Right to Health – Case Laws
Peer Review : 28th Oct 2006.

I INTRODUCTION

The Law and the Human Right to Health and Healthcare

Ravi Duggal

Background

The Indian Constitution provides a framework for a welfare/socialist pattern of development. While civil and political rights are enshrined as fundamental rights that are justiciable, social and economic rights like health, education, livelihoods etc. are provided for only as directive principles for the State and hence not justiciable. The latter comes under the domain of planned development, which the State steers through the Five Year Plans and other development policy initiatives.

Post-independence India adopted a development paradigm that aimed at creating limited entitlements to a wide range of resources for the underserved people. But this development paradigm also included a wide array of support for private capital to flourish. The Indian State almost monopolized infrastructure development right until the nineteen nineties. While this was critical to India's economic development it also contributed substantially to the growth of private capital. The State also actively participated in the productive sectors of the economy, especially capital goods industry. This often subsidized inputs for private sector growth. A good example from the health sector is the growth of the pharmaceutical industry in India. At one level India's stance of process patents helped private formulation units to manufacture patented drugs and at another level the state actively manufactured basic drugs and supplied to the private formulation industry at subsidized rates. With this approach, which kept the public pharmaceutical companies in the red, by late eighties the public sector drug industry withered away and the private pharmaceutical industry from India had gained in stature to become global players.[1] Such a process happened across other sectors of the economy.

In the social sector the approach was not very different. Again taking an example from the health sector – the production of doctors. Right through the mid-eighties there were only public medical schools and on an average 80% of those graduating from them, almost entirely at the cost to the public exchequer, either entered the private economy or migrated abroad. A good example of how a social investment ultimately benefited private profiteering.

While the development paradigm clearly supported private sector growth, there was a "social" dimension to it. To take the same two examples, while private pharmaceutical industry got a lot of subsidy and support for its growth, drug price control helped keep the drug prices under leash. Similarly, while production of doctors contributed largely to development of private markets in the health sector, the government evolved a system of limited entitlements for healthcare through a primary healthcare system in rural areas, and district and

[1] Presently the Indian Pharmaceutical industry manufactures drug formulations to the tune of Rs. 210 billion and of this exports Rs. 98 billion, which is 47% of total production. The Indian pharmaceutical industry is the 4th largest in the world and accounts for 8% of world production by volume. (MoCF, 2001)

town hospitals and dispensaries in urban areas. While acknowledging this "social" dimension, it must be stated clearly that the development approach was never rights-based and hence the limited entitlements that were made under different development programs, including healthcare, had a very limited impact and this is evidenced through both the large-scale poverty and the low level of health outcomes that we continue to experience in the country.

While development was planned and directed via the Five Year Plans, it was clear right from Plan 1 that the planned development was clearly biased in favour of the economic sectors. The contribution of the Five-year Plans to the social sectors has been abysmally poor; less than one fifth of the Plan resources have been invested in this sector. Health, water supply and education are the three main sub-sectors under social services.

Health care facilities are far below any acceptable human standard. Even the targets set out by the Bhore Committee on the eve of India's independence are nowhere close to being achieved. We have not even reached half the level in provision of health care that most developed countries had reached between the two world wars. Curative health care services in the country are mostly provided by the private sector (to the extent of two-thirds) and preventive and promotive services are almost entirely provided by the State sector.

Planning should have given an equal emphasis to social services, especially health, water supply and sanitation, education and housing which are important equalizing factors in modern society. These four sub-sectors should have received atleast half of the resources of the plans over the years. Only that could have assured achievement of the goals set forth in the Directive Principles and helped the creation of a genuine welfare state.

From the above discussion it is evident that the Five year plans, the cornerstone of the development paradigm, to which large resources were committed, has not helped uplift the masses from their general misery, including in the provision of health care. The Five Year Plans at best contributed in a limited way with a human development approach. The approach in no way was rights based and the State was not adequately meeting its constitutional and international treaty obligations.

Within the State's development strategy the health sector has always been a weak link. For the political class it had little value because at one level the private health sector, atleast for non-catastrophic care, was already well entrenched and was reasonably accessible, and at another level for the poor masses non-catastrophic healthcare attention was way below in their priority list, what with the struggle for basic survival. The political class invested in development where they could maximize their political returns; their concern was for vote-banks and hence the focus of development programs (not rights) was in "rural development", infrastructure development and development through "reservations". Rural development programs helped direct agricultural growth with the goal of achieving self-sufficiency in basic food production keeping the farming community under the belief that all this was benefiting them (in reality the middle and the rich peasantry benefited and the small

peasantry and landless remained under the illusion that their turn in development was next), infrastructure development kept the capitalist class happy as this support helped create space and conditions for their growth, and the reservation policies appeased the oppressed minorities who are often critical to the vote-bank kind of politics in India and decisive in swinging votes one way or the other.

With this kind of a development strategy key social development issues like health, education, and housing got sidelined and never became "political" issues which would drive the development strategy. Hence planned development without a rights based approach can only yield limited results and outcomes. For issues to become sustainable political agendas, they must be contextualised in the rights domain. The right to health and healthcare too cannot be realized through the current development agenda. It has to be constituted as an independent right, like the right to life in Article 21 of the constitution of India and/or through a legislative mandate with clear resource commitments.

The Healthcare System

In the post-colonial period there was no attempt at radical restructuring of health care services as per the framework provided by the Bhore Committee. The Bhore Committee recommendations were not transformed into a legal mandate as was done in Britain where the Beveridge Committee recommendations were translated into the National Health Services legislation. On the contrary the aspects that contributed to inequality in health care were strengthened; as for instance, the production of doctors for the private sector through state financing, production of bulk drugs to supply at subsidized rates to private formulation units, concentration of medical services disproportionately in urban areas, financial subsidies by the state for setting up private practice and private hospitals, allowing large scale international migration of doctors and nurses. All these factors, among others, have contributed to increased inequality in health care and underdevelopment of health in India.

The constitution of India has made health care services largely a responsibility of state governments but has left enough maneuverability for the Centre since a large number of items are listed in the concurrent list. And this the Centre has used adequately to expand its sphere of control over the health sector.[2] Hence

[2] The Constitutional provisions (Schedule 7 of article 246) are classified into three lists, including a Concurrent list which both centre and states can govern but the overriding power is with the centre. The list here includes original entry numbers **Central List:** 28.Port quarantine, including hospitals connected therewith; seamen's and marine hospitals 55.Regulation of labour and safety in mines and oilfields **State List:** 6.Public health and sanitation; hospitals and dispensaries 9.Relief of the disabled and unemployable **Concurrent List:** 16.Lunacy and mental deficiency, including places for the reception or treatment of lunatics and mental deficients 18.Adulteration of foodstuffs and other goods. 19.Drugs and poisons, subject to the provisions of entry 59 of List I with respect to opium 20A.Population control and family planning 23.Social security and social insurance; employment and unemployment. 24.Welfare of labour including conditions of work, provident funds, employers' liability, workmen's compensation, invalidity and old age pensions and maternity benefits 25.Education, including technical education, medical education and universities, subject to the provisions of entries 63, 64, 65 and 66 of List I; vocational and technical training of labour.] 26.Legal, medical and other professions 30.Vital statistics including registration of births and deaths. (http://alfa.nic.in/const/schedule.html)

the central government has played a far more significant role in the health sector than demanded by the constitution. The health policy and planning framework has been provided by the central government. In concrete terms, the central government has pushed various national programs (vertical programs for leprosy, tuberculosis, blindness, malaria, smallpox, diarrhea, filaria, goitre and now HIV/AIDS) in which the states had little say in deciding the design and components of these programs. The states have acquiesced to programs due to the central government funding that accompanies them. These programs are implemented uniformly across the length and breadth of the country. Then there are the centre's own programs of family planning and universal immunization which the states have to implement. Hence, central government intervention in the state's domain of health care activities is an important feature that needs to be considered in any analysis of public health care services.

The large cities, depending on their population have a few state run hospitals (including teaching hospitals). At the district level on an average there is a 150 bedded Civil General Hospital in the main district town and a few smaller hospitals and dispensaries spread over the other towns in the district and sometimes in large villages. In the rural areas of the district there are rural hospitals, primary health centers and sub-centers that provide various health services and outreach services.

Table A shows that for the country as a whole presently there are an estimated 22,000 hospitals (30% rural), 23,000 dispensaries (50% rural) and about 1.5 million beds (21% rural). The rural areas in addition have 23,500 PHCs and 140,000 sub-centers. However, when this data is represented proportionately to its population we see that urban areas have 4.48 hospitals, 6.16 dispensaries and 308 beds per 100,000 urban population in sharp contrast to rural areas which have 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and 44 beds per 100,000 rural population. The city hospitals and the civil hospitals are basically curative centres providing outpatient and in-patient services for primary, secondary and tertiary care. In contrast the rural institutions provide mainly preventive and promotive services like communicable disease control programs, family planning services and immunization services; curative care in the rural health institutions are the weakest component in spite of a very high demand for such services in rural areas. As a consequence this demand is met either by the city hospitals or by private practitioners. Medical Education is imparted largely through state owned or funded institutions at a highly subsidized cost to the students. There are 195 recognized allopathic medical colleges in the country producing over 20,000 medical graduates every year; and out of these, 75% are produced in public institutions. However, the outturn from these institutions does not benefit the public health services because 80% of the outturn from public medical schools either joins the private sector or migrates abroad. Here it would be in order to also give a brief description of the private health sector and health insurance coverage in India.

