Chapter 2
Citizenship, Health Care Jurisprudence and Pursuit of Health Justice

Abstract  This chapter discusses the interrelationship between citizenship, health care jurisprudence and health justice. The socio-political processes that shaped the access to justice as a fundamental right making it an integral part of the ‘right to life’ (personhood) jurisprudence paved the path to reconceptualise the SRHC not merely as access to services, but also as a matter of social justice and fundamental right to life, a process of claiming citizenship in the pursuit of health justice. In India, courts have been accessed either as a last resort of justice or as a ‘strategic instrument’ to claim citizens’ power vis-à-vis the State or medical profession. Health care jurisprudence, i.e. the body of judicial-legal principles emerging from the judgments of Supreme Court of India (SCI) in health care litigations, attains significance due to the power it enjoys as the domestic law or policy, in accordance with the common-law tradition. Engaging judicial power in health and health care, and the emerging health care jurisprudence symbolises the role and power of the courts in actualising citizenship especially in the matters of social rights.

We thus find ourselves at a crossroads: health care can be considered a commodity to be sold, or it can be considered a basic social right. It cannot comfortably be considered both at the same time. This, I believe, is the great drama of medicine at the start of this century. And this is the choice before all people of faith and good will in these dangerous times. (Farmer 2003: 175)

The association between citizenship and health justice is neither direct nor straightforward. The discourses on citizenship often revolve around civil and political rights, reflecting one dimension of an individual’s relationship with the State. Social, economic, and cultural rights (referred to as social rights in this book for brevity) that include health and health care, manifest a much neglected but larger facet of citizens’ relationship with the State. Social rights in general, and each of its components, are constitutive of a bundle of rights and entitlements. Globally, policies and legislations concerning these domains of rights have been evolving gradually through arduous and cumbersome processes. The lack of uniformity and cohesiveness, both in their articulation as well as enforcement, makes social rights a challenging terrain for research. With multiple actors with competing power relationships, the path to the goal of health justice, too is uneven and bumpy. This chapter explores the different facets of the relationship between health justice and citizenship actualised through
the social right to health care. Engaging judicial power for realising citizenship with the goal of achieving health justice lays out a significant framework for the discourse of social rights jurisprudence.

Section one begins with discussing the reciprocity and the power relationship between the State and citizens. Power of the State is operationalised through laws including public health laws invoked strongly during epidemics and pandemics. Whereas citizens are asymmetrically placed vis-a-vis the State and claiming of citizen power, viz. realising citizenship, is articulated through the language of rights. This book primarily focuses on the social dimension of citizenship, referred to as social citizenship, within the framework of a citizenship theory that was propounded by Marshal and explores the association of this social citizenship gained through SRHC (Marshal and Bottomore 1992). Section two critically examines citizens’ inevitable interface with the medical and legal professions in the pursuit of SRHC. Professional power is at the core of these professions where a citizen is constantly in a relationship of dependency, either for treatment (medical profession) or for mediating social rights (legal profession). It is followed by a discussion in section three on the emergence of social rights jurisprudence, that is catalysed by the renewed focus on public health and law and ethical framework bolstering the concepts of rights. This section examines the assumptions underlying the realisation of SRHC. Social citizenship through SRHC is gained quite predominantly through engaging judicial power, and both the positive and negative elements that drive citizens to courts are discussed in section four. Section five outlines the trajectory of how the powerful and elitist judicial institution became amenable to citizens through historic reforms in the higher judiciary in India. The overarching global crisis on citizenship that is discussed in section six contextualises the challenges in actualising social citizenship and health justice.

### 2.1 State, Social Citizenship and Rights

Citizenship, a concept which became part of the wide discourse in the west after the French revolution, along with the idea of civil society, have been central to the modern political thought. The concepts of ‘civil society’ and ‘citizenship’ have been often juxtaposed and sometimes used interchangeably to denote the relationship of the individual with the State. Though described in diverse ways, such as active, passive, political, and democratic, citizenship is essentially about the nature of social membership within modern political collectives. It is concerned with the content of social rights and obligations, the form or type of such obligations and rights, the social forces that produce such practices, and the various social arrangements whereby such benefits are distributed to different sections of society (Stewart 1995; Turner 1990, 2000). Political theorists agree that ‘citizenship has become an indispensable component of modern social theory as a perspective on social rights, welfare issue, political membership and social identity’ (Turner 2000: ix).

As indispensably related to justice, rights, obligations and social contract, Marshal and Bottomore (1992) propound the idea of multidimensionality of citizenship. He
defines citizenship in terms of its three constituent elements—civil, political, and social. The civil element is composed of the rights necessary for the individual freedom—liberty of the person, freedom of speech, thought and faith, the right to own property, and to conclude valid contracts, and the right to justice. The political element is the right to participate in the exercise of political power. The element of social citizenship includes a wide range of positive measures that range ‘from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilised being according to the standards prevailing in the society’ (Marshal and Bottomore 1992: 30). Referring to the State institutions, he also associates courts of justice with civil rights, parliament with political rights and educational system and all social services with social rights.

Historically, in the gradual consolidation of the nation-state process, sovereignty came to rest in the State and not with the citizens. State, through the power of law, regulates social relations. Jurgen Habermas explains this phenomenon of legal regulation of social relations as ‘juridification’ (Veitch et al. 2012). According to Habermas, juridification is observed in the modern State in its tendency to increase enactments of formal (positive or written) laws, both in horizontal—new laws covering new areas—and vertical expansion—newer dimensions in the existing laws—of laws. The expansion of laws or juridification correspondingly goes hand in hand with the increase in litigations. Historically, such a continuous process has given rise to the emergence of courts as powerful constituents in the liberal democratic State. The power of courts takes a centre stage as citizen—State relationship gets defined through laws which encapsulate rights and duties.

In his analysis of State and citizenship, Habermas locates juridification in the processes of reproduction of political systems of power and money on the one hand, and ‘lifeworld’ on the other. The latter designates all other dimensions of society including rights and liberties.

Juridification, then, is a process by which system and lifeworld, and the relationships between them, are legally structured and regulated. This process facilitates the growth of the capitalist economy but also, and crucially, establishes and guarantees political and social liberty as the State seeks to legitimise its actions through the concessions of political rights and freedoms (Veitch et al. 2012: 257).

The political freedom of citizens that define citizenship are crystallised through the juridification process that can be viewed from the standpoint of power. For the State, these are concessions given by the State to seek legitimacy. For citizenry, it resulted in institutionalising class power (i.e. power of certain classes) in legal form and in turn restrain State power. The imprint of the latter on the historical trajectory of citizenship is well noted. From the pre- Magna Carta period itself and later during the French Revolution, as Tigar and Levy (2005) note, the movement for citizenry rights was led by the bourgeoisie who emphasised on individual liberties, and consequently civil and political rights movement got enormous latitude over social rights. Often, in the historical city-state-based citizenry movement led by bourgeois leadership, citizenship was largely established and maintained through military force and invariably excluded women, slaves, homosexuals and later subaltern people.
In the eighteenth and nineteenth centuries, there were occasional glimpses of egalitarian thought, however, were not essentially linked to citizenship. The Poor Law enacted in England, for example, treated the claims of the poor (women, destitute and paupers who were not considered citizens), not as an integral part of the rights of the citizens. Divorce of social rights from the status of citizenship could be seen here as the claims could be met only if the claimants ceased to be citizens (Rosen 1958).

Power and claims of citizenship established through political power, lie at the core of social rights. Social rights are integral to social citizenship, and cannot be granted only as concessions or as benevolence. Marshal argues, therefore, ‘the normal method of establishing social rights is by the exercise of political power, for social rights imply an absolute right to a certain standard of civilisation which is conditioned only on the discharge of the general duties of citizenship’ (Marshal and Bottomore 1992: 36). As the struggle for such an idea of citizenship continued, some aspects of its realisation were seen in the mid-twentieth century, in the aftermath of World War II.

In the post-world war II period, the philosophical foundations of the relationships between human beings and State came to be defined through language of rights, primarily the human rights treatise. Backed by an international consensual, these attained the status of legal instruments under the international law. The political, civil, and social rights attaining the status of a commonly agreed international human rights law began a new chapter in the history of social rights.

The discourse on rights identifies at least five different types of rights. One, personal rights that relate to life, liberty, security, property, conscience); two, legal rights that refer to the due process, equal protection under the law; three, political rights denoting participation, suffrage, assembly; four, social and economic rights that include, among others, standard of living, employment, health care, education, and nutrition); and five, collective rights that include rights of ethnic communities, self-determination, and minority rights (Pinto 2018; Mishra and Subbiah 2018; Gauri 2004). While referring to human rights or rights in general, they are understood in terms of negative and positive rights. Both these concepts relate to the role of the State in the realisation of these rights. In negative rights, the State is restricted from interfering into the personal liberties of individual human lives, whereas positive rights make it incumbent on the State to take proactive measures for their realisation that include policy, budgetary allocations, and implementation mechanisms. Social rights, including SRHC belong to the genre of positive rights (Pinto 2018). For the fulfilment of all rights, especially the social rights ‘require restraint, protection and aid from the entity from whom rights are claimed, and that a reasonably effective and well-funded State is a sine qua non for all rights’ Gauri (2004: 467).

Health along with education have attracted significant attention in contemporary scholarship on social rights. These are considered as fundamental to realise humanhood and dignified existence (Pinto 2018). Notably, therefore, scholars have expounded on the indispensability of these rights to human existence linking them to concepts such as human agency, needs and capabilities, human dignity, and self-respect. They are posited as fundamental and as absolutely necessary to the exercise
of human agency. Rawls (1971, 1999, 2001) explains such basic requirements as ‘primary goods’, Shuhe (1996) as ‘basic needs’, and, Nussbaum (2000) and Sen (1980, 1982) as ‘capabilities’.

Social rights to health and education are deemed to be essential to live with human dignity in the modern and contemporary society, without being excluded from others and to relate to fellow human beings. Relatedly, ill-health (disease) and ignorance (lack of education) are considered obstacles that deter human beings from exercising their agency to live a fully human life. Accordingly, the philosophical and ontological ground of ‘human dignity’ finds a vital resonance in justifying social rights, especially the right to health and education. Rawls (1971, 2001), for example, proposes ‘self-respect’ as one of the core primary goods, and health and education are construed as the social bases of such self-respect. Similarly, from the capabilities approach such fundamental self-respect is foregrounded as ‘the ability to appear in public without shame’ (Sen 1999).

For the full realisation of citizenship, along with the civil and political rights around which a strong jurisprudence has already been established, social citizenship needs emphasis. Such a citizenship is realised through social rights that are construed to be pathways towards this goal of ultimately balancing citizens’ power vis-à-vis the State. However, in the matter of SRHC, the entities to be considered in such a balance of power of citizens, also extends to the medical and legal professions as well. Both these professions encapsulate the power the professions wield and a corresponding dependency that marks citizens’ relationship with them. Medical profession is the indispensable intermediary in the delivery of health care to citizens, and the legal profession, similarly is indispensable for the processes of seeking legal justice.

