consent: Whoever commits the offence defined in the last preceding section without the consent of the woman, whether the woman is quick with child or not, shall be punished with [imprisonment for life], or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.

Section 314. Death caused by act done with intent to cause miscarriage: Whoever, with intent to cause the miscarriage of a woman with child, does any act which causes the death of such woman, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine; if act done without woman’s consent, if act done without woman’s consent and if the act is done without the consent of the woman, shall be punished either with [imprisonment for life], or with the punishment above mentioned.
It is also seen that when implementation is perceived to be effective and stringent, as is seen in the instances of action under PCPNDT Act, the medical professional associations have raised their ante against it. The associations of radiologists have persistently lobbied for the appropriate amendment of PCPNDT Act. Such organised resistance by the medical associations has also been seen in other issues such as against bringing medical professionals under the CPA 1986. In the instances when the provisions of other legislations are used, the medical professionals and associations have steadily engaged courts and legal measures to obstruct such proceedings.\(^\text{13}\)

### 4.1.5 Oversight–Quasi-Judicial (Ombudsman) Institutions

**Statutory Commissions**

Various statutory commissions at the state and national level—NHRC and SHRCs, district consumer fora and commissions, MCI, and its state bodies—are vested with judicial power and they function as quasi-judicial institutions. In principle, these bodies are vested with powers of civil court to take cognizance of the complaint, summon respondents and witnesses on matters relating to healthcare violations. However, except for NHRC and MCI (and its state bodies), most of the other institutions have not used their power for addressing health care matters. In some states these institutions serve only decorative and cosmetic functions without any institutional capacity or willingness to engage with patient’s grievances or violations they face.\(^\text{14}\)

Citizens who accessed NHRC to draw its attention to the failures of the healthcare system, have received precious little. NHRC’s legislative mandate is limited to take cognizance of human rights violations committed only by public servants. Its jurisdiction is barred if any other commission of enquiry is instituted by the government on any matter of human rights violation or by the limitation period of one year from the occurrence of the alleged violation.\(^\text{15}\)

\(^{13}\)In the case of an infants’ death due to negligence of the private hospital, when the appropriate authority under KPME Act 2007 was moved to impose the highest available penalty of Rs. 25,000/-, the hospital brought an injunction from the Dharwad bench of the HC of Karnataka; doctors have started issuing defamation notices to patients when they speak out against medical negligence as in the case in Kolkata where a neurosurgeon has filed a defamation suit of 10 crores in a case where the person blamed doctor for the serious health condition of his wife in a fakebook post.

\(^{14}\)Files accessed on the complaints filed with women’s commission, SC/ST Commission and State Human Rights Commission in Madhya Pradesh, by Maternal Health Rights Campaign (MHRC) reveals that though over 50 complaints on gross negligence and deaths of women were filed, they did not receive a single reply. Similarly, activists who approached the chairperson of the women’s commission were given to understand that the chairperson had not even taken cognisance of the complaints. (Personal discussion with Advocate Azam Khan and Ajay Lal, MHRC activists, Delhi, 1 September 2016).

\(^{15}\)Vide, Section 12(a) and 36 of the Protection of Human Rights Act 1993.
Table 4.2  Health related complaints filed with various national commissions (Source RTI filed in 2016 April seeking data for the period 2000–2016)

| Statutory commissions                                    | Period       | SRHC    | Other    | Total   |
|---------------------------------------------------------|--------------|---------|----------|---------|
| National Commission for Women                           | 2000–2014    | 5829a   | 134,970  | 140,799 |
| National Commission for Scheduled Tribes                | 2007-2016    | 2       | 375      | 377     |
| National Commission for Minorities                       | 2011–2015    | 0       | 7501     | 7501    |
| National Commission for People with Disability          | 2007–2015    | 1b      | 20       | 21      |
| National Commission for the Protection of Children’s Rights | 1991–2014 | 0       | 35       | 35      |
| National Human Rights Commission                        | 2005–2016    | 12,406c | NA       | 12,406  |
| National Commission for Scheduled Castes                | 2004-2016    | NA      | NA       | NA      |

a Acid attack (105), Rape (5542), reproductive health matters (27), sex-selective abortions (155)
b Medical Reimbursement and Cochlear Implants
c Total: 12406, Disposed 11102, pending 1304 (no disaggregated data provided)

Source Author

Statutory commissions are constituted for varied sections of vulnerable groups in India—Women’s Commission, Minority Commission, Scheduled Castes Commission, Scheduled Tribe Commission, Commission for People with Disability and National Commission for the Protection of Child Rights, and are empowered to take up the issues of health rights violations of these respective social groups. However, the analysis of the data obtained through RTI overwhelmingly indicates that most of these commissions except for women’s commission in some instances, have not handled the issues of health care violations. (See Table 4.2) NHRC under the leadership of then proactive Chairperson/s (such as J.S. Verma, J.), in the 1990s, seemed to make a difference when it took an active role on issues of health care violations, especially related to mental health care institutions. (Vide Chap. 3, Sect. 3.3.2.3 on psychosocial disabilities) The Commission also added its weight to the civil society PILs while it intervened as a third party, as in the case of silicosis. In a very promising move, NHRC held public hearings jointly with Jan Swasthya Abhiyan (Civil society coalition for health) in 2004. Its recommendations included declaring health as a fundamental right and to implement it with appropriate legislation. Further, it formulated a charter of patient’s rights in 2018 and has recommended it to the MoHFW of the union government (National Human Rights Commission 2018). Except in some rare cases, NHRC which is constituted of retired judges and headed by a retired Chief Justice of SCI, operates as a very dogmatic, bureaucratic and an orthodox institution. Operationally, it functions as an extension of bureaucratic court formalities rather than an ombudsman body constituted to protect human rights of citizens, while dealing with gross violations of health rights (Jan Swasthya Abhiyan

16 Swasthya Adhikar Manch v. Union of India and Ors. WP 33 of 2012 (Along with AR 79 of 2012 and KM 558 of 2012); Interview with the petitioner—senior health rights activist from Madhya Pradesh, dt. 03 July 2015.
4.1 Procedural Justice and Healthcare

The civil society leaders consulted opined the NHRC or SHRC bodies as being non-proactive and unresponsive.

Medical Councils

The MCI is the apex professional regulatory body in India for the allopathic medical professionals which is constituted under the Indian Medical Council of Act 1956. Its affiliate bodies in the states are constituted under various state acts. The medical councils are quasi-judicial bodies to which MCI is the appellate body. The mandate of the MCI is regulation and conduct of medical education and medical profession (the allopathic medical doctors). The other systems of medicine have their own regulatory bodies. The accounts of respondents who have filed complaints in medical councils and doctors who have fought against the non-transparency and corruption in these bodies, allude to the non-transparency, corruption, nepotism, and professional collegiality over protection of patient rights. The MCI itself was suspended and put under its supervision by the SCI for corruption and mal-administration. (Vide: Chap. 5, Sec. 5.2 Health Justice Triad)

As an exclusive body of allopathic medical professionals, the patients do not have a free and open atmosphere for putting forth their grievances in state medical councils. The appellate procedure to pursue the case in the MCI against medical doctors is not feasible for them. Above all, the penalty that will be imposed at the end of a tedious process is only suspension of licence of the doctor, often tokenistic and without any monitoring on enforcement of the MCI orders. Such remedies do not have any relief for the suffering patients or their survivors. As this ombudsman body was steeped in corruption, in a sweeping change in 2019, the central government promulgated the National Medical Commission Act 2019, repealed the IMC Act 1956 and thus effectively dissolved MCI. What it augurs for patients and for grievance redressal is yet to be seen through the rules that will be formulated by the Government of India.