The private health sector in India is very large, perhaps the largest in the world. In 2002 an estimated 62% of hospitals, 54% dispensaries and 35% of beds were in the private sector. (Table A) An estimated 75% of allopathic doctors are in the private sector, about 80% of them being individual practitioners. In the case of non-allopathic doctors over 90% work in the private sector. Private health services, especially the general practitioners, are the single largest category of health care services utilized by the people. It is important to note here that in addition to persons practicing medicine as private practitioners a large number of unqualified practitioners also need to be included. Hence, the exact number of practicing doctors in the country is not known. From available data it is known that in year 2004 there were over 660,000 registered allopathic doctors and over 780,000 registered non-allopathic doctors. And out of this total of 1.4 million about 1.2 million are estimated to be in the private sector. Further, in both rural and urban areas a large number of unqualified practitioners exist and it goes without saying that they are all a part of the private sector. Beyond this information very little further knowledge about the private health services sector is available.

The private health sector, especially the allopathic, constitutes a very strong lobby in India. There is virtually no regulation of this sector. The medical councils of the various systems of medicine perform only the function of registering qualified doctors and issuing them the license to practice. There is no monitoring, continuing education, price regulation, prescription vetting etc., either by the medical councils or the government. The private healthcare sector is strongly backed by the private pharmaceutical industry (largely multinational), which again constitutes a very powerful lobby that has kept at bay any progressive policy initiatives, such as the recommendation of the Hathi Committee Report.[3] Pharmaceutical formulation production in India is presently worth over Rs. 280 billion and over 98% of this is in the private sector. Thus together the private health services and the pharmaceutical industry are organized into a network that is one of the most powerful private health sectors in the world.

Given this domineering position of the private health sector and the context of large-scale poverty the health outcomes are not expected to be very good. In Table A we do see substantial improvements in health outcomes such as IMR, CBR, CDR and life expectancy over the years but the rank of India globally has not changed significantly vis-à-vis these indicators. Infact the latest Human Development Report shows a downward trend in India's global ranking[4]. (UNDP, 2003). This climb down and slowing of growth in India's human development

[3] The Hathi Committee's recommendations pertained to removal of irrational drug combinations, generic naming of essential drugs, development of a National Formulary for prescription practice.

[4] India's human development index rank is down from 115 in 1999 to 124 in 2000 and 127 in 2001, though still better than the 1994 rank of 138. India is on the fringe of medium and low HDI group of countries. India's improvement in the HDI in the last 26 years has been marginal from a score of 0.407 in 1975 to 0.590 in 2001 - this works out to an average increase of 1.7% per annum. The slowing down of growth is shown in the table below: (Source: UNDP HDR, various years)

	1975	1980	1985	1990	1995	2000
HDI score	0.407	0.434	0.473	0.511	0.545	0.577
Annual % increase over previous period	--	1.3	1.8	1.6	1.3	1.1

score is perhaps linked to the declining investments and expenditures in the public health sector (as also the social sectors as a whole), especially in the nineties. In the mid eighties public health expenditure had peaked because of the large expansion of the rural health infrastructure but after 1986 one witnesses a declining trend in both new investments as well as expenditures as a proportion to the GDP, and as a percent of government's overall expenditures. (Duggal et.al., 1995 and Duggal, 2002). In sharp contrast out-of-pocket expenses, which go largely to the private health sector, have witnessed unprecedented increases. (See Table A)

Table A: HEALTHCARE DEVELOPMENT IN INDIA 1951-2004

			1951	1961	1971	1981	1991	1996	1997	2001-02	Latest**
1	Hospitals*	Total	2694	3054	3862	6805	11174	15170	15188	18436	22000
		% Rural	39	34	32	27		34	34	30	30
		%Private				43	57	68	68	62	75
2	Hospital & dispensary beds*	Total	117000	229634	348655	504538	806409	892738	896767	914543	1500000
		% Rural	23	22	21	17		23	23	21	21
		%Private				28	32	37	37	35	50
3	Dispensaries*		6600	9406	12180	16745	27431	25653	25670	22291	
		% Rural	79	80	78	69		41	40	50	
		% Private				13	60	57	56	54	
4	PHCs		725	2695	5131	5568	22243	21917	22446	22842	23500
5	Sub-centres				27929	51192	131098	134931	136379	137311	140000
6	Doctors	Allopaths	60840	83070	153000	266140	393640	462745	496941	605840	660000
		All Systems	156000	184606	450000	665340	920000		1080173	1297310	1430000
7	Nurses		16550	35584	80620	150399	311235	565700	607376	805827	880000
8	Medical colleges	Allopathy	30	60	98	111	128	165	165	189	195
9	Out turn	Graduates	1600	3400	10400	12170	13934				20000
		Postgraduates		397	1396	3833	3139		3656		6000
10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3	38.4	91.3	104.9	220	280
11	Health	IMR/000	134	146	138	110	80	72	71	66	65

	outcomes										
		CBR/000	41.7	41.2	37.2	33.9	29.5	27	27	25	24
		CDR/000	22.8	19	15	12.5	9.8	9	8.9	8.1	8
	Life Expectancy	years	32.08	41.22	45.55	54.4	59.4	62.4	63.5	64.8	65
	Births attended by trained practitioners	Percent				18.5	21.9	28.5			
12	Health Expenditure Rs. Billion	Public CSO private	0.22	1.08 2.05	3.35 6.18	12.86 29.70	50.78 82.61	101.65 329.00	113.13 373.41	211 1100	249 1464
	Health Expenditure as percent of GDP	Public Private CSO	0.25	0.71 1.34	0.84 1.56	1.05 2.43	0.92 1.73	0.91 2.95	0.88 3.00	0.89 5.32	0.91 5.40
	Health Expenditure as % to Govt. Total	Public	2.69	5.13	3.84	3.29	2.88	2.98	2.94	2.72	2.60

*Data on hospitals, dispensaries and beds pertaining to the private sector is grossly under reported and figures for 2001-02 for public facilities also suffers from under-reporting as a number of states do not send uptodate information. Thus the actual figures should be much higher, and especially so for the private sector

**Latest years – rounded figures are estimates by author and figures pertain to years 2003/2004
Source : 1. Health Statistics / Information of India, CBHI, GOI, various years; 2. Census of India Economic Tables, 1961, 1971, 1981, GOI 3.OPPI Bulletins and Annual reports of Min. of Chemicals and Fertilisers for data on Pharmaceutical Production 4. Finance Accounts of Central and State Governments, various years 5. National Accounts Statistics, CSO, GOI, various years 6. Statistical Abstract of India, GOI, various years 7. Sample Registration System - Statistical Reports, various years 8. NFHS - 2, India Report, IIPS, 2000

HUMAN RIGHT TO HEALTH AND HEALTHCARE[5]

The above review of health and healthcare reveals the failure of the Indian State to assure health and healthcare as a right. What we see is that some earnest efforts at the policy level were made but they failed miserably in practice because of inadequate resource support and a lack of political will to back the cause of healthcare as a right.

As stated earlier, the Bhore Committee recommendations provided a good beginning to establish health and healthcare in the rights domain. At the same historical moment Britain had a similar plan and they were able to put it in place. Of course in Britain's case there was the working class struggle, which created the political will within the Labour Party to back this cause. While the latter kind of support was not there in India, the fervour of a newly Independent country to radically transform the life-situation of its people was there but this was not translated into assuring economic and social rights to the people.

The Constitutional and Legal Dimension

India joined the UN at the start on October 30th 1945 and on 12th December 1948 the Universal Declaration of Human Rights was proclaimed and India was a party to this. The formulation of India's Constitution was certainly influenced by the UDHR and this is reflected in the Fundamental Rights and the Directive Principles of State Policy. Most of the civil and political rights are guaranteed under the Indian Constitution as Fundamental Rights. But most of the Economic, Social and Cultural Rights do not have such a guarantee. The Constitution makes a forceful appeal to the State through the Directive Principles to work towards assuring these rights through the process of governance but clearly states that any court cannot enforce them.[6]

The experience of governance in India shows that both fundamental rights and directive principles have been used as a political tool. While the fundamental rights are justiciable, and on a number of occasions citizens and courts have intervened to uphold them, there have also been numerous instances where even the courts have failed either because the ruling government has steamrolled them or the court orders have been ignored by governments. In case of the Directive Principles it is mostly political mileage, which determines which of the principles get addressed through governance. For instance, Article

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[5] The debate on terminology on 'right to health' and 'right to healthcare' is endless and here we will not get into this bottomless pit. Suffice to say that right to health is not independent of right to healthcare and hence they must be seen in tandem. The WHO definition was influenced largely by Sigerist, who argued that state of health is a physical, mental and social condition and "health is, therefore, not simply the absence of disease – it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts on the individual" (Sigerist, 1941, p.68). This broad definition, including social well-being is often criticised for being too broad and as a consequence the concern for access to healthcare is lost. While Sigerist gave this broad definition he also emphasized that healthcare protection and provision was the right of the citizen and a duty of the state to respect this. The focus in this paper is on the right to access healthcare and other related rights, and as a consequence health. Hence, the use of the phrase 'right to health and healthcare' in the present paper. For a debate on the definitions and further references see Brigit Toebes, 1998.