2.2 Medical Profession, Legal Profession and Power

The concept of power is central to both medicine as well as law, though it is more obvious in the latter compared to health care and medicine. Medical profession and by extension health care providers and health systems, are fundamental to health care and realigning citizens’ relationship with them is essential to SRHC and health justice.

Medicine (medical profession) and courts (legal profession) are advanced on the power of knowledge, viz. law and biomedicine, respectively. They share a common legacy in the exercise of power over their clients which is marked by dependency of the latter on the knowledge, skills, and professional expertise of the former. A few critical accounts narrate the close linkages between the power of medical knowledge exercised by a doctor and the magisterial powers that came to be historically vested in the medical profession owing to this expertise, suggesting the overlap between these two professions and their interface in the sphere of SRHC. The magisterial powers seamlessly linked the medical professionals to the enforcement agencies such as police and legal institutions.
2.2.1 Doctor-Magistrate and Protection of Medical Hegemony

Foucault captured the close association of the medical profession with judicial power through the concept of ‘doctor-magistrate’. His accounts provide a picture how the judicial power was so enmeshed with the political power in protecting the hegemony of the elite medical profession.

The term ‘doctor-magistrate’ suggests an overwhelming social power that a doctor enjoys. Foucault notes that the doctor was deemed to be ‘the guardian of public morals and public health alike’ with the varied roles assigned such as a ‘technician of medicine’, ‘economic role in the distribution of help’, and ‘a moral, quasi-judicial role’ (Foucault 2010: 48–49). The gradual increase in their judicial power was aided by a widespread radical thought during the French revolution that in an ideal State there would be no hospitals, leading to the belief that the medical professionals would be playing a far greater role in the society, rather than in health care institutions. Gradually, however, as the hospitals became vested with increasing legal power, in turn, it led to the concentration of judicial power and authority in the medical profession. Much of the legal and quasi-legal activity of exercising judicial power by the medical profession primarily focussed on controlling the unqualified or medical malpractice, and such people involved in malpractices were termed as ‘charlatans’ or quacks. Saving the patients from the medical practice was considered important. This power of the profession defined the medical jurisprudence through the health courts that were being proposed. Law and jurisprudence, thus, for most part during this time, concerned themselves with restoring a medical profession defined by qualifications and protected by laws. In areas where there was no legislation, the doctors formed their own mechanisms of control over others who practice medicine without qualification.

Medical teaching was thought to be another way to restore the integrity of the medical profession, and qualified doctors started their own teaching practice. This led to medical teaching becoming another important area to be regulated and reorganised. A jury composed of doctors and pharmacists was set up intended that ‘…doctors would once again be able to control their own recruitment; they would be reconstituted as a body capable of defining their own criteria of competence’ (Foucault 2010: 93). Solving the problem of practice of medicine was considered more important compared to the reform in medical teaching, and it was believed that unless the former was tackled, the latter would not be reformed. Thus, the idea of self-regulation became entrenched in the organisation of the medical profession itself, where they regulated and judged their own.

Thus, we see a gradual transition in the medical profession’s power over the human body explained through the concept of ‘medical gaze’ from the individual body to the social body, i.e. society at large. Body and social body, accordingly, form the loci of continuum of power in medicine. Foucault subtly explains the medical professional’s transition from the patient’s bedside space to that of the judicial or quasi-judicial space, and from an individual space to that of social-political space in
the late eighteenth and early nineteenth century France through medical professionals joining forces as a social organisation. For example, in the eighteenth century, the doctors organised themselves as ‘Society of Royal Medicine’ (Société Royale de Médecine). Foucault poignantly notes on this development as follows:

[But], above all, its role was constantly being enlarged: as a control body of epidemics, it gradually became a point for the centralisation of knowledge, an authority for the registration and judgement of all medical activity (Ibid. 31).

As a corollary to the new acquired status as a social organisation, a realignment of medical professionals’ new role in relation to the State and police is thus observed. Foucault notes the subtle contours of the power that is ingrained in such a new role:

[m]edical experience and the doctor’s supervision of social structures, the pathology of epidemics and that of the species are confronted by the same requirements: the definition of a political status for medicine and the constitution, at state level, of a medical consciousness whose constant task would be to provide information, supervision, and constraint, all of which ‘relate as much to the police as to the field of medicine proper (Ibid. 29).

The transition of medical gaze from the space of a body to the constitution of political status that marks the birth of the modern clinic (hospital), in addition, is characterised by the emergence of medical consciousness. It is signified by the ‘essential mutation of medical knowledge’ and mutation of discourse that takes shape through the system of reorganisations of the structure and grammar of the discourse between the patient and the doctor (Ibid. pp. xii–xxii). Hence, the new power that the medical profession gained through the medical consciousness in this transition is equally political. Foucault’s observation on the new power in society that the medical profession attained, resonates generally with their alignment with the State and ruling classes in Europe which allowed them to draw close linkages with courts. This was part of upholding the medical hegemony and their newly assumed judicial power as doctor-magistrates that further consolidated their power (Foucault 2010, 2014). Given its preoccupation with protecting medical hegemony by regulating the unskilled medical practitioners, it is not very clear if such a power was deployed for the betterment of patient care. The interest of the patient appears to only be a footnote to strengthening its argument against unqualified medical practice leading to the consolidation of power.

The medical profession being the exponent of different types of power predicates such a consolidation of power as a profession and perpetuation of medical hegemony. The power exercised to control the medical profession (Gilson and Raphaely 2008; Friedson 1970), doctor’s power of discourse over illness (Illich 1977), and employing ‘negative power’ of resistance against regulation along with a lack positive power of intellectual capital contributing to policy processes (Sheikh and Porter 2010), allude to perpetuating self-interest by the profession. While Foucauldian insights (Foucault 2010) reconstruct the phenomena of the eighteenth and nineteenth century Europe, the historical narratives of Star (1982) account for the interface of courts in the ascendency of the medical profession in its rise as an economic power in the twentieth century in the USA. Parallels to this can be seen in contemporary India too where the medical profession has grown to wield enormous economic and political power.
The display of collective power through public protests by medical professionals against laws enacted to regulate hospitals or doctors, or organised demonstrations to summon the government to agree to their demand to enact laws protecting them, or engaging courts against parliamentary laws seeking to curb their powers or in instances of citizens challenging their power, echo the acts of advancing self-interest by the medical profession. Historically, along with social power it wields being an elitist profession, it has sustained its hegemony through its closeness to the royal power, aligning itself with the ruling classes and elite powers, as demonstrated by its complicity even in the horrific political programs such as Nazi led genocide in the twentieth century.

In India, such advancing of self-interest, expansion of medical hegemony and legacy of aligning itself with the powerful and economic interests is reflected in the phenomena of medical profession that has nose-dived so deeply into commercial health care where the patient interest is only secondary to profiteering (Gadre and Shukla 2016). Health and medical care dispensed through the skills of medical professionals. The skills and competence of the medical professionals are at the heart of the vast sway that the private-commercial establishments have over patient care in India. Further, given the fact that the private-commercial health care is so entrenched in the public health care provisioning itself in recent years, the role of the medical profession becomes indispensable to the discourse on SRHC.

Therefore, in building our argument for health justice and social citizenship through consolidating SRHC, claiming citizenship cannot be posited as a process in relation to the State alone. It also includes the non-State actors such as the medical profession and health care establishments. Denial of services to vulnerable citizens, lack of affordable health care of quality and violations of dignity and health rights are a challenge to the realisation of complete citizenship. In doing so, engaging the power of courts in reinforcing State accountability, and enforcing the rights through social rights jurisprudence assumes significance.

### 2.2.2 Legal Profession and Courts

As discussed in the previous section (vide, Sect. 2.2.1), the medical profession shares close affinity with the legal profession as much as it enjoys legal-judicial power in several aspects of dispensing health care. Laws and courts are the instruments of the State in the exercise of its power. There were six categories of law through which power was wielded—viz. Roman Law (Law laid down by Roman Empire); Feudal law (rules which defined the relationship of homage, dominance, exploitation and protection of personal feudal ties between lords and vassals); Canon Law (Law codified by Catholic Church); Royal Law (Law of monarchs); Law Merchant (the international law of traders), and Natural Law (the bourgeoisie invoking divine sanction for using force and violence). These six categories of law reflect power and the competing interests that prevailed in the feudal lords or merchants in their struggle
against the ruling monarchs to capture and control lands or expand and protect trade, as the case might be.

Court became the symbol of power in this contestation, and judges and courts came to occupy the centre stage in such negotiations of bourgeoisie with the State. The colonies and other parts of the world modelled their legal institutions and jurisprudence on that of France and England, it is the legal legacy of these European countries that pervades the larger part of the world even today (Tigar and Levy 2005). In the modern nation-state, the judiciary enjoys the status as the arm of the political State and the legal profession has become indispensable mediators for and representative of citizens’ claims to rights in courts. They are fundamental to defining and redefining rights and those processes that re-configure citizenship vis-a-vis the State and other actors. In the context of this book, the other actors include the medical profession, health care establishments, allied health care professions and plethora of health care related services and institutions that deliver them.

2.3 Social Rights and Health Care Jurisprudence

Health care as a social right which could be partially or fully enforceable invoking the judicial power or using the legal power for making the State accountable is a late 20th century development. Such a discourse has developed over the last two centuries in varying political climates through the interface of State and citizens seeking health care often through the instrumentality of law. SRHC has provided the politically sound stage for advancing social citizenship, and is founded on the key political-moral foundations that include welfare-state, health as a special public social good, citizenship and state accountability, and health as part of distributive justice and ethics. Redden (2002: 356) elaborates the close association of health care and citizenship narrative:

It is undeniable, however, that health care is relevant to citizenship and is often debated in the language of rights. The tension or balance between individual liberty (rights and freedoms) and collective welfare is the substance of citizenship. Thus, health care (as distribution, provision, and access) is an issue of citizenship.

Historically, in relation to public health, the pathway to health care jurisprudence can be traced through three trajectories, viz. (1) emergence of public health as discipline of ‘population’ health (State and its law making power is used to impose public health measures on citizens as collective); (2) emergence of health care as a social right and reinforcement of social citizenship (idea of welfare-state, duties of the State and rights of citizens are articulated); and, (3) philosophical—ethics perspectives on balancing power asymmetry between citizens and medical profession (patient and doctor relationship is grounded on the ontological dignity and well-being of a citizen as patient is endorsed as an ethical value). This section discusses social rights jurisprudence that include health care jurisprudence and its interface with public health and ethics while outlining the underlying assumptions of SRHC.
2.3.1 Population Health

Health care as a system of organised provisioning of health care emerged as part of the historical evolution of public health as a population health discipline. The understanding of public health propounded in the 1920s, and re-articulated in 1988 by the Institute of Medicine—IOM (1988), links the idea of health and health care to the population and to the collective action of society. Winslow (1920) describes public health as the ‘science and art’ of preventing disease, prolonging life, and promoting physical health and efficiency through organised community efforts for the preventive, promotive, curative and rehabilitative aspects, to ensure to every individual in the community ‘a standard of living adequate for the maintenance of health’. IOM emphasised population health and collective action while it defined public health as ‘one of the efforts to protect, promote and restore the people’s health. It is the combination of sciences, skills and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions’ (Koplan et al. 2009: 1993).