4.1.6 Constitution Based Remedies (Writ Petitions)

Writ jurisdiction of courts is enshrined in the constitution of India to protect the fundamental rights of citizens under articles 124–144 of the Constitution of India. As right to health care is declared as a fundamental right by the SCI, any aggrieved citizen can access apex court under section 32 and HCs under article 226 of the Constitution. The writ petitions can also be filed as individual petitions (Government of India 2015). The health care jurisprudence discussed in this book emanates from this judicial remedy (Vide, Chap. 3). It has the potential to bring about systemic

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17 When NHRC presided over the public hearings on health care violations organised jointly by Jan Swasthya Abhiyan (coalition of civil society organisations in India for health rights) and NHRC in 2017, the acting chairperson and member secretary, a retired judge of SCI, dismissed cases filed which had exceeded one year and even refused to listen to the issues of medical negligence.

18 Vide Section 60 of the National Medical Commission Act 2019.
change, which is not yet exploited adequately, and it is a very expensive mechanism to be used for individual remedies. When the outcome of the writ petition is deemed to be not fair and just, then occasionally review petitions are filed in the courts. In very exceptional circumstances curative petitions too are filed.\textsuperscript{19} Civil society in India has used this constitutional provision quite extensively on various matters with varied degrees of satisfaction in outcomes. However, as petitioners expressed, accessing constitutional courts both in the states and at the apex level is tedious, time-consuming, expensive, and contingent on pro-bono lawyers who can plead in those courts.

\section*{4.2 Health Justice: Substantive Justice}

The aspirations of justice in health care are articulated in the goal of the medical profession itself. The Constitutional goal for the welfare-state of India is stated to be substantive equality, justice (social economic and political) and a solidarity among citizens articulated through the concept of ‘fraternity’. This resonates closely with the noble goals of both the professions, viz. of the medical profession, which is to alleviate suffering, and of the legal profession which is to uphold justice. The voices of citizens aggrieved by the aberrations and violations in accessing health care supported by the voice of civil society demanding substantive social citizenship coalesce to form a formidable force in demanding SRHC and social citizenship through the mediation of the courts. The SCI is approached by citizens as the court of last resort seeking substantive justice in health care. What has been the role of the world’s ‘most powerful court’ (as Justice V. R. Krishna Iyer remarked) in furthering substantive health justice, the translatability of health care jurisprudence into substantive justice, is a deeper question that underlies the research of this book.

Implementation of judgments paves the path for the realisation of health care jurisprudence and is a step towards realising social citizenship. Nonetheless, from judgment to justice could be a long and arduous path where implementation of judgements itself is said to be ‘an acid test of any legal system’ (Baluarte 2010). M. C. Mehta, an ardent environmental rights jurist, Mehta (2009:457) poignantly indicate to the reality check despite having a robust jurisprudence. Environmental justice jurisprudence signifies a mature jurisprudence through litigations in Constitutional Courts for over four decades. He notes:

\textsuperscript{19}The curative petition is fairly a new concept in the Indian legal system. It is the last judicial resort available for redressal of grievances in court which is normally decided by judges in-chamber. It is only in rare cases that such petitions are given an open-court hearing. The concept of curative petition was first evolved by the Supreme Court of India in the matter of Rupa Ashok Hurra versus. Ashok Hurra and Anr. AIR 2002 SC 177 where the question was whether an aggrieved person is entitled to any relief against the final judgement/order of the Supreme Court, after dismissal of a review petition. It is done under Article 137 of the Constitution of India. Reference of 8 petitions on IPC 377 to a five-judge bench is the recent instance of a curative petition being admitted.
the Supreme Court of India adopted a landmark legal principle of environmental law, or issued a judgment that provided long overdue protections, seem to paint a rosy picture. Yet, as any resident or visitor to India will tell you, our battle for sustainability and justice is far from being won. Despite India’s dazzling GDP growth rate, the air in our cities is still badly polluted as automobile numbers explode. Despite the rise of our modern cities, our rivers are still teeming with disease and filth from uncontrolled municipal sewage. Despite our focus on infrastructure, ground water is still being extracted, far in excess of its carrying capacity, for the uncontrolled development of residential high-rises.

Such an observation echoes both the potentials as well as the limits to the jurisprudence in accentuating social rights.

The aspirations of justice in civil society is a quest primarily for distributive and restorative justice, that seek a systemic change in terms of plugging loopholes or policy gaps, implementation of policy and putting in place policy and regulatory framework. The politics that drives citizens to courts on the one hand signifies a grievous sense of injustice and indignity that is experienced in the face of gross violations, and on the other, it is also driven by the aspirations of justice. Locating the miscarriage of justice in health in institutional failures and varied types of violations (Vide. Fig. 4.1), the aspirations of justice in health care posit itself as a quest for distributive and restorative justice. Such a quest seeks systemic changes for making health care a matter of citizens’ legitimate entitlement and a matter of justice.

The litigations analysed that range from individual petitions (claims) to collective claims testify to the underlying quest for health justice. Scholars engaged in comparative research note that in India individual health rights claims are less common (Roseman and Gloppen 2011). This research too found very few individual litigations demanding personal benefits as compared to several PILs that demanded, inter alia, plugging loopholes and policy gaps, implementation of the people oriented policies, and putting in place regulatory and redressal framework in favour of citizens. Essentially it reinforces the understanding that health care litigations in India aim at systemic changes and strengthening the health care system.

4.2.1 Assessing Systemic Impacts and Limitations

In an emerging and exploratory domain of social rights jurisprudence and SRHC, lack of adequate evaluatory frameworks and tools are challenges to gauge the impacts of jurisprudence on equity and social justice in health (Yamin and Gloppen 2011). Change in the health system is the ultimate aim of social rights jurisprudence in health. While the specific orders in litigations are tangible legal instruments, their outcomes in terms of systemic changes will only become visible over a longer period of time that need to be assessed. In this section we discuss the possibility of health justice employing the concepts of justiciability, enforceability, and transformability.