[6] Article 37 pertaining to the application of the principles contained in Part IV of the constitution states, "The provisions contained in this Part shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws"

46[7] has been implemented with a fair amount of seriousness through the policy of reservations for scheduled caste, tribes and other backward castes/classes because it is the most powerful tool for success in India's electoral politics. But Articles 41, 42 and 47, which deal with social security, maternity benefits and health, respectively, have been addressed only marginally.

When we look at right to health and healthcare in the legal and constitutional framework, it is clearly evident that the Constitution and laws of the land do not in any way accord health and healthcare the status of rights. There are instances in case law wherein for instance the right to life, article 21 of the Indian Constitution, or various directive principles have been used to demand access to healthcare, especially in emergency situations or references made to the ICESCR, CEDAW, UDHR etc. See Box 1 for a brief on some of the well-known cases.

These are exceptional cases, and even if the Supreme or High Courts have upheld some decisions as being a right, for instance getting atleast first aid in emergency situations from private clinics or hospitals, or access to public medical care as a right in life threatening situations, or right to healthy and safe working environment and medical care for workers etc., the orders are rarely respected in day to day practice unless one goes back to the courts to reiterate the orders. Infact, this is often the case even with fundamental rights, which the State has failed to respect, protect, or fulfill as a routine, and one has to go to the courts to demand it. For a population, which is predominantly at the poverty or subsistence level, expecting them to go to the courts to seek justice for what is constitutionally ordained as a right is unrealistic as well as discriminatory. Hence, mere constitutional provision is not a sufficient condition to guarantee a right, and more so in a situation like health and healthcare wherein provisions in the form of services and commitment of vast resources are necessary to fulfill the right.

Despite the above, it is still important to have health and healthcare instituted as a right within the constitution and/or established by a specific Act of Parliament guaranteeing the right.

Box 1

A review of court cases related to health issues shows that very little has been battled over the general right ot health and healthcare. The largest chunk of cases refer to negligence in medical practice and liability related cases under Law of Torts and the Consumer Protection Act. Supreme Court cases dealing with violation of human rights on health matters have generally used Article 21 - the right to life, as most such cases have been in situations of emergency or extreme distress. And often in the latter the cases are workplace related for the health and safety of workers or their right to medical care. Our search generated only one case where for the general population the right to a functioning primary health centre was obligated by the court (Mahendra Pratap v/s

[7]Article 46 - Promotion of educational and economic interests of Scheduled Castes, Scheduled Tribes and other weaker sections: The State shall promote with special care the educational and economic interests of the weaker sections of the people, and, in particular, of the Scheduled Castes and the Scheduled Tribes, and shall protect them from social injustice and all forms of exploitation.

Orissa State). Also there have been a number of cases pertaining to environmental health, like pollution of rivers, air etc.. which violate preconditions for good health. Below we have extracted selected cases that have used the rights perspective on health related matters:

Access to Healthcare

1. Mahendra Pratap Singh v/s Orissa State : Constitution of India, 1950 - Articles 226 and 227 - Writ of mandamus - Scope of - Prayer is made for issuance direction to take effective measures to run Primary Health Centre at Pachhikote. Held, Keeping in view the entire gamut of facts, considering the public oriented geneson's ad on a conspectus of prevalent scenario direction issued that the Grama Panchayat would comply the formalities by end of December and the Secretary - Health would depute a responsible office to visit the building meant for hospital and thereafter make suitable arrangement for running the P.H.C. Result - Writ application disposed of. **OJC Nos. 6359 of 1995 Date of Judgment : 29/07/1996** (source JUDIS Orissa). *This is probably the only case in which a judgement on right to health for a general population has been given.*

Access to Healthcare by Workers and Right to a Healthy Work environment

1. Bandhua Mukti Morcha v/s Union of India: Constitution of India.-Article 32(1)-Mode of

interpreting Article 32 and Article 21 Right to life meaning right to live with dignity as in Francis Mullen v/s Union of India. The petitioner, an organisation dedicated to the cause f release of bonded labourers in the country, addressed a letter to Hon'ble Bhagwati, J. alleging: (1) that there were a large number of labourers from different parts of the country who were working in some of the stone quarries situate in district Faridabad, State of Haryana under "inhuman and intolerable conditions; (2) that a large number of them were bonded labourers; (3) that the provisions of the Constitution and various social welfare laws passed for the benefit of the said workmen were not being implemented in regard to these labourers. The petitioner also mentioned in the letter the names of the stone quarries and particulars of labourers who were working as bonded labourers and prayed that a writ be issued for proper implementation of the various provisions of the social welfare legislations, such as, Mines Act, 1952 Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979, Contract Labour (Regulation and Abolition) Act, 1970, Bonded Labour System (Abolition) Act, 1976, Minimum Wages Act, Workmen's Compensation Act, Payment of Wages Act, Employees State Insurance Act, Maternity Benefits Act etc. applicable to these labourers working in the said stone quarries with a view to ending the misery, suffering and helplessness of "these victims of the most inhuman exploitation." The Court treated the letter as a writ petition and appointed a commission to inquire into the allegations made by the petitioner. The commission while confirming he allegations of the petitioner, pointed out in its report that (i) the whole atmosphere in the alleged stone quarries was full of dust and it was difficult for any one to breathe; (ii) some of the workmen were not allowed to leave the stone quarries and were providing forced labour; (iii) there was no facility of providing pure water to drink and the labourers were compelled to drink dirty water from a nullah; (iv) the labourers were not having proper shelter but were living in jhuggies with stones piled one upon the other as walls and straw covering the top which was too low to stand and which did not afford any protection against sun and rain; (v) some of the labourers were suffering from chronic diseases; (vi) no compensation was being paid to labourers who were injured due to accidents arising in the course of employment; (vii) there were no facilities for medical treatment or schooling. At the direction of the Court, a socio-legal investigation was also carried out and it suggested measures for improving the conditions of the mine workers. HELD: The State Government's objection as to the maintainability of the writ petition under Article 32 of the

Constitution by the petitioners is reprehensible. If any citizen brings before the Court a complaint that a large number of peasants or workers are bonded serfs or are being subjected to exploitation by a few mine lessees or contractors or employers or are being denied the benefits of social welfare laws, the State Government, which is, under our constitutional scheme, charged with the mission of bringing about a new socioeconomic order where there will be social and economic justice for every one equality of status and opportunity for all, would welcome an inquiry by the court, so that if it is found that there are in fact bonded labourers or even if the workers are not bonded in the strict sense of the term as defined in the Bonded Labour System (Abolition) Act 1976 but they are made to provide forced labour or are consigned to a life of utter deprivation and degradation, such a situation can be set right by the State Government. Even if the State Government is on its own inquiry satisfied that the workmen are not bonded and are not compelled to provide forced labour and are living and working in decent conditions with all the basic necessities of life provided to them, the State Government should not baulk an inquiry by the court when a complaint is brought by a citizen, but it should be anxious to satisfy the court and through the court, the people of the country, that it is discharging its constitutional obligation fairly and adequately and the workmen are being ensured social and economic justice. **Date of Judgement: 16/12/83** (Source: JUDIS, Supreme Court of India). *This case might highlight the plight of the stone quarry workers and their bonded status but such is the working environment of over half the population of the country.*

2. Paschim Banga Khet Mazdoor Samity v/s State of West Bengal: Constitution of India Article 21 and Directive Principles. The Constitution envisages the establishment of a welfare state at the federal level as well as at the state level. In a welfare state the primary duty of the Government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare state. The Government discharges this obligation by running hospitals and health centres which provide medical care to the person seeking to avail those facilities. Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The Government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21. In the present case there was breach of the said right of Hakim Seikh guaranteed under Article 21 when he was denied treatment at the various Government hospitals which were approached even though his condition was very serious at that time and he was in need of immediate medical attention. Since the said denial of the right of Hakim Seikh guaranteed under Article 21 was by officers of the State in hospitals run by the State the State cannot avoid its responsibility for such denial of the constitutional right of Hakim Seikh. In respect of deprivation of the constitutional rights guaranteed under Part III of the Constitution the position is well settled that adequate compensation can be awarded by the court for such violation by way of redress in proceedings under Articles 32 and 226 of the Constitution. [See : Rudal Sah v. State of Bihar, 1983 (3) SCR 508 Nilabati Behara v. State of Orissa. 1993 (2) SCC 746: Consumer Education and Research Centre v. Union of India, 1995 (3) SCC 42]. Hakim Seikh should, therefore, be suitably compensated for the breach of his right guaranteed under Article 21 of the Constitution. Having regard to the facts and circumstances of the case, we fix the amount of such compensation at Rs. 25,000/-. A sum of Rs. 15,000/- was directed to be paid to Hakim Seikh as interim compensation under the orders of this Court dated April 22, 1994. The balance amount should be paid by respondent No. 1 to Hakim Seikh within one month. **Date of Judgement: 06/05/96** (Source JUDIS, Supreme Court of India). *This case*

reflects the right to health care in an emergency situation and state hospitals are duty bound to attend immediately to such patients and cannot refuse medical aid.