In the backdrop of the rapidly growing industrialisation, public health arose as a more organised State response to the problem of sanitation to protect the public from the spread of communicable diseases in the mid-nineteenth century in Europe (Rosen 1958). From the eighteenth till the first half of the nineteenth century, the approach of controlling diseases in society was by intervening in the environment related issues such as sanitation. The Sanitary Condition of the Labouring Population, a report researched and submitted by Edwin Chadwick in 1842 represents the sanitation movement which was prevalent during the mid-nineteenth century in England. Other dimensions that came to be part of public health included welfare or social security measures in the mid-twentieth century or ‘social determinants of health’ in the early twenty-first century (Mckowen et al. 1972; Rosen 1958; CSDH-WHO 2008).

State used law very strongly to enforce public health measures for over two centuries. In the eighteenth century itself, within a short time the efforts organised by society to protect, promote, and restore the people’s health was crystallised in England as a legislation, viz. the Public Health Act 1848, thus making legal measures a key dimension of such organised efforts. Jurisprudence in health care has its roots in approaches such as these that were taken for public health in Europe in these two centuries. Johanna Peter Frank (1745–1821), a health philosopher of the eighteenth-nineteenth century, conceived public health as good health laws enforced by the police and enunciated the principle that the State is responsible for the health of its people. Such thinking led to the first ever Public Health Act 1848, thus the State taking responsibility for the health of its people (Park 2011). Christopher Reynolds conceives the history of public health in many respects as a legal history, as law provides the powers and creates structures that assist in the system of public health (Reynolds and Howse 2004). Besides, public health law forms one of the chief organising forces for public health in any country (Turnock 2007: 76).

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1Edwin Chadwick’s report on sanitation, i.e. The Sanitary Condition of the Labouring Population (1842).
The important functions of law in public health are conceived to be providing environmental controls to protect health, stopping the spread of disease, promoting conditions to advance health, providing services in general or to certain groups in the population that need them, providing financial assistance for the development of health resources and programme, and providing means to advance the quality of care (Gostin 2000, 2014).

However, such legal measures have not always resulted in a greater citizenship for people, especially for those who need health care the most. Laws stressing population health affected people differently. This approach essentially entailed exercise of State power through its legislative authority and coercive machinery of enforcement. The character of law was such that quite often the poor and vulnerable were the intended targets. Did the courts protect the rights of these vulnerable citizens? The accounts of Tigar and Levy (2005) indicate that the courts continued the legacy of the bourgeois capitalist mercantile class by aligning with the ruling powers and the State. Foucault (2010) records the complicit role of the courts with the State as illustrated by the Royal Courts in England. The historical accounts note the court rulings generally divested the vulnerable of their powers.

Public health historians recount the repercussions of such consolidation of power between State, medical profession, and courts to the lives of vulnerable, especially women and people with psychosocial disabilities in Europe and USA. The history of public health itself is closely knitted with the socio-cultural processes and politics of the state. Rosen (1958) while elucidating the history of public health in Europe recounts several laws such as Poor Laws being anti-poor resulting in divesting many of their power of citizenship. These measures were invariably meant to protect mercantilism and the urban elites, who often exuded exclusion and discrimination towards the poor and the labourers.

In the U.S.A., in the backdrop of epidemics and deaths, the issue of compulsory vaccination became a law in the early twentieth century. Such laws have been upheld by the Supreme Court rulings as in the case of Jacobson v. Massachusetts 1905 (Albert et al. 2001). Similarly, laws and litigations, accompanied by contentions and debates, in and around the themes of reproductive and sexual health, have emerged during the twentieth century (Bruinius 2006). The treatment of the mentally ill, termed as insane and lunatics, being locked up in jails, workhouses and madhouses using the State powers illustrate the use of such powers. As in the USA, so in India, there are multiple legislations that are enacted, and they reflect the character of the State and the socio-political dynamics characterising such period. A typical illustration is the mental health care laws of the 19th—twentieth century where a person with mental illness was criminalised without any rights (Davar 2012, 2015). The Comstock laws of the USA where the State deployed its coercive power on matters related to population control and reproductive health care is another poignant illustration for using them against the vulnerable (Bruinius 2006).

Prejudicial mind-sets coupled with unfounded fears, many countries have focussed on reproductive health care related laws, many of whom have been infringing the rights of women (Rao 2008). This forms an important theme of health care jurisprudence. Several countries in the late 19th—early twentieth centuries,
enacted number of laws in the domains of reproductive health covering birth control, contraception, sterilisation, abortions and population control, as part of national health policies and programmes. Arguments backed by theories such as Malthusian theory and eugenics have led to the legalisation of such policies through legislations or landmark judgments which remained uncontested for many decades. The utilitarian logic of greater common good has provided an intellectual justification to such arguments. In some cases, such as *Buck v. Bell* (1927), decided by the Federal Supreme Court of the USA, provided the legitimation to eugenicists to promote sterilisation for racial purity. This has historically influenced even the genocidal programme of Germany under Hitler (Bruinius 2006). Similarly, with the influence of Comstock Act passed by the U. S. Congress in 1873, all activities promoting abortions or contraception were rendered illegal as it was considered obscene till *Roe v. Wade* (1973) reversed some of those prevailing orders, making contraception and legal abortions a possibility. The jurisprudence and legislations in reproductive health, often, had a suppressive reach over individual rights and their bodies, especially in the case of mentally ill and the poor. They also had a far-reaching influence over policies in other parts of the world, even after these legislations had been repealed or reversed in the country of their original enactment (Bruinius 2006).

In the twentieth century, the power of medical industry and technology coupled with the hegemony of medical knowledge often overshadowed other efforts of public health as an organised community effort and diminished the role of citizens to that of clients and beneficiaries. Turnock (2007) acknowledges that the purpose of public health includes protecting and promoting health, and together, ensuring the protection of rights of individuals in the processes used to protect and promote health. However, populations with lesser wherewithal to leverage power still lack agency to exercise their influence and to interact with public health law.

During this period, the relationship between a health service provider, primarily a doctor, and an individual (patient) was characterised as a contract, governed by the law of contract and this gave rise to several lawsuits. Study on the health lawsuits in the eighteenth century England reveals that the law of contract and torts were the primary legal instruments widely used in England to redress violations in health care, as health service was considered a contract (Teitelbaum and Wilensky 2009). However, the safeguards under law of contract and tort are limited to a few issues between the health care provider and the client, and do not cover several areas such as violations that can spring up due to the policies of the State including the preventive and promotive care and non-availability of life saving services. History of public health overall points to a greater emphasis on the coercive powers of the State in comparison to that of citizens from the eighteenth to the mid-twentieth century, which had the overriding effect on citizenship in the sense of individual liberties and rights. Safeguarding the liberties of citizens against the intrusive and invasive State power, however, is a late twentieth century development.
2.3.2 The Social Right to Health Care

The closest interrelationship between citizenship and health and health care can be traced not in the history of citizenship in general, but in social rights theories which became one of the core themes in the post-war Keynesian reconstruction and in the construct of welfare-state. During the mid-twentieth century, in the post-depression era, the Keynesian model provided a theoretical framework to the idea of a welfare-state.

Welfare-state is a creature of the framework of capitalist economy and the interventions in the social sphere (lifeworld) is intended to mitigate the ‘worst effects of the capitalist system’ (Veitch et al. 2012: 257). Legal interventions in social rights including health care are described as ‘juridification of life-risks’ intended to secure individuals against economic risks and to improve equality of opportunity. The human rights law symbolises such a juridification of great significance in the second half of the twentieth century. It is under the overwhelming influence of human rights, the broad theme of social rights and health care rights gained ground.

The Keynesian economic-political philosophy contributed in prompting the State to focus on social welfare and public health. The political experiments in social democracy which are not only economic growth but on distributive justice, fair wages and general welfare of citizens are the leads that link public health in general and health care in particular to justice and rights (Edgren 1995; Qadeer and CSD 2015). The National Health Service (NHS) of the United Kingdom (UK) and the Canadian Health Care illustrate how within the capitalist economies, health care of citizens received prominence as part of social security and welfare measures. Both were supplemented by legislations (Maioni 2010; Redden 2002). In the case of the UK, the Beveridge Report 1942 was followed up by instituting NHS, backed by the National Health Service Act 1946. Similarly, in Canada, Canada Health Act 1984 provided the legal framework for health services in Canada.

Human rights framework incorporates within itself a systemic vision and individual liberties and enables the identification of the barriers for such an attempt that stem from State-citizenship and societal relationships. It facilitates identification of violations such as discriminations that exist in the design or implementation of health policies to the detriment of health as illustrated by population policies that have often failed to respect individual decision-making and informed choices. The Alma Ata Declaration in 1978 played a pivotal role in bringing the idea of human rights into health and health care policy discourse for the first time. The Declaration which focused on primary health care positioned health as part of the development paradigm locating the root causes of diseases in the social conditions 2000. Considering primary health care as fundamental to human well-being, it stressed that it should be universally accessible to individuals and families in the community in

\[\text{In the 1970s and 1980s WHO played a key role in putting the agenda of Comprehensive Primary Health Care onto the agenda of governments and member nations. The Alma Ata declaration on Primary Health Care was a commitment of the world nations to ensure health as a basic right and make provisions in their respective national health systems.}\]
ways acceptable to them, through their full participation at a cost the community can afford (WHO and UNICEF 1978).

Owing to the character of the first generation human rights that primarily focused on civil and political rights, the emphasis still remained on the rights of individuals for long (Yamin and Gloppen 2011). It is only in the late twentieth century, issues of marginalised groups, the interdisciplinary themes of public health, health systems and law research gradually emerged (Burris et al. 2010). Alongside, during this period, the focus on the second and third generation human rights—that broadened their scope to economic, cultural and social rights and identifying vulnerable social groups and articulating their human rights—has propelled health care related issues such as health care rights, health care system, rights of patients, duties of doctors, and regulation of private health care, into public gaze.

The political churnings of the late 1980s and early 1990s in many parts of the world too had significant implications on repositioning citizenship in relation to social rights. Flood and Gross (2014) locate the resurgence of SRHC in various socio-political and economic churnings that took place in this period include the end of cold-war era symbolised by the collapse of the Soviet Union Block and breaking of the Berlin wall, end of apartheid regime in South Africa and transitions from dictatorial regimes to popular democratic governments in many Latin American countries. The new constitutions promulgated in these countries, explicitly provided for social rights on par with the civil-political rights. The constitutionalisation of right to health care as a fundamental right and consequently making provisions for health care and its various components through an express provision by the State or under the stewardship of the State provided a much-needed impetus to argue for health care as a fundamental right (Biehl et al. 2016).

2.3.3 Ethical Arguments for Social Rights

Medical ethics and bioethics which evolved strongly in the aftermath of world war II in the backdrop of gross human atrocities committed, consolidated the foundations of moral-ethical argument for human dignity. To a large extent the discussion on health care continues to be around individuals. A strong individualised narrative of health care generally becomes inevitable in health rights discourse, as medicine too focuses on treatment and cure of individual patients (Childress et al. 2002). As discussed in Chap. 1 (Vide. Sect. 1.2.2), the firm grounding of health as a ‘special social good’ safely located SRHC in the paradigm of social justice that is inalienably related to distributive justice, protection and promotion of human dignity, and ethics (Chapman 2015; Daniels 1981; Daniels et. al. 2004; Ruger 2006). The latter are vital to the construction of social citizenship as a concept.

