Humans have been struggling for better quality of life for hundreds and thousands of years. The journey from the jungle—where ‘survival of the fittest’ was the rule—to modern human societies has progressed to a stage where ‘survival of the weakest’ is the main human value today. The absolute dominance of few individuals, who treated people as ‘subjects’ without any rights, could not continue for long. Last few centuries have witnessed several social revolutions such as French, American, and Russian revolution which changed the social, economic, and political structure of the societies around the world, and the rights of every human have been recognized.

The Article 25 of the Universal Declaration of Human Rights (1948) by the United Nations grants the right to a standard of living adequate for the health and well-being to humans including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond human control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, enjoy the same social protection. (1)

International Covenant on Economic, Social and Cultural Rights (1966) further state in Article 12 that the States recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and the steps to be taken to achieve the full realization of this right include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child,
(b) The improvement of all aspects of environmental and industrial hygiene,
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; and
(d) The creation of conditions which assure to all medical service and medical attention in the event of sickness.(2)

In 1946, detail plans for health development had been presented in the ‘Report of the Health Survey and Development Committee’ to the Government of India under the chairmanship of Sir Joseph Bhore. (3) And in 1950 Indian constitution proclaimed it as a ‘sovereign socialist secular democratic republic’, which guarantees “the right to life and liberty” (Article 21) and includes among the duties of the State “to raise the level of nutrition and the standard of living and to improve public health” (Article 47). (4, 5)

World Health Organization had also advocated Primary Health Care strategy in 1978 for achieving the Health-for-All by year 2000. (6) Consequently Government of India also formulated its first National Health Policy in 1983. (7) United Nations had also presented comprehensive millennium development goals (MDGs) in year 2000 to be achieved by year 2015 which includes health goals also, and now a post-2015 agenda for sustainable development is being discussed. (8)
Despite these efforts, large inequalities still exist between and within countries. Life expectancy at birth varies from nearly 51 years in Chad to 84 years in Japan.\(^{(9)}\) In Indian states also it varies from about 62 years in Assam to 74 years in Kerala.\(^{(10)}\) What are the causes of these inequalities? Why some societies are healthier than others? Why disease occurs? These questions have been intensely debated around the world during the 19\textsuperscript{th} century.

Max von Pettenkofer (1818-1901), a German physician, had advocated that environment and host factors play an important role in disease causation besides the agent.\(^{(11)}\) This line of thinking was later denoted as the ‘Epidemiological Triad’. This idea of the Triad found reflection in the first text book of epidemiology by Stallybrass in 1931 in Liverpool, UK.\(^{(12)}\) The occurrence of disease due to the loss of equilibrium between Agent, Host, and Environment has now been accepted unequivocally as the theory of disease causation.

It is not enough to have the knowledge about disease causation; political actions are needed to redress the problem. Rudolf Virchow (1821-1902), who is regarded as the father of social medicine, outlined the power of social policies in disease prevention; he said “Medicine is a Social Science and Politics is nothing but Medicine at a larger scale.”\(^{(13)}\) He practiced social medicine; would be seen at the barricades. As member of Municipal Council of Berlin, he worked towards modern water and sewerage system for the city. Later on, Thomas McKeon (1912-1988), a Professor of Social Medicine in Edinburgh, empirically showed that rise in overall standard of living, especially nutrition status, resulting from better economic conditions was responsible for the decline in mortality.\(^{(14)}\) He also highlighted the role of social policies in health development in his book ‘Introduction to Social Medicine’.\(^{(15)}\)