3. CERC v/s Union of India: Constitution of India Articles 21, 38, 39(e), 41, 43, 48-A. This was public interest case filed by Consumer Education and Research Centre on behalf of workers in asbestos mines and industries. The contention was that the employer, the Union government, was obliged to provide protection against work hazards in such work which causes asbestosis as well as carcinoma of the lungs. Using the above provisions of the constitution the Court stated that the employer should have provided protective measures to prevent workers from getting affected by occupational disease. Justice Ramaswamy held that the right to health and medical care to protect the workers health and vigour while in service or post-retirement is a fundamental right of a worker under Article 21 read in conjunction with provisions of Directive principles to make the life of the workman meaningful and purposeful with dignity of person. He further stated that all agencies whether the state or private industry is enjoined to take all such action which will promote health, strength and vigour of the workman during the period of employment and leisure and health even after retirement as basic essentials to live life with health and happiness. (Source: 1995(3) SCC p 42, as quoted in Toebes, 1998). *Another worker's health related judgment specifying the workers right to health and security.*

4. CESC v/s Subhash Chandra Bose: Constitution of India Article 21 and 39 (e), UDHR Article 25 and and ICESCR Article 7(b).This case concerned a litigation between the Calcutta Electricity Supply Corporation and its electrical contractor over who carried responsibility for the workers social security - health and occupational hazards. The contractor claimed that its employees had been employed under the responsibility of CESC and that the employers were covered by the Electricity Act, which included the liability of providing social security. The Supreme Court dismissed the claim, that the immediate employer (contractor) had to be held responsible. In a dissenting opinion Justice Ramaswamy invoked international human rights conventions and Article 39 of the Directive Principles of the constitution which provides for protection of the health and strength of workers. He cited Article 21 stating that the right to livelihood springs from the right to life as set forth in Article 21. He claimed that medical facilities were part of social security and that the right to health is a fundamental right to workmen. (Source: 1992(1) SCC, p 441 as quoted in Toebes, 1998) *This is perhaps one rare case with regard to health which has invoked the international human rights provisions for right to health and healthcare. But it must be noted that the judgment focused only on this right for the worker and not any citizen.*

Ruth Roemer discussing this issue writes, "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 official policy of the government and is reflected in the basic law of the land". (Hernan L. et.al.,1989)

To take an example, government policy vis-à-vis healthcare services has mandated entitlements under the Minimum Needs Program started with the Fourth Five Year Plan, that there should be a civil hospital in each district, a primary health centre in rural areas for each 20,000 –30,000 population (depending on population density and difficulty of terrain) and five such units being supported by a 30 bedded Community Health Centre, a subcentre with

two health workers for a rural population unit of 2500-5000 population, and similarly a Health Post for 50,000 persons in urban areas. But what is the real situation. Almost every district (except perhaps the very new ones) does have a civil hospital (and each district did have a civil hospital even during the colonial period!). The situation regarding PHCs varies a lot across states from one PHC per 7000 rural population in Mizoram to one per over 100,000 in some districts of the EAG[8] states. The villagers deprived of this entitlement cannot go to the courts demanding the right to a PHC for their area because such a legal backing does not exist. Further, in many states where this ratio is honoured for PHCs or CHCs, adequate staff, medicines, diagnostic facilities, maintenance budgets are often not available to assure that proper provision of services is available to the people accessing these services. (MoHFW, 2001) Further still, if one looks at distribution of healthcare resources across regions, rural and urban areas, one sees vast discrimination – in metropolitan areas public health budgets range from Rs.500-1300 per capita in sharp contrast to PHC areas with only Rs. 40- 120 per capita; urban areas across the country have a bed-population ratio of over 300 beds per 100,000 population in contrast to rural areas having around 40 beds per 100,000 persons. This is gross inequity but there is no law presently that can help address this.

Apart from the above a small privileged section of the population, largely what is called the organized sector, that is those working in government, private industry and services have some form of health/social insurance coverage, either through social security legislation like Employee State Insurance Scheme, Central Government Health Scheme, Maternity Benefit Scheme, and various other schemes for mine workers, plantation workers, beedi workers, cinema workers, seamen, armed forces, railway employees etc., or through employer provided health services or reimbursements. This population estimated to be about 12% of the country's population might be said to have right to healthcare, atleast during the working life of the main earner in the family. Another 1% of the population is covered through private health insurance like mediclaim (Ellis, Randal et.al, 2000). In these cases entitlement is based on employment of a certain kind, which provides rights on the basis of protective legislation that is not available to the general population. While this is a positive provision, it becomes discriminatory because the entitlement as a right is selective and not universal.

Hence mere entitlements having basis only in policy or as selective rights does not establish a right and neither can assure equity and non-discrimination.

At the global level the International Covenant on Economic, Social and Cultural Rights (ICESCR) mandates right to health through Article 9 and Article 12 of the covenant:

> **Article 9**
> The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.
> **Article 12**

[8] EAG stands for Empowered Action Group states which include the following: Rajasthan, Madhya Pradesh, Chattisgarh, Uttar Pradesh, Uttaranchal, Bihar, Jharkhand and Orissa

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions, which would assure to all medical service and medical attention in the event of sickness.
Also **Articles 7 and 11** include health provisions: "The States Parties ... recognize the right of everyone to ... just and favourable conditions of work which ensure ... safe and healthy working conditions; ... the right to ... an adequate standard of living."

India ratified this Covenant way back on 10th April 1979, and having done that became obligated to take measures to assure health and healthcare (among others) as a right. As per Articles 2 and 3 of this covenant States ratifying this treaty are obligated to:

Article 2
1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.
2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.
Article 3
The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

It is now over 25 years since India committed to this treaty. Post-ratification efforts through the 6th Five-year Plan and the first National Health Policy in 1982 were indeed the first steps in honouring this commitment. As we have seen above the rural public health infrastructure was expanded considerably during the first half of the eighties, more resources were being committed to the

health sector etc., but somewhere by mid eighties the commitment seems to have lost ground. In the nineties with the economic crises the public health sector lost out completely, with the final blow being delivered by the National Health Policy 2001. Interestingly, the last decade of the 20th century also saw the declining commitment to Health For All by the WHO, when in the 1998 World Health Assembly it announced its policy for Health for All in the 21st Century. WHO had started towing the World Bank line from the 1993 WDR Investing in Health, which asked poor country/developing country governments to focus on committing public resources to selective care for selected/targeted populations, and to leave the rest to the market. With inter-governmental commitment to assure the right to the highest attainable standard of health waning, it became even more difficult for the Indian State to honour its commitment to ICESCR in an economic environment being largely dictated by the World Bank. At another level the Committee of the Economic, Social and Cultural Rights, which is supposed to monitor the implementation of ICESCR, has also failed to get countries like India to take measures to implement the provisions of the ICESCR. India has not even filed its initial report under the ICESCR.[9]

There are other international laws, treaties and declarations, which India is a party to and which have a bearing on right to health. Provisions in most of these also relate to fundamental rights and directive principles of the Indian Constitution as well as relate to many policy initiatives taken within the country.[10] See Box 2 for extracts from these laws.

International law apart, as discussed earlier, provisions within the Indian Constitution itself exist to give the people of India right to healthcare. Articles 41, 42 and 47 of the Directive Principles[11] enshrined in Part IV of the Constitution provide the basis to evolve right to health and healthcare:

> **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.

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[9] Article 51 of the Constitution titled promotion of international peace and security gives assurance that India will honour its international commitments, including respect for international laws and treaties which it has signed and ratified – "The State shall endeavour to- (a) promote international peace and security; (b) maintain just and honourable relations between nations; (c) foster respect for international law and treaty obligations in the dealings of organised peoples with one another; and (d) encourage settlement of international disputes by arbitration"

[10] For instance the impact of CEDAW, Cairo and Bejing Declarations is closely linked to the formulation of a policy on women and women's empowerment, and setting up of the national and state Commissions on Women, the Rashtriya Mahila Kosh and of formulation of many development programs for women like DWACRA, savings and credit programs etc.. Similarly the various human rights treaties like those dealing with racial discrimination, torture, civil and political rights etc.and the UNCHR have been instrumental in India setting up the National and State Human Rights Commissions. The NHRC has presently set up a separate cell to monitor ICESCR as also for right to public health.

[11] "The courts are much more aware of and attentive to their obligation to implement socio-economic uplift programmes and to ensure decent welfare for all. The state has a duty to all citizens to adhere to that part of the Constitution which describes the directive principles as 'fundamental' to the governance of the country. The courts have therefore been using the directives as an instrument to determine the extent of public interest in order to limit the extension of fundamental rights. In doing so they have upheld a number of statutes on the grounds of public interest, which in other circumstances may have been nullified." (De Villiers, 1992).