Relating to citizenship, we note that two key themes in such a positioning of health care have accelerated the processes of health and court interface, thus giving social rights jurisprudence the much-needed impetus. They include the issue of State accountability in relation to citizenship and renewed interest on the distributive justice
dimension of health. The former has emerged from human rights discourses, and the latter from ethics.

The Universal Declaration of Human Rights (UDHR) and the body of human right treatise has redefined the ways of thinking social citizenship, by redefining an individual’s relationship with the State through the language of rights in an international law framework. Human rights perspective envisages a citizen’s full participation in the democratic governance, which is envisaged to be transparent, accountable, and participatory from the side of the State. Accountable governance also provides a compelling moral argument for social inclusion (Gauri 2004). Citizens challenging the State in court of law demanding accountability from their governments, nationally and internationally, illustrates such an assertion of citizenship. This process, however, has been gradual over the past three centuries. In diverse socio-political settings through this period, a range of public discourses and policy debates drew the significant linkages between contextual social factors and the issue of health and wellbeing of subjects. Notably in the aftermath of the second world war in the twentieth century, they were consolidated into a broader umbrella of social rights, and became part of the modern political agreements between the nation-states and a global consensus on human rights (Table 2.1).

Distributive justice is an important dimension of justice framework emerging from the ethics discourses for bolstering equity and justice. It provides an important framework to bolster the realisation of the citizenship of the most marginalised. Arguably, such a concept takes the SRHR beyond the personal realm of doctor-patient relationship. Distributive justice in public health care conceptualises health care as part of the justice framework and envisages equitable distribution of health care resources such as infrastructure, services, health care professionals, resource allocation and the protection of the rights of patients as well as various providers. Human rights law, in addition, proposes judicial remedy as one of the options to compensate for the wrong. General Comment 3 alludes to this as it states: ‘[A]mong the measures which might be considered appropriate, in addition to legislation, is the provision of judicial remedies with respect to rights which may, in accordance with the national legal system, be considered justiciable’ (UNOHCHR 1990: Article 5).

In health care, divesting of health care of its character of being a ‘public good’ and its rampant commodification and marketisation has aggravated violations of people’s rights. The narratives of patients analysed in litigations in this research testify to this growing trend. (Vide. Chap. 3) Resisting this commodification of health has an overriding importance as a precondition for the participation of and as citizens in the democratic, economic, and civil life (Flood and Gross 2016: 452). The ethics and human rights perspectives, with their emphasis on human dignity and autonomy of the citizens provide an antidote to the power asymmetry that the citizens are confronted with. Relating to SRHC, dignity and autonomy would consist of, at the minimum, of respecting general moral considerations (Childress et al. 2002: 176), locating citizenship in the sovereignty of people [calling on State accountability] Kothari (2002) and considering health care as part of the distributive justice framework [availability health systems and resources] (Gauri and Brinks 2008). Fulfilment of rights becomes the moral obligation of various actors including governments and
### Table 2.1 Prominent content of health related social rights from 18th to 21st centuries

| Period                                  | Issues and processes in focus                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Late 18th, 19th and early 20th century   | Sanitation, control of infectious diseases/epidemics; reproductive and sexual health laws including abortion, sterilisation, contraception, birth control, population control etc.                                                                                                                                                                                     |
| Mid-20th century                        | Rights of individuals in medical care (deficiency and inadequate care with adverse outcomes), medical negligence, and issues of mental health care highlighted                                                                                                           The social rights jurisprudence emerged under the international human rights law after the Second World War |
| Late 20th century                       | The regional human rights courts such as European Human Rights Court, Inter-American Human Rights Court along with the adoption of human rights treatise in domestic legal framework increased the scope of judicial intervention and court led jurisprudence in health care                                                                                                     Litigations begin to make a shift from being predominantly individual to that of issues of the masses                                                                                                         New initiatives in public health law research —1990, call for global health law especially in the globalised concern for the eradication of HIV/AIDS emerges                                                                 |
| Late 20th–early 21st century (1990 onwards) | Debates on increasing people’s access to health care (Affordable Care Act – USA)                                                                                                                      Detailed articulation of right to health care in the human rights law framework (General Comment 14)                                                                                                                                     Litigations on violations of right to health care using international and national laws and protocols                                                                                     Transition from authoritarian regimes to new democracies propel the nations to draft new constitutions which include people’s aspirations for social rights                                                                 Constitutionalisation of health care as ‘a fundamental and justiciable right’ in several countries (e.g., Thailand, Venezuela, and South Africa)                                                                 WTO and TRIPS agreements propel the issues of health care and medicines into the domain of international trade as part of patents and compliance to international trade agreements. This is a new issue of health care jurisprudence in domestic and international courts Natural and human made disasters, terrorism and issues of security, epidemics and pandemics prompt nation-states to enact more laws often compromising human rights and SRHC, leading to further legal contestations |
private health care providers, and correspondingly deficiencies and violations invoke criticism, moral pressure and justifiable State or courts directed external intervention, as ‘social rights have become critical elements of modern social compact and modern personality’ (Gauri 2004: 468).

2.3.4 Assumptions Underlying SRHC

From the judicialisation or legalisation perspective, SRHC implies the extent to which the public social good of health care can be converted into legally justiciable right or entitlement. Such a right must lay down obligations and duties on some parties and define nature and scope of liberties entailed for the other. The possibility of judicialisation of health care augmenting social citizenship through reinvigorated SRHC is contingent upon a few assumptions and conditions which are at the centre of conceptualising social rights. These assumptions include (1) conceiving State as the symbol of power and as the primary duty bearer with a core minimum obligation for social rights of citizens; (2) a well-functioning democracy; (3) the ability and power of the legal system including courts to deal with the issues of health care; and, (4) the political will to realise SRHC through strengthening public health care system. The key assumptions and factors that form the conditions for such an understanding of SRHC are discussed in the following section.

2.3.4.1 The Concept of Core Minimum as the State Obligation

The human rights framework and the concept of social rights hinge on the core concept of the State and its duty to promote, protect and fulfil the human rights of all citizens. The scope of core minimum in social rights connotes the protection of a minimum level of enjoyment of rights. The General Comment 3 of International Covenant on Economic, Social and Cultural Rights (ICESCR) proposes ‘a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent on every State party’. In health care, for example essential primary health care is proposed as the core minimum, ‘failing which it is prima facie failure to discharge its obligations under the Covenant’ (UNOHCHR 1990: Article 5). In litigating social rights, the courts also need to subscribe to such a conception of a State with obligations. Coomans and Universiteit Maastricht (2006) argue that the studies of justiciability and enforceability including that of using the judiciary shows the willingness of courts to adopt the concept of protection of a minimum level of enjoyment of rights. Contemporary literature point to at least three approaches that bring out the mandatory nature of these social rights:

1. The obligation approach is based on the standard human rights framework of ‘respect, protect and fulfil’ mandate where the State is singularly identified as
2. The accountability approach largely focuses on the accountability of the State. State is not only accountable to follow this human rights mandate (mentioned above), but is accountable to create conditions for the availability, accessibility, acceptability, and quality of care as per the mandate of General Comment 14 (UNOCHR 2000). Its accountability also springs forth from its electoral or constitutional mandate to its people; and,

3. The enforcement approach is linked to judicial decisions of Constitutional courts which citizens approach when the obligations are not fulfilled or when accountability is breached.

Comparative studies suggest that courts employ the idea of core minimum to enforce the obligation of the State. The right to food case in India, for example, uses the concept of core minimum obligations of the State to ensure nutritional security of vulnerable citizens. However, we do not find such a case in the right to health care litigations, though the core minimum of the right to health care is defined in General Comment 14 to include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health (UNOCHR 2000). It acknowledges that the right to health to be a right to the enjoyment of a variety of facilities, goods, services and conditions that are necessary for the realisation of the highest attainable standard of health, while stressing on the system that should be made available, accessible, acceptability while ensuring quality of care (UNOCHR 2000: Articles 8–12).

### 2.3.4.2 A Well-Functioning Democracy

A democratic State implies a strategic relationship between various actors such as individuals, collectives in society, State institutions and machineries such as legislative, executive, judiciary, and also the non-State actors such as media, corporate sector, non-profit sector and the like. A liberal democratic State is guided by the rule of law in which citizen participation and dissent too have an important role to play in policy formulations. A well-functioning democracy, well-demarcated or popular policies, cooperative governments are likely to accentuate the possibility of the realisation of SRHC or health rights (Gauri and Brinks 2008). The directives of judges are likely to be adhered to if it has the political, bureaucratic, or civil society support. It is likely to have broader impact if it is taken forward through policy decisions (Rosenberg 1991). The favourable environment to facilitate litigations is said to be consisting of processes of democratisation, social mobilisation, economic empowerment which can exist in a well-functioning democratic State.

Capabilities within various actors are likely to catalyse and sustain SRHC, and when necessary pursue litigations and enforce their outcomes. An autonomous judiciary which is the hallmark of a well-functioning democracy, has powers to demand

3People’s Union for Civil Liberties v. Union of India WP (Civil) No. 196/2001.
accountability from the State and non-State actors as well. Overall, these relate to the kind and level of democracy that is functioning in a given country within which the judiciary is located. The judicial review and judicial independence will gain traction only in a society where the constitutional demarcations between different institutions are well laid out, space for dissent exists, vibrant political parties are present and also a vibrant civil society and coalitions are active. In such circumstances, litigations in health care can represent the civil society’s feedback to the State on its obligations and accountability to the SRHC of citizens.

Provisioning for rights including right to health care are impacted by political, social, and economic contexts of a given country even beyond the formal laws and constitutional articulations. Flood and Gross (2016: 6) illustrate that ‘two systems with similar rights provisions but different social/political systems… show dramatic differences in the realisation of health rights’. Democratic ethos is likely to provide the best possible ecosystem for the realisation of SRHC.

2.3.4.3 Access to Justice and Capability of Courts to Deal with Health Care

In the judicialisation of health care, access to justice is the gateway to act upon the SRHC. Access to justice itself is determined by several factors such as costs of litigations, inaccessibility of courts and, as in the case of many countries, the alienation of the justice system from the cultural contexts of natives and indigenous communities. Albeit, the international human rights laws and treaties, domestic constitutions and legislations play a vital role in articulating rights to health care to facilitate access to justice for the matters of health care, in many countries it has been realised that access to justice alone is not sufficient to ensure its realisation. Courts cannot function unless other supplementary systems such as ‘tutela’ (ombudsman) in Colombia or ‘Commissioners of Courts’ as occasionally practised in India, are put in place (Lamprea 2016; Srivastava et al. 2009).

The advancement of SRHC takes place through the mediation of Courts under various circumstances and societal conditions which are related to the policy context and political environment. Gauri and Brinks (2008) note that courts are impactful when the political ecosystem is conducive and garner support from other political actors. This in turn leads to attracting more strategic litigations resulting in the possibility of a robust jurisprudence. On the other side, judicial remedies for social rights are deemed to be difficult due to the nature of inequitable, underdeveloped, weak, and less than impartial legal systems in many developing countries. Substantial increase in social rights litigations in such countries have the potential of further damaging the existing efficiency of the courts.