Justiciability
In relation to the social rights, Coomans (2006:4) broadly defines justiciability to mean ‘the extent to which an alleged violation of an economic or social subjective right invoked in a particular case is suitable for judicial or quasi-judicial review at the domestic level’. The historic baggage of treating economic-social-cultural rights as being inferior to civil-political rights has overshadowed the popular imagination on social rights as being inferior to civil-political rights. Such a cleavage is also reflected in the Constitution of India and the approach of court institutions and legal profession. The legal profession as a whole and judiciary, lack orientation to human and social rights. Interviews with judges and discussions held with law experts dealing with judicial academies confirmed such a view.20

India’s Constitution enshrined both these aspects, but with divergent and variant emphasis. The liberal democratic rights were justiciable while the positive rights were not and were subject to ‘progressive realisation’. The social rights, being placed under DPSP and hence were not justiciable. India took about three and a half decades to constitutionally establish the justiciability of the social rights in principle in the late 1970s and such a move came through the judiciary known for their radical views amidst the huge political turmoil of the 1970s (Gadbois 2011).

Justiciability of social rights is established in multiple ways. In the Constitutions of new democracies such as many Latin American Countries, South Africa, and some of the neo-colonial countries such as Thailand, the new Constitutions expressly included the expression of right to health care as a constitutional right. Such Constitutional provision seems to advantage the social rights as shown in these countries. In India, however, this was achieved by a progressive judiciary through a series of judgments on social rights and right to healthcare. However, this is no guarantee for the realisation of rights as it requires systems and mechanisms which need to be put in place by the executive. It is rightly observed that ‘the constitutionalisation of social and economic rights does not result in their automatic protection’ while their absence does not prevent countries either in instituting fairly well crafted welfare policies, irrespective of the nature of political regimes (Uitz and Sajo 2006:121).

The findings of the research described and analysed in chapter three and supported by sound academic literature, confirms that the Constitutionalisation of right to healthcare has been achieved in India. Theoretically, it would imply that any violation of SRHC can now be brought into the Constitutional Courts with a comparative ease. The philosophical barrier to justiciability or access to justice in healthcare violations has now been crossed. However, such a move does not guarantee the redressal for any violation, better access to healthcare or the re-distribution of the public good of healthcare. Significantly, due to the power embedded in the jurisprudence laid down by the SCI, patients and citizens stand a greater chance of being heard in the highest court of the land. That, however, stands no guarantee for the resolution of grievances in local courts or through independent tribunals or authorities. The

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20Discussion with an associate professor of law engaged in judicial academies, New Delhi, 11 February 2017, India Habitat Centre, New Delhi. The constitutional expert also remarked that during the training in judicial academies, most of the time is spent on the skills of drafting judgments and sentencing.
only limited option that is available for citizens with a relatively fair ease is the consumer redressal fora. It still does not solve the systemic issue of inadequacy of the overall grievance redressal and justice dispensation mechanisms in health care at an individual or collective level for different kinds of violations that take place.

Muralidhar (2006:256–264)21 draws attention to a couple of important barriers for the justiciability of social rights. These include law and policy divide (courts are reluctant to touch the policy arena), conflict of rights claimed, failures of the legal system which is ridden with formalism, lack of legal aid, the negative experiences the poor have of the police/law enforcement agencies and the court system as they are dragged there for reasons linked to their poverty, and failures to integrate non-formal legal system. Enforcing jurisprudence towards the realisation of SRHC is usually the missing link between court declarations and the lived reality of people’s lives.

Enforceability

Execution of the court order, response of compliance, remedy from the government machinery or department which allegedly is non-compliant or non-adherent or unaccountable is an uphill task for the courts to do. There is no independent agency or authority to aid the courts, and hence, courts are dependent on the executive. In many instances, the courts have instituted ad hoc committees or have appointed amicus curiae led by some expert or advocates to submit reports to the court.

The lack of defining the justiciability of social rights and lack of a legal framework makes enforceability an uphill challenge for the judiciary. Placing health care in India under the DPSP, i.e. chapter four of the Constitution of India is itself a constitutional limitation on its realization. Comparative studies on the justiciability and enforceability show that mere constitutional provisions on social rights are not sufficient for an effective realisation of SRHC (Coomans and Universities Maastricht 2006). The governments of the day continue to put forth arguments of ‘lack of resources’ and resort to the proviso ‘progressive realisation subject to the availability of resources’ for the lack of substantial measures in the realisation of SRHC. A finely articulated legal framework within the constitutional vision that restrains the State from being regressive in its policymaking and that obligates it to institute mechanisms such as strengthening primary healthcare along with adequate budgetary allocation is necessary. Health care being a terrain of ever-expanding thematic domains, specialized judicial institutions akin to the National Green Tribunal or a national regulatory authority akin to the telecom regulatory authority of India (TRAI), for example, would go a long way in aiding the courts enforce compliance with the jurisprudence, even as continuing to be institutional ombudsperson.

Transformability

Translation of orders into institutional rules and mechanisms which empower and enable citizens/patients to access health care and access redressal is the core of health justice. There are several factors interlinked with justiciability and enforceability, that are instrumental to the transformation of healthcare jurisprudence into health

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21 The author later became a judge of Delhi High Court in 2010.
justice. In India, translation of orders into accessible entitlements or redressals is said to be the primary gap in health justice. In an international symposium which discussed ten years of jurisprudence in reproductive health care matters in India in 2017, litigants, advocates, constitutional experts resonated a similar perception. They overwhelmingly contended that outcomes in the form of implementation of the orders continued to be a gaping hole in the far advanced reproductive health jurisprudence in India (Jindal Law School—CHLET 2017).

Transforming social rights into legal rights is said to be one of the key outcomes of judicialisation of social rights. Some of the leading researchers in social rights have proposed equity to be central to such outcomes along with health system changes. Yamin and Gloppen (2011:337) argue that judicialisation should be located within broader efforts to achieve justice in health, including comprehensive and democratic priority setting. One difficulty, however, in assessing the effect of judicialisation is that impacts such as improved health delivery system, fixing loopholes and changing the behaviour of the providers, evolve over a period. Besides, impacts such as those related to equity and social justice are complex to be assessed. Gauri and Brinks (2008: 304) describe this process as ‘legalisation of policy’ which is explained as engaging legal actors and use of legal concepts in policy making. The various stages of such legalisation include legal mobilisation (placing of cases on the courts’ docket), judicial decision, response (bureaucratic, political, or private party response) and follow-up litigations. These researchers agree that assessing court impact beyond the court orders is a daunting task and methodologies for such a venture have not yet been adequately developed (Gauri and Brinks 2008).

The ten health care domains analysed in Chapter three, point to varied and differential outcomes in each of the domains, with a negligible perceived impact on the health care system. The individual elite citizens such as bureaucrats and higher rank government officers have effectively gained from such jurisprudence as compared to other citizens, especially the vulnerable citizens. The gains though are individual in nature, have also gained currency as the rightful claims of the entire elite class as can be seen by the policy provisions that have followed including provision of health care overseas done at State expenditure (Baru 2013). On the contrary, the jurisprudence laid down in the Paschim Banga Case had a potential for systemic reform at least in primary health care that is very close to the people. This jurisprudence was progressive in nature and had references to the domain of emergency health care, essential medicines and drug pricing which was articulated in terms such as ‘absolute and ethical duties’ of the medical profession and the ‘constitutional duty’ of the State in saving lives. Though this is one of the earliest litigations, the jurisprudence was not consistently applied to the subsequent litigations. Even one of the key components of ‘emergency care’ being a fundamental right was not transformed into a legal right for the poor citizens. The gains of this jurisprudence, however, benefited the middle/upper class citizens, two decades later, in a litigation by SaveLIFE Foundation concerning the emergency care that is essential for the victims of road accidents. The litigation outcomes resulted in the legal protection that was required for good Samaritans (by-standers) in saving the lives of such accident victims. This litigation
overwhelmingly highlighted the concerns of middle/upper classes driving on highways rather than the disadvantaged citizens struggling to access basic health care. Paradoxically, the jurisprudence laid down in *Paschim Banga case* (1996) formed the key legal reasoning in the writ petition of SaveLIFE foundation (2017) concerning accident victims.