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.

47. Duty of the 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 medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

Thus social security, social insurance, decent standard of living, and public health coupled with the policy statements over the years, which in a sense constitutes the interpretation of these constitutional provisions, and supported by international legal commitments, form the basis to develop right to health and healthcare in India. The only legal/constitutional principle missing is the principle of justiciability. In the case of education the 93rd amendment to the Constitution has provided limited justiciability. With regard to healthcare there is even a greater need to make such gains because often in the case of health it is a question of life and death. As stated earlier, for a small part of the working population right to healthcare through the social security/social

Box 2

The WHO constitution states the following Principles: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger. Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development. The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health. Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people. Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.- WHO Constitution

"Everyone has the right to a standard of living adequate for ... health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of ... sickness, disability.... Motherhood and childhood are entitled to special care and assistance...." --Universal Declaration of Human Rights, Article 25

"States Parties shall ... ensure to [women] ... access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.... States Parties shall ... eliminate discrimination against women in ... health care ... to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning....; ensure ... appropriate services in connection with pregnancy.... States Parties shall ... ensure ... that [women in rural areas] ... have access to adequate health care facilities, including information counselling and services in family planning...." --Convention on the Elimination of All Forms of Discrimination Against Women, Articles 10, 12, and 14

"States Parties undertake to ... eliminate racial discrimination ... and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, ... the right to public health, medical care, social security and social services...." -- Convention on the Elimination of All Forms of Racial Discrimination, Article 5

"States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health...." --Convention on the Rights of the Child, Article 24

In the 1977 World Health Assembly member states pledged a commitment towards a health for all strategy, ".. the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.." (AL Taylor –Making the World Health Organisation Work : A legal framework for universal access to the conditions for Health, American Journal of Law and Medicine, Vol 18 No. 4, 1992, 302). At the International conference which followed in 1978 at Alma Ata this was converted into the famous primary health care declaration whereby Governments would be responsible to the people to assure primary health care for all by the year 2000. Primary health care is "essential health care which is to be universally accessible to individuals and families in the community in ways acceptable to them, through their full participation at a cost the community can afford" (WHO, Primary Health Care, 1978, p. 3) – Alma Ata Declaration on Health For All by 2000

"Health and development are intimately interconnected. Both insufficient development leading to poverty and inappropriate development ... can result in severe environmental health problems.... The primary health needs of the world's population ... are integral to the achievement of the goals of sustainable development and primary environmental care.... Major goals ... By the year 2000 ... eliminate guinea worm disease...; eradicate polio;... By 1995 ... reduce measles deaths by 95 per cent...; ensure universal access to safe drinking water and ... sanitary measures of excreta disposal...; By the year 2000 [reduce] the number of deaths from childhood diarrhoea ... by 50 to 70 per cent..." -- Agenda 21,Chapter 6, paras. 1 and 12

"Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care.... The role of women as primary custodians of family health should be recognized and supported. Access to basic health care, expanded health education, the availability of simple cost-effective remedies ... should be provided...." --Cairo Programme of Action, Principle 8 and para. 8.6

"We commit ourselves to promoting and attaining the goals of universal and equitable access to ... the highest attainable standard of physical and mental health, and the access of all to primary health care, making particular efforts to rectify inequalities relating to social conditions and without distinction as to race, national origin, gender, age or disability...." --Copenhagen Declaration, Commitment 6

"The explicit recognition ... of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.... We are determined to ... ensure equal access to and equal treatment of women and men in ... health care and enhance women's sexual and reproductive health as well as Health." --Beijing Declaration, paras. 17 and 30

"Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life.... Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology.... To attain optimal health, ... equality, including the sharing of family responsibilities, development and peace are necessary conditions." --Beijing Platform for Action, para. 89

"Strategic objective ... Increase women's access throughout the life cycles to appropriate, affordable and quality health care, information and related services.... Actions to be taken: ...

Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation...; Provide more accessible, available and affordable primary health care services of high quality, including sexual and reproductive health care...; Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to health services...; reduce maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015;... make reproductive health care accessible ... to all ... no later than ... 2015...; take specific measures for closing the gender gaps in morbidity and mortality where girls are disadvantaged, while achieving ... by the year 2000, the reduction of mortality rates of infants and children under five ... by one third of the 1990 level...; by the year 2015 an infant morality rate below 35 per 1,000 live births.... Ensure the availability of and universal access to safe drinking water and sanitation...." --Beijing Platform for Action, para. 106

"Human health and quality of life are at the centre of the effort to develop sustainable human settlements. We ... commit ourselves to ... the goals of universal and equal access to ... the highest attainable standard of physical, mental and environmental health, and the equal access of all to primary health care, making particular efforts to rectify inequalities relating to social and economic conditions ..., without distinction as to race, national origin, gender, age, or disability. Good health throughout the life-span of every man and woman, good health for every child ... are fundamental to ensuring that people of all ages are able to ... participate fully in the social, economic and political processes of human settlements .... Sustainable human settlements depend on ... policies ... to provide access to food and nutrition, safe drinking water, sanitation, and universal access to the widest range of primary health-care services...; to eradicate major diseases that take a heavy toll of human lives, particularly childhood diseases; to create safe places to work and live; and to protect the environment.... Measures to prevent ill health and disease are as important as the availability of appropriate medical treatment and care. It is therefore essential to take a holistic approach to health, whereby both prevention and care are placed within the context of environmental policy...." --Habitat Agenda, paras. 36 and 128

insurance route exists. The fact that this exists shows that for the larger population too it could be worked out. And that afew people enjoy this privilege is also a sign of discrimination and inequity, and this violates not only the non-discrimination principle of international law, but it also violates Article 14 of the constitution, Right to Equality, under the chapter of Fundamental Rights.

With regard to the question of justiciability of international law there is a problem in India. Like its colonial exploiter Britain, India follows the principle of dualism. This means that for international law to be applicable in India, it needs to be separately legislated. Since none of the international human rights treaties have been incorporated or transformed into domestic laws in India, they thus have only an evocative significance and may be used by the Courts or petitioners to derive inspiration from them. (Nariman,1995) Thus on a number of occasions many of these human right treaties, which India has ratified, have been used by the Indian Courts in conjunction with fundamental rights.[12]

[12] In a judgment on sexual harassment at the work place, in which the CEDAW and Beijing Declaration was invoked, the Supreme Court outlined this approach as follows – Any international convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into these provisions to enlarge the meaning and content thereof, to promote the object of the constitutional guarantee (Vishaka v/s State of Rajasthan, writ petition number 666-70 of 1992, quoted in Toebes, 1998)

While international law may be invoked, as discussed above, the absence of justiciability is a major stumbling block. International law has its importance in providing many principles but in India's case, as we have seen above, there is substantial leeway within our own legal framework to evolve the right to health and healthcare. The emphasis needs to shift to critical principles as laid down in the directive principles and each of these, like health, education, social security, livelihood, housing etc. so that each of these can be separately constituted as independent rights. This is the only way of bringing right to health and healthcare on the national agenda, and of course the support of international treaties will have their role in cementing this demand.

Framework for Right to Health and Healthcare

We are in an era which is dominated by global capital. The latter is increasingly taking control of social sectors, where historically the State has played a critical role. Europe is also facing pressures to retract the socialist measures, which working class struggles had gained since 19th century. But we are also in an era wherein social and economic rights, apart from the political rights, are increasingly on the international agenda and an important cause for advocacy.

Thus health and health care is now being viewed very much within the rights perspective and this is reflected in Article 12 **"The right to the highest attainable standard of health"** of the International Covenant on Economic, Social and Cultural Rights. According to the General Comment 14 the Committee for Economic, Social and Cultural Rights states that the right to health requires *availability*, *accessibility*, *acceptability*, and *quality* with regard to both health care and underlying preconditions of health. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. This understanding is detailed below:

> The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:
>
> (a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) *Accessibility.* Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:
Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.
Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.
Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.
(c) *Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
(d) *Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. (Committee on Economic, Social and Cultural Rights Twenty-second session 25 April-12 May 2000)

Universal access to good quality healthcare equitably is the key element at the core of this understanding of right to health and healthcare. To make this possible the State parties are obligated to *respect, protect and fulfill* the above in a progressive manner:

> The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfil*. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires States to take measures that prevent

third parties from interfering with article 12 guarantees. Finally, the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. (Ibid)

(Further) States parties are referred to the Alma-Ata Declaration, which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights. (Ibid)

The above guidelines from General Comment 14 on Article 12 of ICESCR are critical to the development of the framework for right to health and healthcare. As a reminder it is important to emphasise that in the Bhore Committee report of 1946 we already had these guidelines, though they were not in the 'rights' language. Thus within the country's own policy framework all this has been available as guiding principles for now 60 years.

Before we move on to suggest the framework it is important to review where India stands today vis-à-vis the core principles of availability, accessibility, acceptability and quality in terms of the State's obligation to respect, protect and fulfill.