On the issues of SRHC, even well-functioning courts face several challenges. SRHC is a bundle of various services and courts find it difficult the nature and the authority/person responsible for the violation of rights as numerous providers are
involved in the process. The sources include international rights, domestic constitutional rights; legislation based statutory rights and de facto rights based on public policy (Flood and Gross 2016).

The legal systems and the health care systems operate in varied socio-political contexts and yet common economic and global political factors affect all of them simultaneously such as the pressure for downsizing public health care systems, and international pressure to marketise health care. In such contexts, the kind of litigations that come to courts and the response of the courts depend on several factors. For example, the courts may not be able to provide adequate orders which will have substantial impact on the system or court orders may be adverse or orders may not be enforced at all. How much court processes lead to mobilising civil society response then becomes very important for sustaining such demands? A case from Canada4 illustrates that the courts held that the government did not have a legal obligation to fund a particular treatment for autism. This created enormous public outcry that the government was forced to make a policy for such a treatment (Flood and Gross 2016). How long and to what extent courts can function as levers of change in SRHC is a question that always comes back to this discussion on SRHC.

Through extensive case studies Flood and Gross (2016: 16) conclude that ‘courts may not be the best venue if one hopes to improve equity or fairness’. At best, courts might play a positive role in several ways such as protecting the existing standards of equity or filling in some gaps towards this. Equity and fairness cannot be brought by courts alone. If there is an equitable system in place the courts might protect them from external challenges. But the court’s role is limited in bringing about equity by redistributing resources to those most in need and ‘produce equity’. There are only a few illustrations where courts have shown grit and determination to act boldly on social rights. The right to food case in India5 is an example for the issue of social rights and addressing the mother-to-child transmission of AIDS in South Africa is an example6 for court impact on SRHC (Forman and Singh 2016).

From these discussions we surmise that access to SRHC is predicated on the possibility of access to justice. It implies that realisation of SRHC is contingent on socio-political settings of courts including a well-functioning democracy that upholds rule of law and the overarching legal framework that respects international human rights law providing a legal cover to right to health care.

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4Auton v. British Columbia (Attorney General) [2004] 3 SCR 657 (Can).
5People’s Union for Civil Liberties v. Union of India 396/2001 was filed in the wake of starvation death and the court over period of 15 years through ‘continuing mandamus’ has passed several orders which resulted in streamlining several nutritional schemes such as midday meals, nutritious supplementary food to under-five children in Anganwadi centres and so on.
6Minister of Health & Another v. Treatment Action Campaign & Others 2002 (5) SA 721 (CC) (S.Afr.) – the court ordered the government to expand programs to address mother-to-child transmission of AIDS in the public health care system.
2.3.4.4 Public Policy and Political Will Invested in Public Health Care System

The constitutional pronouncement and the existence of a well-functioning public health care system, in addition to the factors mentioned above, are critical to the actualisation of SRHC. The former refers to the policy or constitutional articulation of SRHC in a particular country, whereas the latter denotes the provisions of systemic arrangements and services for the realisation of health care, in some cases not even citing it as a social right. The newer democracies such as Venezuela and South Africa, adopting the international legal instruments into their domestic constitutions have articulated the right to health care as a constitutional or fundamental right. They, however, are not identified as having a well-functioning health care system to provision the SRHC. In fact, establishment of a constitutional right to health is part of the so-called second-generation rights appearing mostly in newer constitutions of emerging democracies (Flood and Gross 2016). Whereas the older democracies and primarily the capitalist countries have provided right to health care through their policies through a well laid out health care system, without having a constitutional articulation on it. In these countries, SRHC exists as de facto rights (as can be seen in Sweden, Canada, United Kingdom and New Zealand). In fact, in countries where SRHC is enjoyed the most are the ones which have a robust public health care system based on a strong and long-term public health policy which may or may not be accompanied by clear constitutional articulation of SRHC.

Having an articulation of SRHC in the constitution and in law does not mean the existence of policy on public health care or a commitment to public spending on health care which is essential for the realisation of SRHC (Pinto 2018). About 68% countries are found to be having some form of articulation of on SRHC that ranges from mentioning SRHC to providing for an affirmative State action in health care provisioning (Kinney 2008). However, her research finds that countries showing the greatest constitutional commitment spend less than half as much per capita on health care compared to countries with no formal constitutional declarations on right to health and health care. The anomaly is due to historical reasons and is attributable to the fact that establishment of a constitutional right to health and health care belongs to the second-generation human rights, which appear mostly in newer constitutions of emerging democracies. By contrast, countries with stronger public health care systems are often rich democracies in which the health care system has been established as part of a welfare-state, ‘developed historically without explicit reference to health rights’ (Flood and Gross 2016: 5).

For accentuating social citizenship through the realisation of SRHC, the existence of a robust public health care system supported by a pro-citizen, pro-people public policy is an ideal mix. Entitlements in health care, even when they are laid down through court interventions, appear to be a piecemeal solution, if not accompanied by a fairly functioning public health care system that can foster them. This seems to be India’s case where Constitutional articulations, legal interpretations, and court orders, among other measures, seem to have a very little impact on the public health care system.
The Constitutional Courts have the potential of overcoming such a divide, both in countries where the Constitutions have conferred justiciable status to social rights as well as in those where they have not. Judicialisation or legal articulation could be a leveraging factor for citizens to strengthen SRHC on both counts, viz. to firm up Constitutional or policy articulation where it does not exist or to reinforce a public health care system where it is fragmented. Both these aspects form inseparable components of a robust health care jurisprudence.

2.3.5 **Typology of Health Care Jurisprudence**

The access to courts through constitutional provisions or on the grounds of law articulating entitlements of individuals and the corresponding duties and the limits of the State powers, facilitates the interface between legal institutions and health care issues for a citizen. Resorting to courts happens on various grounds including redressal of violations, enforcing the duties of the State to safeguards the rights of the individual, to demand for action on policy and implementation gaps such as praying for regulation of the private-commercial health care institutions. The jurisprudence thus laid down is multifarious, relating to varied thematic subdomains or issues within the overarching domain of SRHC.

Medical Jurisprudence

Medical jurisprudence refers to the application of various principles and practices of medicine in courts of law. It deals with the legal responsibilities of a medical practitioner in matters of medico legal cases and forensic matters such as estimation of age, post-mortem, injury report, sexual offences, poison cases, suicide, and paternity detection. The nomenclature of the branch of medicine that deals with such matters also varies and is known by several names such as legal medicine, forensic medicine, state medicine and is often linked to toxicology (Sheikh et al. 2013).

Therapeutic Jurisprudence

Therapeutic jurisprudence refers to the study of law as a therapeutic agent and focuses on the psychological well-being. Applied primarily in the matters of mental health and law initially, the term was made popular by Prof David Wexler, who expanded it to mean legal procedures, study of law, role of legal actors in producing therapeutic and anti-therapeutic effects on those who come in contact with courts and legal procedures. Therapeutic jurisprudence was applied to drug treatment courts and was understood as the problem-solving role of the judiciary in domestic violence courts, mental health courts and juvenile courts (Wexler 2000). Conceptualising health services as an integral part of one’s well-being was another way of rationalising the interface with law. This understanding which has been deep-rooted and emerging from the domain of mental health care has given rise to the notion of ‘therapeutic jurisprudence’. Scholars dealing with this subject matter consider law as a ‘therapeutic agent’ (Yamin and Gloppen 2011; Wexler 2000; Perlin 1993; Hora et al. 1999; Davidovitch
Social Rights and Health Care Jurisprudence

In recent years, the scope of therapeutic jurisprudence has expanded with the hitherto neglected issues of health care and social rights such as disability gaining prominence through international agreements such as Covenant on the Rights of People with Disability (CRPD) that are followed by domestic legislations and subsequent litigations (Ministry of Law and Justice 2016; UNOHCHR 2006).

Public Health Jurisprudence

Generally covered under the theme of public health law, public health jurisprudence deals with using law, legal procedures for effective legal, regulatory and policy solutions to improve public health. It deals with environmental and sanitation matters, food safety, health care reforms, tobacco control and such other issues. It is also referred to as global health jurisprudence in its widest sense while covering the subjects of global infectious diseases such as Severe Acute Respiratory Syndrome (SARS), Influenza (Avian and other zoonotic infections) and in the present-day era, the Coronavirus infection (COVID-19). In outbreaks of epidemics or pandemics which affect populations in large numbers, the public health law scholarship stresses the regulatory and enforcement character of law and the central role of the State in managing them (Gostin et al. 1999; Gostin and Mann 1999).

Social Rights Jurisprudence

In the international human rights law framework civil—political rights are considered negative rights that restrain the State from infringing individual liberties and are rendered justiciable. The economic and social rights, on the other hand, are positive rights that require the State’s proactive intervention for their realisation. In general, these rights that include health and health care, are not justiciable, and are relegated to the policy domain, persuading the State to take measures for their implementation. Under the aegis of progressive constitutional courts across the globe, the justiciability of social rights is gaining momentum through social action litigations ushered in countries such as South Africa and India. They have set precedents where health and health care matters are litigated under the broad umbrella of social rights (Langford 2008).

While a very few countries including South Africa and Venezuela have made a provision for SRHC in their respective constitutions, in most of the countries the civil society has opted for judicial law making as the prime route for enforcing SRHC, by engaging constitutional courts. Filing lawsuits in matters relating to individual patient’s grievances on the grounds of breach of contract or social action litigations directly in constitutional courts in matters gross violations at scale is in vogue in these countries. Medical malpractice and medical negligence form the prominent issues in matters of deficiency of health care services (Budetti and Waters 2005; Yamin and Gloppen 2011).

Aided by the international human rights framework and the gains made in social rights jurisprudence, this evolving domain has covered issues such as access to health care that include medicines, compensation for the deficiency in service and medical negligence. It has spurred the emergence of health care jurisprudence as another
nascent subdomain within social rights jurisprudence, opening the possibility for
civil society to leverage it as another avenue to consolidate social citizenship.

2.4 Drivers of Health Care Litigations in India

Civil society is the prime mover of judicial power in India in matters of SRHC. It
has leveraged international policy frameworks, constitutional provisions, and legal
instruments to do so. This section discusses the socio-political factors relating to
health policy and its implementation in India that form the immediate context of
knocking on judicial portals.

India is a signatory to all core human rights treaties and conventions. The Consti-
tution of India itself incorporated the human rights framework within itself placing
all the civil and political rights in the fundamental rights chapter and the social—
economic rights in the chapter on directive principles of State policy. Adhering very
strongly to the welfare-state idea, in the post-independence era, India took the legisla-
tive route to provide enabling laws strengthening social citizenship (Bhat et al. 2016;
Bhat et al. 2016). Such steps include adoption of the international conventions and
policies into domestic laws and policies on matters of social welfare. India’s adop-
tion of international policies such as Convention on the Elimination of Discrimina-
tion Against Women (CEDAW), legislations around rights of children subsequent
to signing child rights convention (CRC), legislations on disabilities pursuant to
signing the Convention on Rights of People with Disability (CRPD) have certainly
emboldened the efforts for social citizenship. Among others, the political openness
for SRHC is indicated in being signatory to the Alma Ata Declaration for compre-
hensive primary health care and proactive policy to promote drug manufacturing to
meet India’s needs.