The demand for patient rights and the rights of citizens in health care have invariably emphasised systemic change as the most desirable response rather than punitive measures on individual health care providers. In the domains of drugs and medicines, for example, such demand has focussed on implementation of drug pricing, whereas in maternal health care litigations plugging systemic gaps was the key issue. The analysis points to certain gains in some individual litigations addressing specific aspects of health services (for example: female sterilisation and quality of care), and a gaping hole in the translation of the judgments into a systemic response or reform. With an unambiguous jurisprudence laid down, one would expect that the number of litigations in health care would decline. However, the time-period analysis (Fig. 5.3) indicates to a significant increase in health care litigations in the post-2000 period, indicating to the contrary.

Several individual gains can be enumerated based on individual writ petitions filed on some pressing issues. Examples of individual awards such access to termination of pregnancy in some difficult cases such as rape of a minor after the legally permissible period of 20 weeks or individual reliefs gained in getting a patient admitted in hospitals, award of compensation etc. illustrate such limited outcomes. However, there is little or frail evidence to substantiate systemic reforms attributed to the health care jurisprudence in the ten health care domains. Follow up discussions with litigating lawyers and petitioners in Bihar (respondents in the interview), overwhelmingly confirmed that individual outcomes of such jurisprudence are short lived and health centres quickly regress to their previous condition, once the litigation is disposed off.\(^{22}\)

A general perception that is prevailing in civil society is that regardless of a robust jurisprudence on SRHC, there is no substantial and sustained change in the way the healthcare system operates. The continued violations as seen in the unabated maternal deaths are attributed to the malfunctioning health care system (NAMHR 2016; SubhaSri and Khanna 2014).\(^{23}\) The court pronouncements and even the infrequent but furious outbursts of the judiciary against the State officials do not appear to have converted into any policy measures to improve the health care system as can be

\(^{22}\)Follow up Interview, Delhi, dt.11 February 2017: Follow up interviews with Devika Biswas, petitioner (Devika Biswas v. Union of India) and advocate Vikas Pankaj (Patna), India Habitat Centre, New Delhi, 11 February 2017. In the cases of Patna medical college hospital, Guru Gobind Singh hospital (Patna) the HC had ordered shifting maternity ward to ground floor from the second floor. It was followed during the pendency of the litigation. Later, it was shifted back to the first floor. Similarly, the order on sterilization lays down dismantling camps for sterilisation. However, the camps have continued both in Bihar and Madhya Pradesh.

\(^{23}\)A systematic analysis of maternal deaths has been undertaken by two groups of women’s organisations and they indicate the continued gross systemic failures in the post-NRHM period which is renamed as NHM.
gathered from several accounts. The jurisprudence, for example, has not translated itself into any increase in budgetary allocation that has remained abysmally stagnant at 1.2 percent of GDP and consequently there is no reduction in the out of pocket expenditure (National Health Systems Resource Centre 2016); the gross violations of the bodily integrity of women continued in sterilisation camps even during the pendency of a follow up contempt petition in the SCI on the same issue of sterilisation24; and, though emergency medical care was declared as a fundamental right in the mid-1990s, violations in the form of refusal to admit patients resulting in deaths continued unabated.25

It is often contended that judgements, orders, and pronouncements of the courts have only ‘symbolic impacts’ and some of them have ‘instrumental impacts’ (Rodrigues-Garavito 2011, 2017). The symbolic judgments are rhetorical in their formulation, however, are devoid of any concrete measures for change. The ones with instrumental impacts refer to those with some micro or individual need that is fulfilled in health care. The analysis in this research closely resonates with such an opinion. There are several symbolic declarations and a huge list of individual outcomes, without necessarily changing in the health care system. Often the question arises—if it is worth pursuing litigations only to get individualized orders consequential to the larger community or the health care system. The analysis which points to sporadic individual gains and a consistent setback in systemic changes, then necessitates an examination of the structural constraints and the limits to jurisprudence and judicial power.

4.3 Structural Constraints in Health Justice

Employing any mechanism for grievance redressal is only the first step in accomplishing health justice. The probability of such attempts turning into substantial gains for health justice is subject to several structural and institutional considerations related to the actors, power structures, institutional hierarchies, and professional hegemonies.

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24 Rama Kant Rai v. Union of India litigation had detailed orders with protocols. However, the government of India led sterilisation programme for population control continued violating these orders and even deaths en masse (as in Chhattisgarh) occurred during the pendency of Devika Biswas v. Union of India in 2014. The affidavits submitted to the SCI in Devika Biswas versus. Union of India, accounts from various states on the manner of conducting sterilisations of women document that the violations of SCI orders such as conducting sterilisations in school building without basic amenities, conducting as many as 50 deliveries in two hours by consultant surgeons have continued.

25 The issue of Avinash in 2015, where both the parents committed suicide when the child was denied admission in as many as 7 hospitals in Delhi when he needed emergency admission for dengue.
Some petitioners, especially those dealing with medical negligence, have pursued simultaneous and parallel redressal pathways, such as criminal prosecution, compensation under consumer act and complaint against professional misconduct/negligence in the medical council. The overwhelming experience of petitioners and complainants is that these procedures are unfriendly to the petitioners, tedious and invariably render the sufferer or health justice seeker even more vulnerable, fatigued, and frustrated. The lack of an integral and adequate legal framework to address violations of health rights emerges as a key structural constraint in this research.

The prevailing legal framework for adjudicating health care matters in India is weak, fragmented, and inadequate. This is another structural constraint that we have considered at considerable length in this chapter. The legal avenues are dispersed through multiple legal institutions and procedures. As discussed earlier in this chapter, in the criminal prosecution, the State assumes the role of the prosecutor, and the outcome is punitive measures and not systemic change. SRHC is primarily considered a civil or private litigation. In civil procedures, the onus of producing evidence is on the litigants and primarily on the plaintiff (petitioner). In health care violations, there is a serious power asymmetry between the parties as the respondent (e.g. a hospital or a medical doctor) comparatively enjoys greater power vis-a-vis an individual citizen. Aggrieved citizen finds himself/herself at odds with a powerful medical fraternity while pursuing medical negligence complaints. The medical profession is known to exert enormous influence through various associations against any regulatory architecture as now it is known that the regulatory bodies such as MCI, CDSCO, ICMR are mired in deep ‘nexus’, ‘collusion’, ‘partisanship’ and ‘inefficiency’ (Parliament of India—Rajya Sabha 2012, 2016b). Healthcare institutions and the statutory or quasi-judicial regulators often are known to be very inefficient and disinterested in the issues of the poor.