In Table A, we have seen earlier, that the availability of healthcare infrastructure, except perhaps availability of doctors and drugs - the two engines of growth of the private health sector, is grossly inadequate. The growth over the years of healthcare services, facilities, humanpower etc.. has been inadequate and the achievements not enough to make any substantive impact on the health of the people. The focus of public investment in the health sector has been on medical education and production of doctors for the private sector, support to the pharmaceutical industry through states own participation in production of bulk drugs at subsidized rates, curative care for urban population and family planning services. The poor health impact we see today has clear linkages with such a pattern of investment:

- the investment in medical education has helped create a mammoth private health sector, not only within India, but in many developed countries through export of over one-fourth of the doctors produced over the years. Even though since mid-eighties private medical colleges have been allowed, still 75-80% of the outturn is from public medical schools. This continued subsidy without any social return[13] is only adding to the burden of inequities and exploitation within the healthcare system in India.
- public sector participation in drug production was a laudable effort but soon it was realized that the focus was on capital goods, that is bulk drug production, and most supplies were directed to private formulation units at subsidized rates. It is true that the government did control drug prices, but post mid-seventies the leash on drug prices was gradually released and by the turn of the nineties controls disappeared. Ironically, at the same time the public pharmaceutical industry has also disappeared – the little of what remains produces a value of drugs lesser than their losses! And with this withering away of public drug production, essential drugs availability has dropped drastically. Another irony in this story is that while today we export 45% of our drug

[13] Compulsory public medical service for a limited number of years for medical graduates from the public medical schools is a good mechanism to fulfill the needs of the public healthcare system. The Union Ministry of Health is presently seriously considering this option, including allowing post-graduate medical education only to those who have completed the minimum public medical service, including in rural areas.

production, we have to import a substantial amount of our essential drug requirements.[14]

- Most public sector hospitals are located in urban areas. In the eighties, post-Alma Ata and India ratifying the ICESCR, efforts were made towards increasing hospitals in rural areas through the Community Health Centres. This was again a good effort but these hospitals are understaffed by over 50% as far as doctors are concerned and hence become ineffective. Today urban areas do have adequate number of beds (including private) at a ratio of one bed per 300 persons but rural areas have 8 times less hospital beds as per required norms (assuming a norm of one bed per 500 persons). So there is gross discrimination based on residence in the way the hospital infrastructure has developed in the country, thereby depriving the rural population access to curative care services.[15] Further, the declining investment in the public health sector since mid-eighties, and the consequent expansion of the private health sector, has further increased inequity in access for people across the country
- Family planning services is another area of almost monopolistic public sector involvement. The investment in such services over the years has been very high, to the tune of over 15% of the total public health budget. But over and above this the use of the entire health infrastructure and other government machinery for fulfilling its goals must also be added to these resources expended. This program has also witnessed a lot of coercion[16] and grossly violated human rights. The hard line adopted by the public health system, especially in rural areas, for pushing population control has terribly discredited the public health system and affected adversely utilization of other health programs. Further, this program is also gender biased in that it targets only women to achieve its goal of fertility reduction. The only silver lining within this program is that in the nineties immunisation of children and mothers saw a rapid growth, though as yet it is still quite distant from the universal coverage level.

Then there are the underlying conditions of health and access to factors that determine this, which are equally important in a rights perspective. Given the high level of poverty and even a lesser level of public sector participation in most of these factors the question of respecting, protecting and fulfilling by the state is quite remote. Latest data from NFHS-1998 tells the following story:

- Piped water is available to only 25% of the rural population and 75% of urban population

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[14] Data on availability of essential drugs show that in 1982-83 the gap in availability was only 2.7% but by 1991-92 it had walloped to 22.3%. This is precisely the period in which drug price control went out of the window. (Phadke,A, 1998)

[15] NFHS-1998 data shows that in rural areas availability of health services within the village was as follows: 13% of villages had a PHC, 28% villages had a dispensary, 10% had hospitals, 42% had atleast one private doctor (not necessarily qualified), 31% of villages had visiting private doctors, 59% had trained birth attendants, and 33% had village health workers

[16] It must be noted that coercion was not confined only to the Emergency period in the mid-seventies, but has been part and parcel of the program through a target approach wherein various government officials from the school teacher to the revenue officials were imposed targets for sterilization and IUCDs and were penalized for not fulfilling these targets in different ways, like cuts and/or delays in salaries, punishment postings etc.

- Half the urban population and three-fourths of the rural population does not purify/filter the water in any way
- Flush and pit toilets are available to only 19% of the rural population as against 81% of those in towns and cities
- Electricity for domestic use is accessible to 48% rural and 91% urban dwellers
- For cooking fuel 73% of villagers still use wood. LPG and biogas is accessed by 48% urban households but only 6% rural households
- As regards housing 41% village houses are *kachha* whereas only 9% of urban houses are so
- 21% of the population chews *paan masaala* and/or tobacco, 16% smoke and 10% consume alcohol

Besides this environmental health conditions in both rural and urban areas are quite poor, working conditions in most work situations, including many organized sector units, which are governed by various social security provisions, are unhealthy and unsafe. Infact most of the court cases using Article 21 of the Fundamental Rights and relating it to right to health have been cases dealing with working conditions at the workplace, workers rights to healthcare and environmental health related to pollution. (see Box 1)

Other concerns in access are the question of economic accessibility. It is astounding that large-scale poverty and predominance of private sector in healthcare have to co-exist. It is in a sense a contradiction and reflects the State's failure to respect, protect and fulfill its obligations by letting vast inequities in access to healthcare and vast disparities in health indicators, to continue to persist, and in many situations get worse. Data shows that out of pocket expenses account for over 4% of the GDP as against only 0.9 % of GDP expended by state agencies, and the poorer classes contribute a disproportionately higher amount of their incomes to access health care services both in the private sector and public sector. (Ellis, et.al, 2000; Duggal, 2000; Peters et.al. 2002). Further, the better off classes use public hospitals in much larger numbers with their hospitalization rate being six times higher than the poorest classes[17], and as a consequence consume an estimated over three times more of public hospital resources than the poor (NSS-1996; Peters et.al. 2002).

Related to the above is another concern vis-à-vis international human rights conventions' stance on matters with regard to provision of services. All conventions talk about affordability and never mention free of charge. In the context of poverty this notion is questionable as far as provisions for social security like health, education and housing go. Access to these factors socially has unequivocal consequences for equity, even in the absence of income equity. Free services are viewed negatively in global debate, especially since we have had a unipolar world, because it is deemed to be disrespect to individual responsibility with regard to their healthcare (Toebes, 1998, p.249). For

[17] The poorer classes have reported such low rates of hospitalization, not because they fall ill less often but because they lack resources to access healthcare, and hence invariably postpone their utilization of hospital services until it is absolutely unavoidable.

instance in India there is great pressure, especially from international donors, on public health systems to introduce or enhance user fees, because they believe this will enhance responsibility of the public health system and make it more efficient (Peters, et. al.). In many states such a policy has been adopted in India and immediately adverse impacts are seen, the most prominent being decline in utilization of public services by the poorest. It is unfortunate that the Tenth Five Year Plan draft document supports raising more resources by increasing user charges in secondary and tertiary hospitals. It must be kept in mind that India's taxation policy favours the richer classes. Our tax base is largely indirect taxes, which is a regressive form of generating revenues. Direct tax revenues, like income tax is a very small proportion of total tax revenues. Hence the poor end up paying a larger proportion of their income as tax revenues in the form of sales tax, excise duties etc. on goods and services they consume. Viewed from this perspective the poor have already pre-paid for receiving public goods like health and education from the state free of cost at the point of provision. So their burden of inequity increases substantially if they have to pay for such services when accessing from the public domain.

The above inequity in access gets reflected in health outcomes, which too, as we have seen earlier, reflect strong class gradients. Thus infant and child mortality, malnutrition amongst women and children, prevalence of communicable diseases like tuberculosis and malaria, attended childbirth are between 2 to 4 times better amongst the better off groups as compared to the poorest groups. In this quagmire of poverty, the gender disparities also exist but they are less sharp than the class inequities, though they exist within each class. Such disparity, and the consequent failure of the state to protect the health of its population, is a damning statement on the health situation of the country. In India there is an additional dimension to this inequity – differences in health outcomes and access by social groups, specifically the scheduled castes and scheduled tribes. Data shows that these two groups are worse off on all counts when compared to others. Thus in access to hospital care as per NSS-1996 data the STs had 12 times less access in rural areas and 27 times less in urban areas as compared to others; for SCs the disparity was 4 and 9 times, in rural and urban areas, respectively. What is astonishing is that the situation for these groups is worse in urban areas where overall physical access is reasonably good. Their health outcomes are adverse by 1.5 times that of others. (NFHS-1998)

Another stumbling block in meeting state obligations is information access. While data on public health services, with all its limitations, is available, data on the private sector is conspicuous by its absence. The private sector, for instance does not meet its obligations to supply data on notifiable, mostly communicable, diseases, which is mandated by law. This adversely affects the epidemiological database for those diseases and hence affects public health practice and monitoring drastically. Similarly the local authorities have miserably failed to register and record private health institutions and practitioners. This is an extremely important concern because all the data quoted about the private sector is an under-estimate as occasional studies have

shown.[18] The situation with regard to practitioners is equally bad. The medical councils of all systems of medicine are statutory bodies but their performance leaves much to be desired. The recording of their own members is not up to the mark, and worse still since they have been unable to regulate medical practice there are a large number of unqualified and untrained persons practicing medicine across the length and breadth of the country. Estimates of this unqualified group vary from 50% to 100% of the proportion of the qualified practitioners. (Duggal, 2000; Rhode et.al.1994) The profession itself is least concerned about the importance of such information and hence does not make any significant efforts to address this issue. This poverty of information is definitely a rights issue even within the current constitutional context as lack of such information could jeopardize right to life.