However, India lacked a political will to institute credible mechanisms for the
implementation and enforcement of these policy measures relating to health care. As
a consequence, they were neither translated into enforceable health rights nor into
substantive health system measures, deranging their potential of enhancing social
citizenship. In the wake of such commitment deficits and a range of violations of
health rights, civil society has resorted to judicial power as a constitutional tool
to demand accountability from the State for such anomalies and gaps, resulting in
adversely impacting citizens.

The drivers of health care litigations in India are located in the complex ecosystem
of its socio-economic-political processes shaping health care policies and their imple-
mentation. Both the organisation of political governance and health system govern-
nance and the inherent paradoxes further contribute to this complexity. Some of these
factors that compel civil society with no other alternative other than accessing the
constitutional judiciary are briefly discussed in this section.
2.4 Drivers of Health Care Litigations in India

2.4.1 Economic and Development Policies Affecting Health Care System

India is a low-income country with 1595.7 USD as per capita GDP (The World Bank n.d.) and is ranked in the medium human development category at 135 (of 187 countries) in the Human Development Index (HDI). (United Nations Development Programme n.d.) India’s per capita expenditure on public health care by the government (i.e. US$33) and percentage of GDP (i.e. 1.2%) are one of the lowest in the world. The citizens cover 75% of health care costs privately, which is far higher compared even to other low-income countries (National Health Systems Resource Centre 2016).

Ushering in the economic reforms in the 1990s is perceived to have boosted the GDP growth in India (Ramesh 2016). However, it is argued that the socio-economic inequities in this post-reform period have considerably increased and the policies vigorously supporting the corporate private sector compromising the social sectors (social security and welfare of citizens) have increased the social divide and inequities (Qadeer and Council for Social Development (India) 2015). The evidence from the health care services and the health status indicates that the [positive] impact of the economic reforms on health status has been slow, uneven and that the health inequities have widened across states and various geographic and ethnic communities (Qadeer et al. 2001; Baru 2001; Qadeer 2011; Zubrigg 2001).

Of the many factors that continue to challenge the improvement in the health status of citizens are the inequities and inequitable policies. Historical inequities such as socio-economic inequities reflect in the inequities of provisioning of health care and assurance of quality of care (Baru et al. 2010; Baru 2001; Qadeer 2011a, b; Qadeer et al. 2001). Overemphasised policy impetus on a commercially oriented health care system has led to distortion of priorities and a reduced focus on preventive and promotive health measures. Medicalisation and commercialisation of health care inextricably linked to the rise of unregulated commercial health care sector have added to the complexity of health care provisioning in India (Baru 1998, 2005; Qadeer & Council for Social Development (India) 2015; Zubrigg 2001). High Level Expert Group spells out the need for policy correction in the context of 78% out of pocket expenditure as the primary mode for people accessing and availing health services (Government of India-Planning Commission 2011).

2.4.2 Political Organisation and Federal Governance

Politically, India is the largest functional parliamentary democracy in the world with a universal electoral franchise system, committed to the doctrine of separation of powers (executive, legislative and judicial), and being governed by a Constitution considered to be very progressive. ‘Constitutionalism’ or ‘Constitutional Governance’ has come to be the feature of governance in India, wherein the SCI, as the
To the Constitution, is called upon to play a significant role in the Constitutional Governance (Pylee 2003). Following the doctrine of separation and devolution of powers in the federal governance, the powers and roles between the central government and state governments are constitutionally demarcated as part of the ‘the basic structure’ of the Constitution. In this complex arrangement of governance where the balance of power is safeguarded while ensuring the pivotal role of the SCI, it also brings in accountability challenges in health care governance, being sandwiched in the federal and political relationships between the centre and the states.

### 2.4.3 Constitutional and Decentralised Governance and Health Care

The positive interventionist role of the State was accepted in India in the Constitutional scheme in the post-colonial (post-independence) period. State was assumed to be a ‘liberator, equaliser, moderniser and mobiliser’ (Kothari 2002). Kothari (2002: 73–4) succinctly summarises such a presumed role of the State as follows:

> [The State is] a mediator in ameliorating the harshness of traditional social structures for the purpose of ensuring justice and equality, a protector of vulnerable peoples and liberator of oppressed and colonized populations, and an engine of growth and development that would usher in a new civil order based on progress and prosperity and confer rights of life and liberty, equality and dignity, on the people at large.

The SRHC, though undefined in the Constitution, was accepted as an underlying principle in the welfarist policy of the State.

The Constitution of India enshrines several civil and political rights as fundamental rights and reflects both the principles as well as the spirit of UDHR. However, the debate and divide between civil-political and social rights mentioned above, is reflected in its drafting, and organising of the text (Pinto 2018). Civil and political rights are incorporated in chapter III of the Constitution as justiciable fundamental rights, while social rights are addressed rather indirectly by the Constitution and are broadly covered under different sections of the Directive Principles of State Policy—DPSP. CONSTITUTION OF INDIA, ARTICLE 38, 39, 41 AND 42 (Govt. of India n.d.). The latter are non-justiciable rights subject to progressive realisation. This division has serious implications with respect to the justiciability of social rights in general, including one of the most essential – the human right to the highest attainable standard of health, including preventive, curative and rehabilitative medical and health care (Pinto 2018). Articles 38, 39, 41 and 42 of the Constitution of India, Article 39 (e) ‘health and strength of workers (…) are not abused …’; 39(f): ‘that children are given opportunities and facilities to develop in a healthy manner.’; Article 41: ‘… securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement…’; Article 42: ‘humane conditions of work and for maternity relief’; Article 43: ‘conditions of work ensuring a decent standard of life…’.
provide the vision and the aspirations for health governance. These Articles highlight the welfare measures that are required for workers and women, and State’s duty to provide conditions that are prerequisite for leading a ‘healthy life’.8

The closest reference to health care, as articulated in Article 47 of the Constitution of India, recognises the ‘duty of the State to raise the level of nutrition and the standard of living and to improve public health’. Courts have referred to this Article in several landmark judgments in relation to health and health care. (Vide: Chap. 3)

Article 47: Duty of State to raise the level of nutrition and the standard of living and to improve public health:

The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medical purposes of intoxicating drinks and of drugs which are injurious to health.

As we shall discuss later in Chapter three, these Articles of DPSP provide the much-needed critical wherewithal to lay the foundations for health care jurisprudence in India.

However, scholars opine that merely a Constitutional aspiration for SRHC as inadequate and insufficient to achieve such a right. Duggal (2007) argues that despite the Constitutional provisions, it is still important to have health and health care instituted as a right within the constitution and/or established by a specific Act of Parliament guaranteeing the right. Ruth Roemer (cited in Duggal 2007: 6) notes:

The principal function of a constitutional provision for the right to health care is usually symbolic. It sets forth the intention of the government to protect the health of its citizens. A statement of national policy alone is not sufficient to assure entitlement to health care; the right must be developed through specific statutes, programs, and services. But setting forth the right to health care in a constitution serves to inform the people that protection of their health is the official policy of the government and is reflected in the basic law of the land.

8Article 38: State to secure a social order for the promotion of welfare of people: State shall strive to promote the welfare of people by securing and protecting as effectively as it may a social order in which justice, social, economic and political, shall inform all the institutions of the national life; State shall, in particular, strive to minimize the inequalities in income, and endeavour to eliminate inequalities in status, facilities and opportunities, not only among individuals but also among groups of people residing in different areas or engaged in different vocations.

Article 39: Certain principles of policy to be followed by State—The State shall, in particular, direct its policy towards securing e) that health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength; f) that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment.

Article 41: Right to work, to education and to public assistance in certain cases: The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.

Article 42: Provision for just and humane conditions of work and maternity relief: The State shall make provision for securing just and humane conditions of work and for maternity relief.
Apart from the federal feature whereby governance is distributed between the centre and states, another significant feature that characterises Indian Constitutional Governance is operationalising Indian democracy through decentralisation and participatory local governance. The Panchayati Raj Institutions (PRI) are the pivotal institutions of the local democratic governance, and it is envisaged that through the PRIs citizens at their community level are able to participate in governance and adopt measures for the realisation of their basic needs and human rights. Part IX of the Constitution of India and 73rd Constitutional amendment on local governance, makes Panchayati Raj governance and citizen participation, both a constitutional and democratic governance act to be complied with by the Indian State in its programmes and policies.

Participatory and decentralised governance can be instrumental in addressing health system issues most relevant to the people, with greater accountability to the population it serves. Schedule 11 of the Constitution of India has included the health care system—especially the primary health care system—within the purview of local governance. Several policy measures have been initiated to create the community’s increased role in health governance in coordination with the gram panchayats. The NRHM, in its framework of implementation envisages ‘communitisation’ which includes decentralised community based monitoring and planning (CBMP), formation and strengthening of community institutions like the Village Health and Sanitation Committees (VHSCs), and the Rogi Kalyan Samiti (RKS), and management of untied funds by these committees in which the members of the Gram Panchayat (GP) play a key role (Government of India 2015).

However, being starved of funds, human resources and adequate infrastructure, the institutions of health care services themselves are being progressively rendered weak and fragmented. Adding little value to the efficient functioning of the health care system, decentralisation tends to be merely a rhetorical exercise making it a euphemism for evading responsibility for citizens’ health care.

2.4.4 Diffused and Fragmented Health Care System Governance

Within the federal governance of the country, the health care administration is dispersed between the union government, state governments and local governance. The demarcation of subject matters is delineated into union, state and concurrent lists located in the seventh schedule of the Constitution of India. The major policy making, financial allocation, prioritising of the centrally financed nationwide health programmes is decided by the union government. The health care system is governed by the states and implementation of health programmes is done through the complex bureaucracy at different levels of governance.

The MoHFW is the central ministry which administers the health care programmes. However, matters closely intersecting the components of SRHC are
distributed across different government ministries and departments that notably work in isolation without any inter-sectoral coordination (Duggal and Gangolli 2005). For example, drugs and medicines, nutrition, and distribution of food grains are governed by the ministry of chemicals and fertilizers, ministry of women and child welfare, and ministry of consumer affairs, food, and public distribution, respectively. The Central Drugs Standard Control Organisation (CDSCO) and National Pharma Pricing Authority (NPPA), the key drug regulatory bodies in India are located in two different ministries, viz. MoHFW and Ministry of Chemicals and Fertilisers, respectively. Besides, in most of the states, the public tertiary care hospitals are attached to medical colleges and are being governed by the ministry of human resource development through its department for medical education.

The private-commercial health care sector, which accounts for a share of over 75% health care provisioning in India, has no regulatory or governance framework. These in addition to a plethora of allied medical care services such as diagnostics and supplies, operate purely as business enterprises. Besides not being regulated, its governance is delinked from the jurisdiction of MoHFW.