A third structural constraint relates to the institutional complexities of litigating a matter in courts. Compared to other court processes in civil and criminal matters, health care litigations exhibit further complexities due to technicality of the subject matter, plurality of actors, multi-stage process of the litigations and the hierarchies of institutions involved. In the civil-political rights, the relationship between the State and the citizens is direct and rights of citizens, classified as negative rights, restrain the State from encroaching upon the liberties and fundamental freedoms of citizens. However, in matters of healthcare, which is a social right and classified as a positive right, it is the interventionist dimension of the State which is at play. Unlike a civil-political right, health care is not a matter between citizens and State alone. The chain of health justice seeking process involves a plethora of actors such as police, hospitals (institutions for hospital records), prosecution solicitors (lawyers), lawyers and legal assistance for drafting and representation, consumer redressal fora and commissions, doctors and health bureaucrats (designated as ‘appropriate authority’) and so on. The issue of medical opinion and documentary evidence are crucial in matters such as proving failures of sterilisations. In obtaining a medical opinion or in procuring medical records from private hospitals, patients face enormous hostility. The institutional complexities of actors and procedures render the quest for health
justice as a tedious, unpredictable, frustrating, and often in the end, unrewarding process.

Soft power of class camaraderie cuts across legal and medical professions and various institutional actors that a litigant encounter in the health justice seeking process. The professional class of doctors, judges and other social elites tend to be sympathetic and protective each other based on their social class status. The claims of rights against violations are pursued at various levels of the hierarchically ordered judicial-legal institutions, that in themselves mirror the societal hierarchy of the actors and their class status. Even the judicial institutions, that hold the key to restore the power balance between citizens, State and the health care system, carry the elitist character of its historical capitalist-bourgeoisie moorings, as the historical trajectory of these institutions traced by Tigar and Levy (2005) indicate. Thus, for a health justice seeker, making headway through the class-caste-, and patriarchal mindsets in the legal institutions and their mediaries, appears to be the fourth structural constraint that impedes the transformation of health care jurisprudence into health justice. Health care litigations, in themselves, reflect these complexities of actors, institutions and processes. Health justice, therefore, is an outcome that emerges out of such a complex and contested process.

4.3.1 Actors and Institutional Relationships in Social Right to Health Care

In the traditional framework, the relationship between citizens and State in a liberal democracy was explained in terms of social contract between the principal and agent. However, such a framework does not take into account the complexities of societal structures that influence the behaviour of the State, the vulnerability and inequality among citizens, the constitutional obligations of the State, and the accountability of the State to its citizens, all of which go beyond the principal-agent social contract paradigm.

The social citizenship depicted through SRHC is a triangular relationship between the State, healthcare providers and citizens. Gauri and Brinks (2008:10) depicts these institutional relationships in SRHC through the duties and obligations of various actors, and liberties that arise for the citizens. It involves the interface of three sets of actors, viz. State, healthcare providers and citizens (clients or patients, in the context of seeking healthcare). The relationship between State and citizens is described in terms of the duty of the welfare-state to provision or finance health care. The relationship between a second set of actors, viz. the State and health care providers is defined as regulation. The relationship between a third set of actors, viz. health care providers and citizens are depicted as private law relationship. This framework
presents a model to analyse the scope and limits of health care jurisprudence through the differentiated exchange of power between and amongst various actors.\textsuperscript{26}

The health care providers form a key constituent in this triangular relationship as regardless of the model of providing health care, it is dependent on this professional group and the institutional arrangements that are organised around them. They are organised under multiple professional associations in terms of their skills, specialisations or within their geo-political identities. They offer their professional service both in public and private health care institutions. Though there are diverse health care professionals, it is the medical doctors who form the most important group of professionals for the dispensation of health care provisioning. As there is no singular or all encompassing medical regulatory authority in India, the varied components of their functioning are administered by diverse authorities scattered under various ministries. The multiple aspects that come under public scrutiny and regulation include licensing, maintaining quality and standard of care, managing relationship with the State and other professional associations, sanctioning of members, and civil-criminal liability of medical practitioners (Ayres and Braithwaite 1991; Healy and Braithwaite 2006; Makai and Braithwaite 1992). However, from the SRHC perspective, the relationship of health care professionals with patients—referred to as doctor patient relationship—is of seminal importance and is a much-neglected arena considered for regulation. The litigations examined in this book, point primarily to the concerns that relate to protection of patient rights and addressing negligence in the private-commercial medical sector in the overarching unregulated policy atmosphere where the issue of medical negligence does not get adequately addressed (Perappadan 2016a; 2016b).\textsuperscript{27}

This doctor—patient relationship is significantly influenced by private-commercial actors such as pharmaceutical and diagnostic companies who are known to exert power and influence over policy makers and health care professionals. They heavily invest in engaging courts for injunctions, writ petitions, appeals, interlocutory applications to challenge and thwart civil society efforts or to oppose orders of authorities.

\textsuperscript{26}Not all the litigations taken up by the courts in matters related to health care can be explained by the triangular relationship. For example: Courts have taken up issues of strikes by medical doctors, the Courts have intervened as in the much-debated ongoing litigation on Madhya Pradesh Professional Education Entrance Test (known as Vyapam scam). These are strictly professional institutional matters or are private litigations. In a social liberal democratic republic, the State has a greater say in these. And when the State has not exercised its due diligence courts have intervened. Public servants claiming compensation for health care expenditure and enjoy better social security in their relationship to the State as an employee rather than a citizen. State behaves like a private employer. A citizen, to whom the State is obliged to provide social care, enjoys fewer social rights though defined by agent-principal relationship or in a welfare State, a provider and client relationship.

\textsuperscript{27}The resistance of the medical profession against any regulation and to undo the already existing regulatory policies is well recorded. The Indian Medical Association resisted against getting doctors under CPA from 1986–1996; The doctors also protested the Clinical Establishment Act. Post 2010, when the enforcement of PCPNDT regulations have grown to be stringent such as suspension of doctors and suspension of the licences, the Indian Radiological and Imaging Association (IRIA) have gone on an indefinite strike demanding the amendment to this Act. The Indian Medical Association and other doctors have also been demanding the amendment to the PCPNDT Act.
such as NPPA. In summary, the health care providers are a significant yet powerful constituent actors in actualising health justice.