Hugh R Leavell and Edwin G Clark from Harvard and Columbia Universities respectively elaborated in their book ‘Preventive Medicine’ in 1965 that prevention does not only mean prevention of disease and promotion of health but it also includes the prevention of disability and death by early diagnosis and treatment, thus laying the foundations of preventive medicine.\(^{(16)}\) Application of these ideas has played a key role in increasing the life expectancies at a lower income level in developing countries due to the large scale implementation of appropriate technology under the primary health care strategy such as immunization, oral rehydration therapy etc. Samuel H Preston, a Professor of Demography and Sociology in University of Pennsylvania, presented analysis of the mortality trends all over the world in 2007 to find out why mortality declines have occurred especially in the later half of the 20\textsuperscript{th} century. He concluded that no doubt the rise in incomes have led to rise in life expectancies but technological changes in medicine have played an important role.\(^{(17)}\) These ideas of social medicine and preventive medicine played a significant role in the life and work of Sidney L. Kark (1911-1998) who successfully practiced community medicine in South Africa for a number of years before moving on to Israel and USA.\(^{(18)}\)

The importance of population based approaches was once again highlighted by Professor Geoffrey Rose (1926-1993) from London School of Hygiene and Tropical Medicine. According to him “the primary determinants of disease are mainly economic and social and therefore its remedies must also be economic and social ………… medicine and politics cannot and should not be kept apart.”\(^{(19)}\) The Public Health approach, which had led to the enactment of Public Health Act of 1948 in England, once again came to the fore.

The role of public health was re-emphasized by the Expert Committee on Public Health Systems (1996) formed by the Ministry of Health and Family Welfare, Government of India.\(^{(20)}\) Voluntary Health Association of India’s (VHAI) Independent Commission on Health (1997) also stressed the need to open new schools of public health.\(^{(21)}\) Calcutta Declaration on Public Health (1999) emphasized the leadership role for public health and identified the need for creating career structures at the national, state, provincial and district levels.\(^{(22)}\) Sir Michael Marmot also once again brought the focus on social determinants of health in ‘closing the gap in a generation’. He stated “Why treat people……….without changing what makes them sick”.\(^{(23)}\)

However, the focus of right to ‘health’ continued to be only on the right to ‘healthcare’ because in the current era of falling mortality and rising morbidity, the healthcare needs have become the ‘felt need’ of the people. India is also experiencing epidemiological transition. Non-communicable diseases are on the rise whereas communicable diseases (NCDs) also continue to be a public health problem and the agenda of high maternal and child mortality has not yet been tackled. According to the Office of Registrar General of India, NCDs are the cause of death in 42\%, communicable diseases, maternal, perinatal and nutritional conditions in 38\%, and 10\% deaths are due to injuries and ill-defined causes.\(^{(24)}\) The dilemma is how to balance the investment on health promotion and medical treatment.

With technological advancements, the cost of healthcare is rising but investments in health are not rising. India invests only 1.1\% of its gross domestic product (GDP) on health which is much lower than even other developing countries.\(^{(25)}\) Per capita health expenditure in India, Sri Lanka and Thailand is US$ 23, 31, and 71 respectively and
the share of public expenditure in this was only 25% in India compared to 50% in Sri Lanka and Thailand. As a result most people have to pay heavy fee for medical care from out-of-pocket not only when they avail medical services from private sector but also for services available in the public sector medical institutions. According to National Sample Survey Organisation 71st survey round the average cost of hospitalization per case was Rs. 16,956 and Rs. 26,455 respectively in rural and urban area. People have to pay out-of-pocket in public institutions as in these institutions the shortage of drugs and diagnostics is endemic and human resources are also in short supply, more so in rural areas. The health workforce per 10,000 was 11.8 in rural area and 42 in urban areas.

Public health services have been neglected for a long time in India, and the resultant vacuum has been increasingly filled by the ‘quacks’ in the villages and corporate medical care hospitals in the urban areas. National Health Policy (2002) expressed the intention of the government to correct these deviations and some efforts have been made by government of India to reverse this trend. In the last decade, under the National Health Mission (NHM), larger investments have been made with some flexibility. Fund allocation increased from Rs. 4,633 crore in 2005-06 to Rs. 16,948 in 2013-14. Health infrastructure has also improved somewhat. Staffing has also gone up - more so at the grass root level. The number of Auxiliary Nurse Midwives (ANMs) increased from 1,33,194 to 1,93,593. About nine lakh Accredited Social Health Activists (ASHAs) are in place - at least one in every village. About 75% of the babies are now born in health institutions. Infant Mortality Rate has declined from 68 in year 2000 to 40/1000 live births in year 2013, and Maternal Mortality Ratio has also registered a decline from 254 in 2004-2006 to 167/100,000 live births in 2011-2013. It is likely that the 4th MDG will be achieved in India.