The diffused and fragmented health care governance which is devoid of any inter-sectoral coordination and lack of political will of regulation of corporate and commercial health care system is reflected in health system factors such as weak information systems, discontinuity in care, unsupported health workers, haphazard referral system and distorted accountability mechanisms (George 2007). These, along with the underfunded and substantially weakened public health care system with suboptimal capacity to deliver appropriate services and the private health care system with the complete absence of regulatory oversight, contribute to a fertile ground for the violations of citizens’ right to health care. Officially commissioned reports by the government of India themselves bear evidence to such a fragmented system resulting in a plethora of problems such as monstrous proportions of the out of pocket expenditures in health care that impoverishes citizens on account of health care (Government of India-Planning Commission 2011). There are other innumerable ways that accounted for the violations of SRHC that include, among others, medical negligence, discrimination and denial of health care, and medical malpractice and irrational care leading to over expenditure coupled with a compromised quality of care (Pinto 2017; Vasan et al. 2017).

2.4.5 Absence of a Credible and Accessible Grievance Redressal System

Lack of a credible and accessible grievance redressal system and inaccessibility of courts for the regular grievances of patients or citizens is another policy and governance deficit that has been ignored for long. (Vide: Chap. 4 for a detailed discussion) While the factors mentioned above in this section form an overarching policy context, the absence of credible and accessible mechanisms to redress grievances within the
public health care administration or in the regular processes of seeking redressal within the justice system, forms the most proximate driving factor pushing civil society to the higher judiciary. The twin demands of the civil society while resorting to the constitutional judiciary, viz. strengthening of public health care system and regulation of private health care system which is distorting the health care policies in India, have mirrored these policy and governance deficits (Gangolli et al. 2005). The active civil society in India seized upon the constitutional vantage-points for accessing justice that became amenable to citizens along with the constitutional reforms ushered in by the higher judiciary in the realm of fundamental right to accessing justice.

2.5 Accessing Judicial Power and Health Care Jurisprudence

India’s judiciary or court system functions as a single but three-tiered system, the Apex being the Supreme Court of India (SCI). Each state has a designated high court, and sessions courts at the district and Judicial First-Class Magistrate (JFMC) courts at the subdistrict level. The SCI was inaugurated on 28 January 1950 succeeding the Federal Court of the British administration, and has continued to be a powerful institution in the country. The SCI combines within itself two distinct roles, which are bifurcated into two separate institutions in some countries, viz. Supreme Court of Appeals and the Constitutional Court while exercising a vast jurisdiction over a range of legal issues. The powers of judicial review, power of precedent in case-laws, court reforms enabling citizens’ access to constitutional courts for justice, fundamental and personhood jurisprudence, and the role of quasi-judicial institutions, among others, are the foremost factors that have facilitated the health care jurisprudence.

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9The number of High Courts does not exactly match the number of States. In the North Eastern States, except Tripura rest of the states have only one Gauhati High Court with different benches. Similarly, Goa and Maharashtra have one HC.

10Under Article 131 of the Constitution of India (CoI) it exercises original jurisdiction in cases involving the government and appellate jurisdiction in a variety of cases. Under Article 132 of CoI it rules on cases involving constitutional interpretation; Article 133 provides it with the jurisdiction over civil cases that involve a substantial question of law of general importance. In addition, it is an appellate court for some criminal cases, it has the power to grant special leave to appeal. It also enjoys writ jurisdiction over questions of fundamental rights and has authority to issue advisory opinions.
2.5 Accessing Judicial Power and Health Care Jurisprudence

2.5.1 Power of Judicial Review

The power of judicial review is a non-written but a presumptive power. Chief Justice Marshall of the United States of America in 1803\textsuperscript{11} had stated: ‘It is emphatically the power and duty of the judiciary to say what the law is’. In A. K. Kaul v. Union of India\textsuperscript{12} SCI had observations on the judicial review power:

In a written Constitution the powers of the various organs of the State are limited by the Constitution. The extent of those limitations has to be determined on the interpretation of the relevant provision of the Constitution … the task of interpreting the provision of the Constitution is entrusted to the judiciary which is vested with the power to test the validity of the actions of any authority functioning under the Constitution… in order to ensure that the authority exercising the power conferred by the Constitution does not transgress the limitations imposed by the Constitution on the exercise of that power. This power of judicial review is therefore implicit in a written Constitution and unless expressly excluded by the provisions of the Constitutions, the power of judicial review is available in respect of the exercise of powers under any provision of the Constitution.

This power has instituted SCI as the custodian of the Constitution. The power entails review of all legislations passed by the parliament, the compliance of executive action to the constitutional mandate, the power to review the application of constitutional provisions, and to interpret the Constitution.

The executive (ruling governments) have contested this power and have tried to circumvent courts by limiting power of judicial review and passed legislations and constitutional amendments placing them under the ninth schedule of the Constitution which is beyond judicial review. In the landmark Kesavananda Bharati judgment, SCI laid down the ‘basic structure doctrine’ curtailting Parliament’s power to amend the basic structure of the Constitution, wherein it laid down power of judicial review as quintessential and integral to the basic structure of the Constitution.\textsuperscript{13} The fundamental rights jurisprudence that took wings from such an authoritative declaration, and the ensuing expansive definitions of the fundamental right to life, provided the necessary ambience for the SRHC to emerge.

Deploying the power of judicial review has entailed several governance challenges. With the power of judicial review and an unrestricted jurisdiction over fundamental rights, SCI and HC have forayed into the matters of governance and matters of administration, which has been contested as ‘juristocracy’ in the name of judicial activism (Hirschcl 2004; Conant and Conant 2008). Though a pro-citizen trend is traced in several of these judgments that are brought to SCI, it is also acknowledged that ruling in favour of citizens in health care matters by readily recognising it as part of right to life is challenging for the SCI (Shankar and Mehta 2008; Muralidhar 2008). There is a recognition of the inability of the courts to enforce its own orders, and the lack of capacity to handle such complex policy issues entailed in health care matters (Gauri and Brinks 2008). It is noted that in several instances, deploying

\textsuperscript{11}Marbury v. Madison (1803) 1 Cranch 137.
\textsuperscript{12}A. K. Kaul v. UOI (1995) 4 SCC 73.
\textsuperscript{13}Kesavananda Bharati v. State of Kerala AIR 1973 SC 1461.
the power of judicial review meant bypassing the role of regular courts and other institutional mechanisms (Galanter 2000).

2.5.2 Power of Precedent

The judgments of SCI and HCs include the power of precedent based on common law tradition. In common law tradition, the judgements laid down by the constitutional courts are vested with the power of law based on the doctrine of \textit{stare decisis} in jurisprudence and are referred to as case-laws. \textit{Stare decisis} implies ‘to stand by things decided’. According to the Supreme Court of USA it ‘promotes the even-handed, predictable, and consistent development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process’ (Legal Information Institute n.d.).

The doctrine operates both horizontally and vertically. The former refers to a court adhering to its own precedent when it is decided by the bench of same strength. The latter refers to its binding power on the lower courts when it is laid down from a higher court or a bench of higher strength. The precedents of SCI have universal jurisdiction in India, whereas those of HCs are binding within their own jurisdictions and act as persuasive precedents for other HCs. The principles laid down in jurisprudence of SCI in India through judicial interpretation, operate as the domestic law and policy. This power of precedent has significant implications to SRHC evolved through health care litigations.

2.5.3 Court Reforms and Access to Justice

Historically, evolution of the judiciary as an institution points to its emergence as part of the bourgeoisie led liberties and establishments of legal institutions to defend their rights in Europe, and hence bore an elitist character. The masses had very little to do with the affairs of the courts (Tigar and Levy 2005). Following the colonial legacy which ushered in Anglo-Saxon legal tradition in India, the Indian judiciary too is perceived to be carrying the historical colonial legacy of elitism and the disconnect from the masses (Salve 2000; Gadbois 2011). The principle of \textit{locus standi} is one of the key features of the Anglo-Saxon legal tradition and was a major barrier for common people to access courts. Apart from the other requirements such as ability to pay the court fees, this principle implied that only who had an interest or stake in the case or who was a party to the case, had the right or ability to bring a legal action or appear in a court of law. Indian judiciary literally followed this technical-legal framework up to the early 1970s.

However, some of the judicial stalwarts and luminaries made a historic difference to the institutions of justice while others continued the elitist legacy. The social justice
champions among the Indian Judiciary argued for doing away with these technical-legal procedures as the first step to make a transition to social justice, a principle enshrined in the preamble of the Constitution of India itself. These path-breaking court reforms aimed at the realisation of access to justice as the fundamental right, are attributed, among others, to stalwart judges such as P. N. Bhagwati and V. R. Krishna Iyer (Gadbois 2011).

V. R. Krishna Iyer, J. in his landmark judgment *Municipality of Ratlam v. Vardhichand* lays down the concept of processual jurisprudence:

> The truth is that … a few profound issues of processual jurisprudence of great strategic significance to our legal system face us and we must zero-in on them as they involve problems of access to justice for the people beyond the blinkered rules of ‘standing’ of British Indian vintage. If the centre of gravity of justice is to shift, as the Preamble to the Constitution mandates, from the traditional individualism of locus standi to the community orientation of public interest litigation, these issues must be considered. In that sense, the case before us between the Ratlam Municipality and the citizens of a ward, is a path-finder in the field of people’s involvement in the justicing process, sans which as Prof. Sikes points out, the system may ‘crumble under the burden of its own insensitivity’ (*Municipality of Ratlam v. Vardichand and Others*, para 114)

Doing away with the principles of *locus standi* began with the issue of providing effective legal aid to indigent prisoners and under-trials that necessitated a liberal interpretation of Article 32 of the Constitution. It acknowledged the social, economic and other vulnerabilities of the aggrieved persons that impaired their access to the justice system. Subsequently it liberalised the principle of *locus standi* to accommodate any ‘public-spirited person’ or a person with ‘public interest’—and not merely the aggrieved—to have the *locus standi* to approach the higher judiciary with a public cause that infringed fundamental rights of citizens from disadvantaged sections. Once, the bureaucratic and administrative procedures acting as impediments in bringing public interest matters before the SCI were cleared away, even postcards written by desperate citizens were admitted as writ petitions as part of the newly considered epistolary jurisdiction of the constitutional courts. In due course, several issues of violations and social injustices such as bonded labour, environmental degradation, and exploitation of workers and women were brought within the ambit of fundamental right to life through a very creative and expansive interpretation of Article 21 (right to life and liberty), known as the personhood jurisprudence. The reciprocity between a proactive judiciary and indigent citizens awaiting access to justice, often through the interventions of public-spirited citizens, thus laid a firm foundation for the social rights jurisprudence in India.

Several authors have attributed this creative and proactive nature of the SCI, to the responsibility that the Apex Court took upon itself in the post-emergency period to redeem its tainted image it had owing to its dubious role during the pre-emergency and emergency period (Mody 2013). It was criticised for conniving with the ruling

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14The paragraph or page numbers of an order cited in the quotes or in-text references, refer to the litigation cited or mentioned immediately before it in the text.

