Right to Healthcare: The Way Forward

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Abstract

From the Bhore Committee Report of 1946 to the present Universal Health Coverage (UHC) 2011, nothing much has changed in terms of health status in India. The overall health status continues to be dismal and disappointing. One factor that is mainly responsible for this state of affairs is that healthcare has not been realized as a right. If healthcare becomes a right, the state will become responsible and accountable to the people, for enhancing their health. If people are invoked into a sense of belonging to the health system and made to look at healthcare as their right, there is a strong possibility of a positive change in the overall health status of the people. The article looks at healthcare from the rights perspective and explores the methods in which it can be translated into reality. It tries to look at the moral basis of the right to healthcare. For healthcare to be achieved as a right, the state can no longer be a mute spectator of the predominant market forces dictating the healthcare delivery system. The article argues that translation of healthcare as a right is only possible if the state takes full responsibility to improve the health status of the people.

Keywords: Health as a right, health policy, health for all, healthcare planning, right to healthcare, state intervention in health, universal health cover

Introduction

In 1944 and 1945, a committee was constituted to look into the future development of health in India. The committee came up with a report on curative and preventive services in health.[1] The report submitted by the committee came to be known as the Bhore Committee Report. The Bhore Committee assessed the condition of health in India and provided statistics on disease burden of the country. It not only pointed out the inadequacies in medical service alone but also stressed upon the socioeconomic determinants of health such as poverty, illiteracy, poor nutrition, and environmental conditions.[2] Despite that the report kept health independent of the overall planning under the assumption that inequality would somehow be tackled.[3] The Bhore committee recommended that healthcare planning should not exclude anyone from accessing health service on the basis of one's ability to pay. The report emphasized more on rural areas, preventive health, and training of social physicians.[4]

After the Bhore Committee of 1944-1945, numerous committees on health were instituted1. These committees gave emphasis on the different aspects of health that resulted in the formation of three-tier system of health centers in the public sector for primary, secondary, and tertiary healthcare. Two important national policies5 have also been enunciated. The National Population Policy (2000), the Report of the National Commission on Macroeconomics and Health (2005), and most recently, the High Level Expert Group (HLEG) on Universal Health Coverage (HLEG 2011)6 are some of the important steps taken by the Government of India in the area of health. However, many earlier efforts had never resulted in available, accessible, equitable, affordable, and quality healthcare for the majority of the population.

Responding to health needs

So far, whatever the efforts being made, one important thing that is missing all through is the integrative approach to health services. It needs to be understood that “the health service sector is a multilayered complex of services that calls for an integrative approaches where epidemiological similarities and linkages allow shared interventions.”[5] A well-thought-out integrated approach

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is missing, and contrary to this guiding principle, the healthcare policies have drifted towards vertical programs, that eat into the general health services and leave it impoverished. Moreover, the dismal picture of health “reflects both an inability to mobilize the requisite resources and institutions to transform health around the values of primary healthcare.”[5] It is pertinent to mention here that health sector in India is acted upon by many forces that pull it in different directions, namely “a disproportionate focus on specialist hospital care, fragmentation of health systems, and the proliferation of unregulated commercial care.”[6]

Although the public sector in India is the main provider of preventive services, 80% of the outpatient visits and 60% of the hospital admissions are privately provided.[8] According to Government of India Report 2009, “71% of health spending is out-of-pocket and every year such expenditure forces 4% of the population into poverty.”[7] The recent development in the form of universal healthcare seems to be an initiative, at least on paper, which once implemented will ensure universal health coverage to all. However, its translation will have its own difficulties like how can harmonious integration be brought about between the two conflicting sectors, that is, the public and the private sector. As observed by Baru, “commercial interests pose a serious challenge to universalize access to healthcare, because for-profit healthcare privileges individual responsibility and choice over social solidarity, which raises ethical dilemmas for designing a health service that is universal and equitable”.[8]

Health needs are dynamic variables which keep changing with the exigencies of time. So, health policies need to be tailored accordingly. India is presently faced with problems such as incomplete epidemiological and partial demographic transition. In addition to that the redress of social determinants[3] of health and inequity in health status pose a major challenge to the healthcare planning in India.[4] Environmental degradation, emerging infectious diseases, and antimicrobial resistance are yet other challenges that have to be essentially considered in order to deal with the problem in a holistic way.[9] There is also a heavy burden of disease due to the growing and greying population, poverty, unemployment, and lifestyle changes.[10] India’s public health infrastructure is unable to respond to these new challenges, as the delivery system is not functioning optimally and is not based on the current needs of the community.[9] Had there been a harmonious integration and intersectoral linkage in healthcare system of India, the health problems would have been tackled to a considerable extent. As pointed out by Imrana Qadeer, “integration optimizes material and manpower resources and increases the organizational efficiency of services at all levels.”[11]