The relationship between the State and citizens is established through the constitutional framework of the welfare-state and in health care it manifests as health care provisioning or resource allocation/financing. The relationship between the State and health care providers is termed as regulation. The State is vested with power to make policies so that health care provisioning is distributed equitably and constitutionally obligated to protect citizens. State also is an active player in the production of human resources, primarily through providing and regulating medical education. In recent years, the State being lenient towards private-commercial ventures in health care, the regulatory aspect of this relationship has taken a back seat. The relationship between the healthcare providers and citizens, considered a private law relationship, does not always have a defined and cohesive legal framework to mediate this relationship. It is a contentious domain especially for issues such as patient rights, as on the one hand the State is reluctant to introduce regulatory policy against the powerful actors (viz. private-commerical health care providers) setting the stage for increased citizen vulnerability, whereas the civil society on the other hand is demanding protection of patient rights through greater legalisation. In the face of regulatory policy vacuum, health care jurisprudence evolved through litigations in the context of gross violations, has emerged as the primary avenue laying down the rules of this relationship in India (Pinto 2018). The extent of realisation of SRHC will finally rest on the duties and liberties that extend between healthcare providers and citizens (clients). Among others, these will include patients’ claim for accessing health care, for compensation under law of tort, duty of the health care providers to safeguard confidentiality, obtaining informed consent prior to the treatment, ethical and moral requirements for medical practitioners to treat certain class of patients such as rape victims (Ibid.).

Each of the three key actors is constitutive of a plurality of actors such as individuals, institutions, professional associations, government service delivery systems and administrative bureaucracies located at various levels of the central and State administrative jurisdictions. The administrative actors include multiple ministries at the union and state levels, institutions involved in policy making at various levels of governance, the health bureaucracy in the health care system, and the processes of policy making and provisioning. Similarly, the healthcare providers include a range of professionals, professional associations, private hospitals, charitable institutions, and corporate health care institutions, diagnostic entities and so on. The citizens seeking health care exhibit a very complex mix. Citizens who access health care and often seek curative care as patients differ in their social status, class they belong to, and their healthcare needs vary subject to their identities. Those drawn from the higher strata of society such as the political class (legislators), government bureaucrats (the executive) and judges (the judiciary) are entitled to a separate set of privileges and health care arrangements provided by the State. The courts have continually intervened in streamlining the health care access and reimbursement of expenditure to the higher cadre of bureaucrats. In addition, for citizens in organised employment in
India, access to healthcare is fairly well crafted. For example, the organised industrial workers have ESI hospitals and the armed forces and railways have separate health care facilities. The infringement of entitlements that these classes experience is markedly different from the violations of rights in health care that the vast majority of citizens belonging to informal and unorganised workers experience.

These citizens or ‘masses’ as referred in this book, have to depend solely on the public health care services or face the threat of being further impoverished due to health care expenditure. These vulnerable citizens are not a homogenous group either, and their health care needs too vary. Undoubtedly, they are the most powerless actors in the triadic relationship of power as they lack necessary economic-social and political power to negotiate for their social rights. They stand to lose their wellbeing and health status when the public health care system deteriorates or malfunctions. SCI has in its ruling articulated and reinforced the inalienable right to health and health care enshrined in various the International Conventions. To the vulnerable citizens, the language of rights matters the most as a tool to negotiate for their health care (Pinto 2018). Although the language of rights was incorporated in the framework of NRHM with an aim to strengthening the health care provisioning in India, in recent years such a policy aspiration is progressively being shunted out from public discourses (Mo HFW—Govt. of India 2005). Over the years, with the deteriorating situation of healthcare, the violations of their rights are perceived to have increased, a state of affairs which is described in popular media as a state of ‘malady nation’.28

### 4.3.2 Multi-stage Complex Process of Litigations

The in-depth investigation through interviews and discussions with several health activists affiliated to various networks revealed that pursuing a litigation is a multi-stage and multi-level process that involves a multitude of actors. In addition, the health care litigation appears as an intense socio-political process played out at different levels involving several actors at each stage. Yamin and Gloppen (2011) provide a framework to locate the various stages of litigation in the life cycle of a litigation, i.e. claims formation stage (pre-adjudication), adjudication phase, outcome, and social equity phase. A four-stage process similar to this is also noted by Gauri and Brinks

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28 The Hindu carried six-part coverage on the status of healthcare in India under the title ‘malady nation’ from 8th to 13th August 2016. (Malady Nation: Remediing India’s healthcare colossus, http://www.thehindu.com/sci-tech/health/malady-nation/article15317635.ece Accessed 10 July 2017).
In the analysis of legalisation process that is also referred to as ‘strategic litigation process/es’.\(^{29}\) In addition to the actors discussed (Vide: Sec. 4.3.1), the importance of the context, mechanisms and the outcomes is important to analyse in order to understand the litigation as a socio-political process, and not merely as an act of litigation occurring in the courts in isolation. The explanatory components of ‘realist evaluation’\(^{30}\) framework—‘mechanism’, ‘context’, ‘outcome pattern’, and ‘context-mechanism-outcome pattern configuration’—proposed by Pawson and Tilley (1997) provide a lens to view this process. This paradigm lends an analytical frame to construe the long-drawn litigation as a dynamic process, subject to be affected by various socio-political factors. We also recognise and acknowledge the influence of several contextual factors and actors over the litigation process, including the judiciary and court institutions, who are ‘embedded in social systems’ and are susceptible to and are conditioned by externalities such as ‘unanticipated events, political change, personnel moves, physical and technological shifts... media coverage, organisational imperatives’. (Pawson and Tilley 2004)\(^{31}\) Table 4.3 provides a synthesis of the stages of the health care litigation process, plurality of actors and mechanisms.

In the claims formation stage the civil society organisations and their networks are the key actors and other important actors include the suffering and affected (victims/survivors/relatives), media, the investigating machinery (police).

Similarly, in the adjudication stage, the courts and the judiciary are the key actors and other equally important actors include lawyers, the government representation in the court (advocate and solicitor generals, civil society organisations and networks and, media. In the post-adjudication stage or the outcome stage the executive (government) is the prime actor and the other significant actors include civil society and networks and media. The role of the legislature which is the representative of the citizens in taking the issue of health care violations and suffering is very way-ward and ad hoc and not forthcoming except in some instances.

During the post-1990s, with the policy incentives provided for commercialisation of health care in India, the private corporations have emerged as key players in healthcare services. Such a phenomenon is reflected in several healthcare litigations. While in many litigations they are respondents, they are also seen to be using court power for their strategic purposes such as to resist any regulatory measure taken by the government, to challenge government directives or as impleaders to influence court

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\(^{29}\) The strategic litigation process is a litigation-stage based framework builds on several socio-legal literature analysing strategic litigation processes, the different stages involved in it, and its outcomes and impacts in different stages. It is primarily developed by the theoretical works of (Gloppen 2006, 2008a, 2008b; Galanter 1974; Rosenberg 1991; McCann 1994; Epp 1998; Feeley and Rubin 2000; Hertogh and Halliday 2004; Hirsch 2004) The recent works of Langford (2008), Gauri and Brinks (2008), Yamin and Gloppen (2011), Flood and Gross (2014, 2016) further adapt it for their analysis and consolidated this framework.

\(^{30}\) Though in the original work the framework was named as ‘realistic evaluation’ later, through the usage and references of other researchers the nomenclature came to be known as ‘realist evaluation’ as explained by (Pawson and Tilley 2004).