Finally there are issues pertaining to acceptability and quality. Here the Indian state fails totally. We have seen earlier that there is a clear rural-urban dichotomy in health policy; urban areas have been provided comprehensive healthcare services through public hospitals and dispensaries and now even a strengthened preventive input through health posts for those residing in slums. In contrast rural areas have largely been provided preventive and promotive healthcare alone. This violates the principle of non-discrimination and equity and hence is a major ethical concern to be addressed.

Medical practice, especially private, suffers from a complete absence of ethics. The medical associations have as yet not paid heed to this issue at all and over the years malpractices within medical practice have gone from bad to worse. In this malpractice game the pharmaceutical industry is a major contributor as it induces doctors and hospitals to prescribe irrational and/or unnecessary drugs.[19] All this impacts drastically on quality of care. In clinical practice and hospital care in India there exist no standard protocols and hence monitoring quality becomes very difficult. For hospitals the Bureau of Indian Standards have developed guidelines, and often public hospitals do follow these guidelines (Nandraj and Duggal, 1997). But in the case of private hospitals they are generally ignored. Recently efforts at developing accreditation systems has been started in Mumbai (Nandraj, et.al, 2000)[20], and on the basis of that the Central government is considering doing something at the national level on this front so that it can promote quality of care.

Establishing Right to Health and Healthcare in India

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[18] A survey in Mumbai in 1994 showed that the official list with the Municipal Corporation accounted for only 64% of private hospitals and nursing homes (Nandraj and Duggal,1997). Similarly, a much larger study in Andhra Pradesh in 1993 revealed extraordinary missing statistics about the private health sector. For that year official records indicated that AP had 266 private hospitals and 11,103 beds, but the survey revealed that the actual strength of the private sector was over ten times more hospitals with a figure of 2802 private hospitals and nearly four times more hospital beds at 42192 private hospital beds. (Mahapatra, P, 1993)

[19] Data of 80 top selling drugs in 1991 showed that 29% of them were irrational and/or hazardous and their value was to the tune of Rs. 2.86 billion. A study of prescription practice in Maharashtra in 1993 revealed that outright irrational drugs constituted 45% of all drugs prescribed and rational prescriptions were only 18%. The proportion of irrationality was higher in private practice by over one-fifth. (Phadke, A, 1998)

[20] In Mumbai CEHAT in collaboration with various medical associations and hospital owner associations have set up a non-profit company called Health Care Accreditation Council. This body hopes to provide the basis for evolving a much larger initiative on this front.

More than half a century's experience of waiting for the policy route to assure respect, protection and fulfillment for healthcare is now behind us. The Bhore Committee recommendations which had the potential for this assurance were assigned to the back-burner due to the failure of the state machinery to commit a mere 2% of the Gross Domestic Product at that point of time for implementation of the Bhore Plan. In the review of the evolution of health policy we have seen that each plan and/or health committee contributed to the dilution of the comprehensive and universal access approach by developing selective schemes or programs, and soon enough the Bhore plan was archived and forgotten about. So our historical experience tells us that we should abandon the policy approach and adopt the human rights route to assuring universal access to all people for healthcare. We are today talking of health sector reform and hence it is the right time to switch gears and move in the direction of right to health and healthcare.

The right to healthcare is primarily a claim to an entitlement, a positive right, not a protective fence.[21] As entitlements rights are contrasted with privileges, group ideals, societal obligations, or acts of charity, and once legislated they become claims justified by the laws of the state. (Chapman, 1993) The emphasis thus should not be as much on 'respect' and 'protect' but on 'fulfill'. For the right to be effective optimal resources that are needed to fulfill the core obligations have to be made available and utilized effectively.

Further, using a human rights approach also implies that the entitlement is universal. This means there is no exclusion from the provisions made to assure healthcare on any grounds whether purchasing power, employment status, residence, religion, caste, gender, disability, and any other basis of discrimination.[22] But this does not discount the special needs of disadvantaged and vulnerable groups who may need special entitlements through affirmative action to rectify historical inequities suffered by them.

Thus establishing universal healthcare through the human rights route is the best way to fulfill the obligations mandated by international law and domestic constitutional provisions. International law, specifically ICESCR, the Alma Ata Declaration, among others, provide the basis for the core content of right to health and healthcare. But country situations are very different and hence there should not be a global core content, it needs to be country specific.[23] In

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[21] In the 18th century rights were interpreted as fences or protection for the individual from the unfettered authoritarian governments that were considered the greatest threat to human welfare. Today democratic governments do not pose the same kind of problems and there are many new kinds of threats to the right to life and well being. (Chapman, 1993) Hence in today's environment reliance on mechanisms that provide for collective rights is a more appropriate and workable option. Social democrats all over Europe, in Canada, Australia have adequately demonstrated this in the domain of healthcare.

[22] A human rights approach would not necessitate that all healthcare resources be distributed according to strict quantitative equality or that society attempt to provide equality in medical outcomes, neither of which would in any case be feasible. Instead the universality of the right to healthcare requires the definition of a specific entitlement be guaranteed to all members of our society without any discrimination. (Chapman, 1993)

[23] Country specific thresholds should be developed by indicators measuring nutrition, infant mortality, disease frequency, life expectancy, income, unemployment and underemployment, and by indicators relating to adequate food consumption. States should have an immediate obligation to ensure the fulfillment of this minimum threshold. (Andreassen et.al., 1988 as quoted by Toebes,1998)

India's case a certain trajectory has been followed through the policy route and we have an existing baggage, which we need to sort out and fit into the new strategy.

Specific features of this historical baggage are:

- a very large and unregulated private health sector with an attitude that the existing policy is the best one as it gives space for maximizing their interests, a complete absence of professional ethics and absolute disinterest in organizing around issues of self-regulation, improvement of quality and accountability, and need for an organised health care system
- a declining public health care system which provides selective care through a multiplicity of schemes and programs, and discriminates on the basis of residence (rural-urban) in providing for entitlements for healthcare
- existing inequities in access to healthcare based on employment status, gender and purchasing power
- inadequate development of various pre-conditions of health like water supply and sanitation, environmental health and hygiene and access to food[24]
- very large numbers of unqualified and untrained practitioners
- inadequate and declining investments and expenditure in public health
- adequate resource availability when we account for out-of-pocket expenses
- humanpower and infrastructure reasonably adequate, though inequitably distributed
- wasteful expenditures due to lack of regulation and standard protocols for treatment

To establish right to health and healthcare with the above scenario certain first essential steps will be compulsory:

- equating directive principles with fundamental rights through a constitutional amendment
- incorporating a National Health Act (like for example the Canada Health Act) which will organize the present healthcare system under a common umbrella organization as a public-private mix governed by an autonomous national health authority which will also be responsible for bringing together all resources under a single-payer mechanism
- generating a political commitment through consensus building on right to healthcare in civil society
- development of a strategy for pooling all financial resources deployed in the health sector
- redistribution of existing health resources, public and private, on the basis of standard norms (these would have to be specified) to assure physical (location) equity

[24] Efforts to prevent hunger have been there through the Integrated Child Development Services program and mid-day meals. Analysis of data on malnutrition clearly indicates that where enrollment under ICDS is optimal malnutrition amongst children is absent, but where it is deficient one sees malnutrition. Another issue is that we have overflowing food-stocks in godowns but yet each year there are multiple occasions of mass starvation in various pockets of the country.