However, uncertainty about the continuation of NHM prevails. Which way the wind will blow? NHM will continue or it will be replaced by National Health Assurance Mission (NHAM)? Whether commitment for universal health care will be on the statute book? Right to health will be guaranteed or it will remain rhetoric? National Health Policy Draft (2015) is merely a statement of intentions rather than actions, i.e., ‘should be done’ needs to be replaced by ‘will be done’ at every place where ever it appears in the policy. At this juncture India is at cross roads.

Two issues are the cause of worry — whether there will be ‘rise in allocation of finances for health’ and ‘whether administrative structures will change for better governance of health’. Whether the current system of health financing through Out-Of-Pocket (OOP) expenditures, which is a very regressive method of health financing, will give way to another regressive policy of market oriented health insurance-based financing or more progressive tax-based financing? Universal healthcare delivery mechanism will be through strengthened and better administered public health system or through purchase of services from private sector corporate hospitals?

Experience from around the world indicates that the ‘free market’ principles do not work in the medical field due to asymmetry of information. USA spends about 19% of its GDP in a largely insurance-based and privately delivered health care model but the rise in life expectancy in USA is less than in other developed countries where tax-based financing through national health service-based public system prevails. Some developing countries such as Thailand and Sri Lanka are now providing universal health care (UHC) at a much lower investment through a tax financed public system.

The out-of-pocket payments, rampant in India, push people to below poverty line. In Punjab a recent survey indicated that median hospitalization costs per case are Rs 17,000 and Rs 19,500 in public and private facilities respectively. About 50% of the people had to borrow money or had donations from relatives to meet out this cost. It has been seen in Haryana also that user charges push people out of the public services. Hospital admissions declined from 1721 to 1321 per lakh population in Yamuna Nagar district of Haryana after introduction of user fee.

It is now clear that poor people are main utilizers of the public services especially in states where public financing is better which has sustained public services. It was observed that higher public spending encourages equity in utilization of services. The public system which is perceived to be of ‘poor quality’ is largely utilized by poor people; it is still serving large number of people. Public subsidies in public health institutions go to poorer section of society.

A study in Punjab observed recently that though public facilities are not very well staffed but the staff client ratio is quite good. On an average each doctors attends to 40 patients per day. A rapid survey in Haryana indicates that 53% targets of UHC are already met. Hence, we need to identify the gaps in public services, and these gaps need to be plugged rather than experimenting with costly tertiary care medical insurance purchased by the govt. and services mainly bought from the private corporate hospitals. In this approach, under the
constraint of limited financial resources, diversion of funds from preventive and primary care to tertiary care is a real risk as has been seen in some of the southern Indian states where such insurance schemes were launched in last decade.[41]

In current scenario where Indian economy is growing, it should not be very difficult to increase the investments in health from current level of 1.1% to about 3% of GDP. New governance structures such as autonomous health centre/hospital boards with the active involvement of local self-government systems needs to be created. Govt. should provide universal coverage of essential health package through tax-based funding; increase budgetary outlays for health progressively; correctly set priorities of health interventions; strengthen public health infrastructure; improve governance of health services—human resource, procurement and distribution; strengthen medical education with quality to generate adequate workforce; ensure regulation of private providers through legislation and enforcement; and strengthen independent monitoring system to build accountability using information technology.

Hard political choices need to be made now. A concerted effort by academia and civil society should be launched to engage with union and state governments. A comprehensive public health law incorporating the right to health should be passed by the Parliament. The right to health cannot be guaranteed in isolation; already right to education, right to livelihood, food security, and right to information exist on the statute. Addition of right to health will make the entitlements of Indian citizen more complete as was envisaged by our forefathers while preparing Indian constitution.

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