15Article 32 (1): ‘The right to move the Supreme Court by appropriate proceedings for the enforcement of the rights conferred by this Part is guaranteed’.
government in the imposition of emergency in 1975, where the civil and political rights of citizens were suspended. Observing SCI’s reform in the post-emergency period, Mehta notes: ‘Ironically, the judiciary emerges out of the Emergency as an even more powerful institution. It managed to legitimise itself, once again, not only as an institution of accountability of last resort but also as an institution of governance’ (Mehta 2007: 160). Baxi (1988) argues that in the 1970s and 1980s SCI moved from a technical-legal phase where the judiciary sheltered itself from the socio-political realities to a more populist direction. The personhood jurisprudence that formed the basis for the jurisprudence of several fundamental rights has singled out Indian judiciary as being progressive, authenticating such a transition.

2.5.4 Personhood Jurisprudence (Expansive Definition of Right to Life)

The judicial innovation of moving beyond the legal and literal interpretation of the expression ‘right to life and liberty’ of Article 21 of the Constitution was an important milestone in establishing social rights jurisprudence (Desai and Muralidhar 2000; Kirpal et al. 2000: 159–92). It started with the case of impounding the passport of Maneka Gandhi where the seven judge constitutional bench laid down a unanimous judgment which is said to have ‘changed the landscape of the Constitution of India’16 (Varshney 2018). The jurisprudence laid down in this case expanded the meaning of right to life and liberty, while mandating any executive action depriving citizens of fundamental right to liberty to follow ‘the procedure established by law’. Laying down the test of reasonability, the jurisprudence prescribing such procedures to be reasonable, just, and fair. In addition, it established the interconnectedness and reciprocity between Articles 21 (of the constitution), 14 (Right to Equality) and 19 (Various fundamental freedoms such as movement, expression, residence etc.), decreeing any deprivation of liberty not to violate the fundamental rights and freedoms laid down in these Articles.

Such a jurisprudence was dynamic and was progressively unfolding various contours of the personhood jurisprudence. Francis Coralie Mullin v. the Administrator17 provides a peek into such a dynamic process in which the SCI further unfolded nuances of right to life stating that ‘the right to life includes the right to life with human dignity and all that goes with it …’. [Emphasis added] This opened up new vistas for human rights litigations that covered a range of civil, political and social rights issues such as rights of prisoners, environmental rights, workers’ right to work,18 right to shelter,19 and the right to food20 (Mehta 2009).

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16See, for example, Maneka Gandhi vs. Union of India (1978) 1 SCC 248.
17Francis Coralie Mullin v. The Administrator (1981) 2 SCR 516.
18Bandhua Mukti Morcha v. Union of India (1984) 3 SCC 161, 183.
19Olga Tellis v. Bombay Municipal Corporation (1986) 3 SCC 545.
20People’s Union for Civil Liberties v. Union of India (2001) 5 SCALE 303.
Despite the landmark jurisprudence laid down facilitating access to higher judiciary, common citizens do not have the wherewithal to access them in every instance of violation they encounter. It is expected that the jurisprudence percolates to other accessible institutions, judicial or quasi-judicial domains for the citizens to access and claim their rights.

2.5.5 Quasi-Judicial Spaces and Ombudsman Institutions

Statutory institutions such as national and state human rights commissions, other statutory commissions such as women’s commission, consumer redressal forums/commissions, and national commission for protection of child rights (NCPCR) are mandated to redress citizens’ grievances, including those concerning health care. Apart from the frequently accessed institutions such as consumer redressal forums and medical councils, this research process led to discovering several other quasi-judicial spaces that are being engaged by civil society organisations on health care matters.

As quasi-judicial spaces vested with the power of civil court, they have the potential to impact the litigation process positively. Scope of their redressal interventions include admitting complaints, taking suo-moto cognizance of violations in their respective thematic competencies and jurisdictions, intervening in matters as third parties in writ petitions, and when called upon in the higher courts or in appeals, the documents admitted as part of their investigation potentially form crucial pieces of legal evidence. Of all these institutions, NHRC illustrates the contributory potential of these bodies to strengthen SHRC. NHRC jointly organised public hearings on right to health care with Jan Swasthya Abhiyan (JSA)21 in 2004. The recommendations of NHRC unequivocally called for a declaration of ‘right to health care as fundamental right’ and spelt out unambiguously that a well-functioning health care system was essential for SRHC (National Human Rights Commission n.d.). This, among other things, led to a draft National Health Bill 2009 which articulated citizen rights and was placed in the parliament (MoHFW-Govt. of India 2009). Similarly, NHRC had taken keen interest in the issues of mental health care in the 1990s and had legally intervened in these matters (Vide. Chap. 3, section on psychosocial disabilities). Similarly, it had intervened as third parties in the environment related litigations such as Silicosis in the SCI. Such interventions had positive bearing on the outcomes in terms of reforming mental health care institutions or in awarding compensations to Silicosis victims. In recent times, NHRC has prepared a Charter of Patient Rights and has submitted it to the MoHFW with recommendations for adopting it as part of the policy (National Human Rights Commission 2018).

Even as there is an impetus for claiming citizenship through social rights and social citizenship, as this book argues, several counter-currents in the global political

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21Largest civil society coalition for health rights in India, a national unit of the global People’s Health Movement (www.phmovement.org).
canvas and that of India have posed serious challenges to such a process in recent years. Social-political churnings of hyper-nationalism based on religion, race and other identities have questioned the foundations of liberal notion of citizenship itself. Such global phenomena challenge the very idea of social citizenship itself. Though it is not the focus of this book to delve into this subject matter, we acknowledge this factor both to understand that the road to citizenship is rocky, rugged, and challenging, as well as to take into account that such churnings have the potential to undo the gains of citizenship that are historically accrued thus far.

2.6 Social Citizenship at Crossroads

Social citizenship is strongly argued on the premise of a certain character of the State that is mandated to uphold rights of citizens and is conscious of its distributive function. The second decade of the 21st century, however, signals the reversal of social citizenship. The Rohingya crisis in Myanmar, the Syrian refugees in a prolonged conflict in the middle east, the rhetoric of banishing immigrants from the USA and the amendments to Citizenship Act in India signal the crisis of the idea of citizenship itself. It also spells a radical departure of the State from the very idea of citizenship which it is supposed to uphold.

The institutional perspectives employed in this book also point to the change in character of the institutions within the State. Changes in the public health care system and State’s complicit role in promoting corporate interests in health care—as observed in India—, are said to be symptomatic of its neo-liberal character which it has obtained. Series of policies and programmes that advance exclusivist models of development reflect appeasement of the middle and upper classes who feel compelled to ‘catch up’ with modern consumerism, and an ‘ideological crystallisation’ that has replaced the welfare-state with the market. The hegemony of the classes is mirrored in the ‘control, camouflage and commandeer’ that is exercised over the State, compelling its withdrawal from the welfarist-emancipatory policies (i.e. the distribution function of the national resources), and in leveraging State power to promote the market forces (Kothari 2002: 79–80).

An analysis of public institutions in judicial, ombudsman, health, and education domains, indicate the decline in their democratic functioning (Kapur and Mehta 2007). Such a development is also a salient feature of the dominant neo-liberal economic order, where the legal and formal agreements of international financial institutions such as the World Trade Organisation (WTO), International Monetary Fund (IMF) and bilateral agreements dominate over the State to change its own legal frameworks in favour of the market. Such realignment of the politics of the State with the market is deemed to result in the decline of the welfare-state itself. The shift in considering health care as a private good from that of being a public good, for example, illustrates the increased marketisation of public goods and services that were hitherto protected in favour of citizens as public goods in the overarching framework of a welfare-state. It is noted that such developments do not merely signify
the overarching influence of the free market over the State, but rather that ‘the State has realigned itself in relation to capital (and in particular corporate capital) in such a way as to demonstrate that the State and the market are not in competition’ (Veitch et al. 2012: 262).

These factors point to the complexity, paradoxes and dilemmas that have come to occupy the terrain of SRHC. On the one hand, the State is minimising its role in the domain of health care resulting in a weakened public health care system, a move that has left citizens at the behest of the market led commercial health care which is unregulated across the globe. This is the prime factor underlying violations of social rights of citizens. On the other hand, there is an increased thrust on engaging the power of law and courts for citizens to claim SRHC from the State as part of realising their social citizenship (Friedman et al. 2013; Gostin 2010, 2014; Gostin et al. 2016; Magnusson et al. 2017; Zuniga et al. 2013). So, will more judicialisation and expanded jurisprudence bring greater SRHC to people? Will more juridification result in greater social citizenship when the State itself is wriggling out of its conformity with such an idea of citizenship? SRHC and health care jurisprudence, currently, are compelled to grapple with this predicament.

2.7 A Brief Synthesis

The discourse on SRHC, social citizenship and pursuit of health justice is located in complex socio-political and economic contexts that shape and determine the approach of the State, the health care systems, juridico-legal system, the demeanour of interface between citizens and medical and legal professions, and the politics that shape the civil society. The quest for health justice, both in terms of accessing health care and the possibility of redressals for violations, are contingent on a fragmented health care system and a seemingly distant justice system.

The discussions in this chapter have foregrounded the composite challenges that exist in the recognition of SRHC, redressal of violations and establishment of health justice. Such challenges emanate primarily from the constitutional governance architecture that relates to the health policy and health care systems in India. As several historical narratives indicate, legal mobilisation for health care is resorted to under varied compelling socio-political circumstances in the lives of the underprivileged, and most of them account for not only the denial and negligence in health care, but dispossession of dignity and citizenship itself. Health care litigations are used as strategic tools by civil society to fix these anomalies and to redress violations of citizens’ rights to health care. Along with courts, civil society too is a central actor in the strategy for achieving SRHC. Civil society coalitions and various ideological formations have played a great role in the mobilisation of courts and advancing the cause of the underprivileged.

The health care jurisprudence presents a viable option to claim social citizenship and health justice by engaging judicial power. Despite all inherent limitations, courts and judiciary are still considered powerful drivers of equality, dignity, and
justice in India. Nonetheless, the contestations and the entrenched competing stakes in health care, are likely to make civil society’s quest for health justice, an arduous journey. Professional associations, pharmaceutical associations, hospitals, and individual medical professionals too are heavily invested in courts in consolidating their power and collaterally thwarting the claims for social rights by civil society. While this sets the stage for contestations to the claims and counterclaims for citizenship in judicial spaces, the cumulative outcomes of health care jurisprudence depend on the position and approach of the State to the issue of citizenship.

State is the powerful patron of citizens in a paternalistic welfare-state framework. It is also the largest litigator and is the default respondent in most health care related litigations of civil nature and the prosecutor in criminal litigations. The approach, character and leanings of the State have severe implications to the outcomes of litigations and to the consolidation of SRHC. The discussions here have alluded to the fluctuating character of the State and its realignment with the commercial health care sector thus posing an insurmountable challenge to the realisation of SRHC. In a democratic polity, civil society has untiringly invoked judicial power to challenge the tendency of the State to abdicate its constitutional duty of welfare of citizens and the related accountability deficits. Within these competing claims and contestations, the judicial power appears to lay down the health care jurisprudence. The components of social citizenship and health justice will be further discussed through health care litigations and health care jurisprudence analysed in the subsequent chapters.

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