Rights-based approach

Health is one of the important determinants of life, or rather a precondition for life. Being healthy means that one can live life to one’s own and to the social expectations. Once a person is ill it interferes with his/her functioning and renders him/her dependable. To live a life of dignity and respect, it is very important that healthcare should be considered as a ‘right.’ Some commentators argue that healthcare is a moral right and others contend that it is a legal right. Yet, there are arguments professed by many other commentators about the abstractness of health as a right. They have gone to the extent of dismissing it as unachievable. Contrary to it, Sofia Gruskin[8] (2006) noted that healthcare as a right is feasible. When health becomes a right three activities can be carried under it, which are as follows:

**Legal category**

It means pursuing legal accountability through national laws and international treaty obligations. This often takes the form of analysing what a government is or is not doing in relation to health and how this might constitute a violation of rights; seeking remedies in national and international courts and tribunals; and focusing on the transparency, accountability, and functioning of norms and systems to promote and protect health-related rights.

**Advocacy category**

Healthcare in the advocacy category is using the language of rights to draw attention to an issue, mobilize public opinion, and advocate for change in the actions of governments and other institutions of power. Advocacy efforts may call for the implementation of rights even if they are not yet actually established by law, and in doing so serve to move governmental and intergovernmental bodies closer to legitimizing these issues as legally enforceable human rights claims.

**Public health category**

Public health practice (category) is applying a human rights framework to the design, implementation, monitoring, and evaluation of programmatic initiatives. Generally speaking, work in this category refers to the inclusion of key human rights components within the programmatic initiatives and in daily practice. This means, among other things, attention to the participation of the affected communities, non-discrimination in how policies and programs are carried out, attention to the legal and the policy context within which the programs take place, transparency in how priorities are set and decisions are made, and accountability for the results.[11]

**Health as a moral right**

There is an underlying understanding that being healthy means being productive for economic activities and being a part of productive workforce that will enhance production of a country, and hence its income (health as an investment). In this construct, people are just made a means to an end. It reflects the skewed understanding of undermining people’s dignity and personhood.

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[3] On the basis of economic, caste, class, sex, and rural urban divide.

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Everyone on the earth, according to Immanuel Kant\textsuperscript{5}, “exists as an end in himself, not merely as a means for arbitrary use by this or that will: He must in all his actions, whether they are directed to himself or to other rational beings, always be viewed at the same time as an end.”\textsuperscript{[12,13]}

John Rawls\textsuperscript{6} in his book, “A Theory of Justice” uses the concept of “original position” in which people choose principles of a just society from a position where no one knows his fortune in the distribution of natural assets and abilities, his strength, his ability, and the like.\textsuperscript{[14]} People in the “original position” are said to be under the “veil of ignorance,” which means they are oblivious of what they are or what their abilities and advantages are. Rawls believes that people in the “original position” will expect an equal share of primary goods\textsuperscript{8} unless the unequal distribution benefits everyone. The people at the “original position” will not either agree on less in the distribution of primary goods nor is it reasonable for them to accept more than what is their due. The rational thing for people is to accept the share of social goods on the basis of Rawls’ first principle, that is, justice as fairness.\textsuperscript{[15]} Health as such does not figure in the list of primary goods furnished by Rawls. However, Ronald Green categorizes health as a primary good. He notes that, “access to healthcare is not only a social primary good, but possibly one of the most important of such goods, because disease and ill-health interfere with our happiness and undermine our self-confidence and self-respect.”\textsuperscript{[16]} Hence, healthcare has to reach equitably to all people irrespective of one’s position in the society.

Amartya Sen observes that there are many such issues that are yet to become rights, but they are so important that they claim to be ‘rights’ and there is always desirability towards the realization of such rights. Amartya Sen addresses the legal feasibility and policy question by contending Jeremy Bentham’s position, who thought that a right has to be legislated and it must be a child of law:\textsuperscript{[17]} Sen argues that it does not need to be necessarily legislated. The rights have an ethical underpinning and their realization is a hallmark of a good society. About the feasibility issue, Sen contends that rights are conceived as valid only if they are absolute, which limits our understanding of rights, and hence their implementation. Sen argues that right to life and liberty (being absolute) can also not be then considered as ‘rights’ because we cannot stop a person from being killed nor can we stop transgression and mass killings. So, we must recognize health as a right and work towards its recognition.\textsuperscript{[17]}

### State intervention in health

In light of the above discussion, it becomes important to state that if healthcare is such an important moral and legal entity, who is to provide healthcare to people? There are two main actors to provide healthcare to people - the state and the private sector. There are set arguments for both state and private sectors as the providers of healthcare. It needs to be understood that state can be highly instrumental in the provision of healthcare than private sector on a number of factors such as health as a public good, ethical and moral value associated to healthcare, its affordability and accessibility. These factors are not taken into consideration by the private sector because their primary value is profiteering in which disease and ill-health get commodified. Thomas Rice\textsuperscript{9} gives an elaborate discussion both on the intervention (discussed later) and nonintervention of state in healthcare. Rice forwards three essential arguments that legitimize state’s nonintervention in health. They are as follows:

- Consumer sovereignty
- Psychology of people
- Fairness

#### Consumer sovereignty

People should be allowed to make choices because people are rational enough to choose goods and services for themselves. They will be better-off doing that than state interfering in their personal affairs.\textsuperscript{[18]} This goes with the liberal approach in healthcare where preference is given to the choice of an individual.\textsuperscript{[19]}

#### Psychology of people

According to this precept, the consumers will be satisfied if they choose things on their own without any interference from state. Here contentment and satisfaction of an individual is given a paramount importance.