\(^{31}\) This research has not used the realist evaluation framework for the design of the research but has adapted the evaluation framework for analysis.
| Table 4.3  Stages and actors in health care litigation process |
|----------------------|------------------|------------------|------------------|
|                      | Key actors                    | Context                                           | Mechanisms                                           | Outcome patterns                           |
| Claims formation stage | Civil society organizations and networks | Weakened public health care system and intensified systemic violations | Mobilisation of public opinion through media, evidence and research, formation or synergising coalitions | Plaint/petition                        |
| Adjudication stage    | Courts and judiciary           | Eco-system of judicial-legal institutions/courts reciprocity by the State | Court and litigation process, engaging a socially sensitive, affordable and capable legal counsel | Order/judgment                             |
| Outcome stage         | The executive/government      | Openness by government to improve system           | Pressure on the healthcare system and enforcement agencies | Enforcement/realisation Redressal of violations |
| Social equity         | Civil Society; litigants; political society (political parties, affiliate organisations) | Political context, willingness of the State to strengthen healthcare system, its resources and capacity | Sustained vigilance and follow up by civil society | Impact on the healthcare system and its policies |

Source: Author

processes by pressing themselves to be noted, counted and heard. It is significantly noted in the analysis of these processes that the politics that drives diverse actors to courts in health care matters varies. The consideration and analysis of the underlying politics behind these litigations bring out the contentious and competing dynamics of power, and define and characterise these litigations, not merely as judicial processes but also as socio-political processes. Citizens, for example, are driven to courts as a last resort in seeking health justice even as they claim entitlements and press for policy
directions as part of their citizenship politics. However, corporations such as pharmaceuticals, private-commercial health care establishments and medical professional associations engage courts to challenge any pro-patient/citizen policy or directive which is perceivably challenges their power, authority or profiteering prospects. With these institutional and competing complexities, SRHC unfolds itself through these healthcare litigations as a cumulative outcome of the balance of power between the key actors, viz. State, professions, and civil society, navigated through a complex juridico-legal eco-system and the fluctuating political-economy contexts determining health policy at the global, national and sub-national (state) levels.

4.4 Health Rights and Epidemics/Pandemics

The COVID-19 pandemic, due to its unprecedented scale and unpredictability of its spread and stinge, has thrown new challenges to the already ailing public health care system in India. In addition, it has also laid bare the approach and intentions of the private-commercial establishments in their resistance in complementing the government’s efforts to enhance public health care capacity for patient care. World over, this pandemic has exposed the vulnerabilities of the health care system and the under-preparedness of the health and bureaucratic machinery to face such a challenge. With the onslaught of the pandemic at a very rapid pace and scale, the government in India was dealing with the challenges of containing the spread and to treat the infected. The number of people infected have been surging every day, globally and in India. In India it was at 2,86,836 confirmed cases and 8108 deaths, and the numbers were still mounting (11 June 2020). By late September 2020, the official extent of infection had crossed 5.5 million with 90,000 reported COVID19 deaths. Public health laws are deployed during pandemics with the primary intention of containing the disease or infections. We briefly discuss measures as related to law and public health here in relation to citizens’ rights to access health care.

The key measures taken by the Government of India include the following:

Invoking Epidemic Diseases Act 1897

The Epidemic Diseases Act, 1897 was enacted in British India for containing epidemics. This Act empowers the government to take necessary containment measures and to prescribe regulations such as inspection of persons and segregation/quarantine. It also makes disobedience of any regulation or order made under this Act a punishable offence. The legislation has provisions to protect persons or officials acting under this Act as no suit or other legal proceeding can be initiated against any person for anything done in good faith (The Wire 2020). Several states passed ‘COVID19 Regulations 2020’ under this Act to enforce related necessary

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32The former figures were at the time of writing the manuscript, dt.11 June 2020, and the latter figures from the Government of India’s official Arogya Sethu App, reflect the rise in infections and mortality, at the advanced stage of publishing this book, i.e. 23 September 2020.
actions such as compelling private employers to treat the employees forced to stay at home as ‘on duty’, to stop all construction work immediately, to shut night clubs and weekly bazaars etc. (Mehta et al. 2020). The Indian Government had taken steps earlier in 2017 to enact a comprehensive legislation. It had introduced a bill in 2017 called the ‘Public Health (Prevention, Control, and Management of Epidemics, Bioterrorism and Disasters) Bill’. The said Bill was to repeal the Act but has lapsed (Ibid.)

Invoking provisions of Indian Penal Code

In the context of epidemics and pandemics, the power of the Indian Penal Code (IPC) 1860 accompanies the Epidemic Diseases Act. Section 188 of IPC imposes punishment for disobeying an order promulgated by a public servant; section 269 and 270 prescribe punishment for negligent and malignant actions which may spread infection of any disease; section 271 prescribes punishment for disobeying quarantine rule (Government of India, n.d.. (b)).

National Disaster Management Act

The current lockdown has been imposed under the Disaster Management Act, 2005 (DM Act). The Constitution of India is silent on the issue of ‘disaster’. In the post-tsunami time, the legal basis for disaster management was established through the DM Act, invoking Entry 23 and Entry 29 in the Concurrent List of the Constitution of India (PRS Legislative Research 2020). The legislative intent of the DM Act is to provide for the effective management of disasters. The Act provides for the National Disaster Management Authority (NDMA) to function as nodal body for coordination of disaster management, with the Prime Minister as its Chairperson. The NDMA lays down policies, plans and guidelines for management of disaster under section 6 of the Act (Ibid.). Similarly, State, District and Local level Disaster Management Authorities were established to respond to disasters in their respective geographic jurisdictions.

The COVID19 lockdown and several other orders are issued under this Act. The national lockdown announced on March 24, 2020, was imposed under DM Act. The Order dated 24 March 2020 of NDMA was issued under Sec. 6(2)(i) ‘to take measures for ensuring social distancing so as to prevent the spread of COVID 19’. Additional guidelines and orders were issued thereafter by the Ministry of Home Affairs (MHA) which is designated as the ministry having administrative control of disaster management. Starting with 24 March 2020 till 11 June 2020 (72 days of lockdown), MHA issued 100 orders/circulars under the DM Act that covered various issues such as extension of lockdown, stranded migrant labourers and containment zones.

In a nutshell, in the context of pandemics, these legislations vest enormous powers with the State and its machinery. However, within the scope of our discourse, the key question that comes up is what about the rights of citizens? Regardless of what

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33Entry 23—‘Social security and social insurance’ and Entry 29—‘Prevention of the extension from one State to another of infectious or contagious diseases or pests affecting men, animals or plants’.
the Constitution of India has laid down concerning citizen rights, what unfolded during the lockdown was an unimaginable quantum of suffering which people from the informal and unorganised sector had to experience. Over 100 million of migrant workers were stranded, going hungry and were walking hundreds of kilometres to reach their villages. This resulted in deaths on the way due to accidents and fatigue. Under the powers of lockdown imposed on the entire country, in several places the communities experienced severe police brutality. Media reports highlighted the inaccessible health care to citizens needing regular care such as maternal services, patients needing dialysis, cardiac patients needing care (Sinha 2020). The outpatient services were closed both in the public and private-commercial hospitals and the public hospitals were turned into COVID19 care centres. The pandemic exposed the frailty of the public health system and several patients were turned away from hospitals (Joseph 2020). Media also reported on the belligerent stance of private-commercial hospitals in several cities including Mumbai and Bengaluru that refused to allocate beds for public health care and had to be coerced into compliance through strict warnings and show-cause notices.