#### Fairness

It is based upon the premise, that it is unfair to tax away the income of rich people, which would then be used for the provision of healthcare for poor. This is human rights violation according to liberal conception. This notion of state’s interference in public life is ruthlessly assailed by Robert Nozick\textsuperscript{10} in his book, *Anarchy, Utopia and the State*. Nozick argues that state becomes the main source of human rights violations when it snatches wealth from one person and spends it on another. More so when that person has acquired wealth legitimately. He contends for the minimal state intervention in providing healthcare services.\textsuperscript{[20]}

This approach goes with the utilitarian conception in healthcare that is based on the precept of ‘maximum happiness to maximum people’.
number of people. It is a concept that has been applied to healthcare economics in 1960s. This evaluation of healthcare has given rise to many controversies regarding the efficiency of markets and state in the production of healthcare goods and services.\textsuperscript{[19]} It has led to split in the opinion and has given rise to three quarters of people advocating for the provision of healthcare in three different ways. These are Marxists, Paternalists, and the Liberals. The Marxists advocate for health as a right.\textsuperscript{[14]} They are highly critical of the laissez-faire economy and reject it as a conspiracy of capitalism that glorifies individual choice in the name of individual freedom. The paternalists on the other hand contend that there are positive and negative externalities associated with healthcare that make healthcare unfit for market forces and thus advocate for free healthcare from state.\textsuperscript{[21]} Liberals advocate that healthcare is like any other commodity and can be exposed to market forces of demand and supply. However, both liberals and paternalists approve of laissez-faire economy.\textsuperscript{[19]} The liberal conception compresses all valuations into utility function that sees humans as rational economic agents with perfect information who maximize their utility at will.\textsuperscript{[21]}

No matter its glorification as a tool of economics applicable to healthcare, utilitarianism has been highly critiqued as something that does not take into account the distribution of healthcare among people. The concept of utilitarianism is antithetical to any concept of moral rights\textsuperscript{[23]} which Jeremy Bentham, a staunch advocate of utilitarianism, calls rights as “rhetorical non-sense and non-sense upon stilts.” Amartya Sen remarks that “utilitarianism is egalitarianism by serendipity, just the accidental result of the marginal tail-wagging of the total dog”.\textsuperscript{[24]} It does not enquire about one’s freedom and fulfillment (Sen, 1999). Utilitarianism evades all these questions and assumes that each one’s marginal utility is the same. The utilitarianism which bases itself on consequentialism “has a tendency to ride roughshod on rights”. Utilitarianism has also been critiqued on the basis of ignoring the nonutility issues.\textsuperscript{[22]}

So, Thomas Rice argues that it is highly desirable on the basis of ethical and moral premises that state intervenes in healthcare. Rice contends that there is an inherent inequality in societies. There is a desirability to equalize such inequality. Thomas Rice argues that “whether one believes in equalizing the Rawlsian primary goods, resources, opportunities, capabilities, or some other construct, there is a common policy implication to ensure that individuals who are at a disadvantage have an equal probability of attaining good health.”\textsuperscript{[14]} It is necessary to redistribute resources from those who have been more fortunate in economic terms. This is an ethical argument on the basis of which government should provide healthcare services to people.

World Health Organization (WHO) also asserts that states have an obligation to provide healthcare to its people. There are three state obligations (respect, protect, and fulfill) towards “health as a right” according to a joint report of the WHO and the United Nations Human Rights Commission (UNHCR). The obligation to respect requires that states refrain from interfering directly or indirectly against “right to health.” The obligation to protect requires states to prevent third parties from interfering in the recognition of “right to health.” The obligation to fulfill requires that states ‘adopt appropriate, legislative, administrative, budgetary, judicial, promotion, and other measures to fully realize the ‘right to healthcare.”\textsuperscript{[10]}

\section*{Conclusion}

In spite of the attempts made by India from the time of independence in terms of health service provisioning, it has not been successful in meeting people’s health needs. This is mainly because the state has never been accountable to the health of the people. If health is given the status of a fundamental right it would make a positive difference to health status in the country. Moreover, the right to health is only possible when the state steps in and ensures that health systems become responsive to the needs of people irrespective of caste, class, sex, and spending capacity. Health is a public good which commands special attention. It is immoral to relegate health to the status of any other commodity and leave it to market forces of demand and supply. With massive inequality existing even today, health being a moral right has to be dealt with humane consideration and cannot be allowed to be operated at the discretion of the market forces. Thus, state must act proactively.

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