In India, the lockdown was enforced brutally which brought back memories of the clamping of emergency in India during 1975–77. The brutality of police knew no bounds and the government ignored the lives and reality of people’s suffering—hunger, starvation, living in inhuman conditions, deaths due to non-COVID causes—with an overemphasis on enforcing the lockdown. It reinforces the idea that during pandemics as in emergency, citizen’s rights are suspended and even when rights of millions were violated in accessing food, water and healthcare, they did not have avenues either to express their grievances or to find resolutions to their pressing issues, within an overarching goal of containing the coronavirus. Notably, while the government turned a deaf ear to the suffering of millions of migrant and starving workers, it was very quick in notifying The Epidemic Diseases (Amendment) Ordinance, 2020 under the Epidemic Diseases Act 1897 to address violence against doctors. The media gave wide publicity to the sporadic events of attack on doctors and doctors too threatened through their associations to boycott work during the pandemic if they were not protected.

The legislations enacted or invoked embolden the hands of authorities with legal powers; however, it does not hold the State to account for the violations of constitutional rights of citizens, and what the State needs to do more fulfil the rights of citizens during pandemics. Citizens in general, and especially those from informal-unorganised sectors are divested of all their social and civil rights in practice. Number of violations such as starvation and malnutrition, inaccessible health care, and non-payment of wages are the continuing pandemics that people face perpetually in their lives. However, during pandemics the consequences are exposed with intensity. For example, migrant workers do not generally have access to the public distribution system in urban areas which results in starvation during pandemics. Similarly, the

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34 For vivid details of the headlines that occupied almost every newspaper and online magazines on the travails and suffering of people in India, pl refer to The Hindu, the Times of India, The Indian Express; online portals - the wire.in, scroll.in, The Caravan starting with 25 March 2020.
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Health cards or maternal health cards in India are not portable, and the migrant workers therefore cannot access this care in urban centres.

The SCI in India responded too late to the migrant crisis, ordering their free transportation to their hometowns. The key lessons from the pandemic strongly indicate that the courts and civil society have an enormous task ahead to strengthen the crumbling public health and health care systems and citizen rights, lest they should be decimated under the pressure of overload during epidemics and pandemics.

4.5 A Brief Synthesis

Number of laws and rules, both in the legal as well as in healthcare institutions, do not favour the deprived-vulnerable-unequal citizens. In addition to the failure of the healthcare system resulting in health care violations citizens have perceived legal-justice institutions as failing citizens causing the perpetuation of the same injustices. Occasionally, such protracted frustrations of patients with the health care system in general, spark off confrontations between relatives of patients or survivors and the medical professionals in specific volatile circumstances, resulting occasionally in assaults on health care professionals, both private and public settings. Hospitals also have been ransacked in some instances. Responding to the outcry of medical professional associations demanding a law to protect doctors, several states have taken legal initiatives to address the same. The Delhi government’s health department has issued guidelines to curb assault on medical staff including the provision of a security guard on duty (Perappadan 2016a). Many states such as Maharashtra have succumbed to this pressure and have enacted such laws. Visits to the private as well as public health care institutions in Bengaluru, Pune as well as in Madhya Pradesh, it was observed that doctor’s chambers are attached with a warning to the patients that ‘anyone who ill behaves with doctors is liable for prosecution and imprisonment up to three years.’ These warnings have now replaced the citizen charters of rights displayed in these hospitals earlier. In the circumstances of COVID19 pandemic and the continued assaults on health care professionals, the ministry of home affairs, has brought out an ordinance under the Epidemic Diseases Act 1897, that includes imprisonment and imposition of fine on offenders (The Wire 2020; PRS Legislative

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35In several instances of very gross violations such as the Bhopal Gas Tragedy, the failure of the courts gave them justice even after three decades of the disaster. In 1991 and murder of eight Dalit youth were lynched with axes by upper caste and another youth got killed by police during protests. The Sessions court in 2007 convicted 21 persons to life imprisonment and another 35 others to one-year rigorous imprisonment. However, in 2014, the High Court quashed the verdict and acquitted all the accused citing lack of evidence. Even after filing appeals in the SCI there is no movement as the public prosecutor is not yet appointed. (Jonathan 2016) In both these cases even after two-and-half decades there is no justice to the victims. In the latter, the perpetrators were let off due to lack of evidence. So also in Narmada Bachao Andolan versus. Union of India, where life and livelihoods of about a million people are affected, the SCI did not take into consideration people’s evidence but went blindly with the affidavits, claims and assurances of the government.
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However, measures to uphold patient rights or to safeguard citizen interest in hospitals are hard to come by.

The prevailing procedures for grievance redressal require the suffering patients and the aggrieved to marshal their resources to navigate through the complex hierarchies and bureaucracies of the judicial institutions. The MCI and its state units, purported to regulate medical professionals, are intrinsically hostile to patients and are designed to protect the erring profession. Besides, some parts of the procedural jurisprudence laid down by the SCI itself, has augmented the impunity of the medical profession as seen in the requirement of an expert medical opinion for criminal prosecution of medical doctors. The current institutional framework for health care justice weighs heavily against the health care seeking citizens, especially those from lower and even middle socio-economic classes. It imposes undue burden on them after having suffered, also to pursue the justice which is uncertain and unpredictable. More importantly, the navigation of the maze of adjudicatory institutions is mediated through the legal profession whose accessibility and affordability are a primary challenge for patients in realizing health justice. The lack of regulation and redressal mechanisms have left patients completely helpless against small, medium, and corporate hospitals. The absence of a policy and legal framework is the key challenge that patients face in seeking a substantive health justice, which needs to be adequately addressed for making health justice an attainable goal for citizens.

Most of the available redressals are individual-centred in character and scope, besides such practice of seeking health justice being adversarial. The contestation based on the evidence and power of the particular institution, a patient is expected to muster resources to move up the appellate institutions, up to the SCI as the final resort. The derailment of health justice is inbuilt in the prevalent procedural mechanism itself. With the lack of a cohesive legal framework, the uncertainty is quite acute and inevitably gives rise to disparate and ad hoc jurisprudence. A regulatory vacuum, frustration of civil society and state of conflict can jeopardise parliamentary democracy itself in the long run (Shah 2002:25).

The health care jurisprudence analysed in chapter three and the justice system analysis in chapter four exhibit a paradoxical and contradictory picture. This is the challenge of SRHC. Therefore, SRHC cannot be deciphered only through a doctrinal framework of jurisprudence. It calls for a deeper power and actor analysis from an interdisciplinary perspective. This is discussed in chapter five through the concepts of health justice triad and the analysis of the limits to jurisprudence.

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