While the above are essential steps for establishing right to healthcare they involve a process that will take some time. As an immediate step, within its own domain, the State should undertake to accomplish the following:

- Allocation of health budgets as block funding, that is on a per capita basis for each population unit of entitlement as per existing norms. This will create redistribution of current expenditures and reduce substantially inequities based on residence.[25] Local governments should be given the autonomy to use these resources as per local needs but within a broadly defined policy framework of public health goals
- Strictly implementing the policy of compulsory public service by medical graduates from public medical schools, as also make public service of a limited duration mandatory before seeking admission for post-graduate education. This will increase human resources with the public health system substantially and will have a dramatic impact on the improvement of the credibility of public health services
- Essential drugs as per the WHO list should be brought back under price control (90% of them are off-patent) and/or volumes needed for domestic consumption must be compulsorily produced so that availability of such drugs is assured at affordable prices and within the public health system
- Local governments must adopt location policies for setting up of hospitals and clinics as per standard acceptable ratios, for instance one hospital bed per 500 population and one general practitioner per 1000 persons. To restrict unnecessary concentration of such resources in over-served areas fiscal measures to discourage such concentration should be instituted.[26]
- The medical councils must be made accountable to assure that only licensed doctors are practicing what they are trained for.[27] Such monitoring is the core responsibility of the council by law which they are not fulfilling, and as a consequence failing to protect the patients who seek care from unqualified and untrained doctors. Further continuing medical education must be implemented strictly by the various medical

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[25]To illustrate this, taking the Community Health Centre (CHC) area of 150,000 population as a "health district" at current budgetary levels under block funding this "health district" would get Rs. 30 million (current resources of state and central govt. combined is over Rs.200 billion, that is Rs. 200 per capita). This could be distributed across this health district as follows : Rs 300,000 per bed for the 30 bedded CHC or Rs. 9 million (Rs.6 million for salaries and Rs. 3 million for drugs and other consumables, maintenance, POL etc..) and Rs. 4.2 million per PHC (5 PHCs in this area), including its sub-centres and CHVs (Rs. 3.2 million as salaries and Rs. 1 million for drugs, consumables etc..). This would mean that each PHC would get Rs. 140 per capita as against less than Rs. 50 per capita currently. In contrast a district headquarter town with 300,000 population would get Rs. 60 million, and assuming Rs. 300,000 per bed (for instance in Maharashtra the current district hospital expenditure is only Rs. 150,000 per bed) the district hospital too would get much larger resources. To support health administration, monitoring, audit, statistics etc, each unit would have to contribute 5% of its budget. Ofcourse, these figures have been worked out with existing budgetary levels and excluding local government spending which is quite high in larger urban areas. (Duggal,2002)

[26] Such locational restrictions in setting up practice may be viewed as violation of the fundamental right to practice one's profession anywhere. It must be remembered that this right is not absolute and restrictions can be placed in concern for the public good. The suggestion here is not to have compulsion but to restrict through fiscal measures. In fact in the UK under NHS, the local health authorities have the right to prevent setting up of clinics if their area is saturated.

[27] For instance the Delhi Medical Council has taken first steps in improving the registration and information sysetm within the council and some mechanism of public information has been created.

councils and licenses should not be renewed (as per existing law) if the required hours and certification is not accomplished

- Integrate ESIS, CGHS and other such employee based health schemes with the general public health system so that discrimination based on employment status is removed and such integration will help more efficient use of resources. For instance, ESIS is a cash rich organization sitting on funds collected from employees (which are parked in debentures and shares of companies!), and their hospitals and dispensaries are grossly under-utilised. The latter could be made open to the general public
- Strictly regulate the private health sector as per existing laws, but also make an effort to change these laws to make them more effective. This will contribute towards improvement of quality of care in the private sector as well as create some accountability
- Strengthen the health information system and database to facilitate better planning as well as audit and accountability.

Carrying out the above immediate steps will create the basis to move in the direction of first essential steps indicated above. In order to implement the first-steps the essential core contents of healthcare have to be defined and made legally binding through the processes of the first-steps. The literature and debate on the core contents is quite vast and from that we will attempt to draw out the core content of right to health and healthcare keeping the Indian context discussed above in mind.

Audrey Chapman in discussing the minimum core contents summarises this debate, "Operatively, a basic and adequate standard of healthcare is the minimum level of care, the core entitlement, that should be guaranteed to all members of society: it is the floor below which no one will fall.[28] (Chapman, 1993). She further states that the basic package should be fairly generous so that it is widely acceptable by people, it should address special needs of special and vulnerable population groups like under privileged sections (SC and ST in India), women, physically and mentally challenged, elderly etc., it should be based on cost-conscious standards but judgements to provide services should not be determined by budgetary constraints[29], and it should be accountable to the community as also demand the latter's participation and involvement in monitoring and supporting it. All this is very familiar terrain, with the Bhore Committee saying precisely the same things way back in 1946.

We would like to put forth the **core content** as under:
Primary care services[30] should include at least the following:

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[28] This implies that the health status of the people should be such that they can atleast work productively and participate actively in the social life of the community in which they live. It also means that essential healthcare sufficient to satisfy basic human needs will be accessible to all, in an acceptable and affordable way, and with their full involvement. (WHO, 1993)

[29] General Comment 3 of ICESCR reiterates this that the minimum core obligations by definition apply irrespective of the availability of resources or any other factors and difficulties. Hence it calls for international cooperation in helping developing countries who lack resources to fulfil obligations under international law.

[30] Most of atleast the curative services will of necessity have to be a public-private mix because of the existing baggage of the health system we have but this has to be under an organized and accountable health care system.

- General practitioner/family physician services for personal health care.
- First level referral hospital care and basic specialty and diagnostic services (general medicine, general surgery, obstetrics and gynaecology, paediatrics and orthopaedic), including dental and ophthalmic services.
- Immunisation services against all vaccine preventable diseases.
- Maternity and reproductive health services for safe pregnancy, safe abortion, delivery and postnatal care and safe contraception.
- Pharmaceutical services - supply of only rational and essential drugs as per accepted standards.
- Epidemiological services including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures.
- Ambulance services.
- Health education.
- Rehabilitation services for the physically and mentally challenged and the elderly and other vulnerable groups
- Occupational health services with a clear liability on the employer
- Safe and assured drinking water and sanitation facilities, minimum standards in environmental health and protection from hunger to fulfill obligations of underlying preconditions of health[31]

The above listed components of primary care are the minimum that must be assured, if a universal health care system has to be effective and acceptable. And these have to be within the context of first-steps and not to wait for progressive realisation – these cannot be broken up into stages, as they are the core minimum and hence non-negotiable. The key to equity is the existence of a minimum decent level of provision, a floor that has to be firmly established. However, if this floor has to be stable certain ceilings will have to be maintained toughly, especially on urban health care budgets and hospital use (Abel-Smith,1977). This is important because human needs and demands can be excessive and irrational. Those wanting services beyond the established floor levels will have to seek it outside the system and/or at their own cost. However this does not mean that higher levels of care should not be part of the core contents. Access to specialist and tertiary services via primary care referral has to also be made part of the chain without any direct cost to the user.

Therefore it is essential to specify adequate minimum standards of health care facilities, which should be made available to all people irrespective of their social, geographical and financial position. There has been some amount of debate on standards of personnel requirements [doctor: population ratio, doctor: nurse ratio] and of facility levels [bed: population ratio, PHC: population ratio] but no global standards have as yet been formulated though some ratios are popularly used, like one bed per 500 population, one doctor per 1000 persons, 3 nurses per doctor, public health expenditure to the tune of 5% of GDP etc.. Another way of viewing standards is to look at the levels of countries that already have universal access systems in place. In such countries one

[31] These services need not be part of the health department or the national health authority that may be created and may continue to be part of the urban and rural development departments as presently.

finds that on an average per 1000 population there are 2 doctors, 5 nurses and as many as 10 hospital beds (OECD,1990, WHO,1961). The moot point here is that these ratios have remained more or less constant over the last 30 years indicating that some sort of an optimum level has been reached. In India with regard to hospital care the Bureau of Indian Standards (BIS) has worked out minimum requirements for personnel, equipment, space, amenities etc.. For doctors they have recommended a ratio of one per 3.3 beds and for nurses one per 2.7 beds for three shifts. (BIS 1989, and 1992). Again way back in 1946 the Bhore Committee had recommended reasonable levels (which at that time were about half that of the levels in developed countries) to be achieved for a national health service, which are as follows:

- one doctor per 1600 persons
- one nurse per 600 persons
- one health visitor per 5000 persons
- one midwife per 100 births
- one pharmacist per 3 doctors
- one dentist per 4000 persons
- one hospital bed per 175 persons
- one PHC per 10 to 20 thousand population depending on population density and geographical area covered
- 15% of total government expenditure to be committed to health care, which at that time was about 2% of GDP

The first response from the government and policy makers to the question of using the above norms in India is that they are excessive for a poor country and we do not have the resources to create such a level of health care provision. Such a reaction is invariably not a studied one and needs to be corrected. Let us construct a selected epidemiological profile of the country based on whatever proximate data is available through official statistics and research studies. We have obtained the following profile after reviewing available information:

- Daily morbidity = 2% to 3% of population, that is about 20-30 million patients to be handled everyday (7 - 10 billion per year)
- Hospitalisation Rate 20 per 1000 population per year with 12 days average stay per case, that is a requirement of 228 million bed-days (that is 20 million hospitalisations as per NSS -1987 survey, an underestimate because smaller studies give estimates of 50/1000/year or 50 million hospitalisations)
- Prevalence of Tuberculosis 11.4 per 1000 population or a caseload of over 11 million patients
- Prevalence of Leprosy 4.5 per 1000 population or a caseload of over 4 million patients
- Incidence of Malaria 2.6 per 1000 population yearly or 2.6 million new cases each year
- Diarrhoeal diseases (under 5) = 7.5% (2-week incidence) or 1.8 episodes/child/year or about 250 million cases annually
- ARI (under 5) = 18.4% (2-week incidence) or 3.5 episodes per child per year or nearly 500 million cases per year

- Cancers = 1.5 per 1000 population per year (incidence) or 1.5 million new cases every year
- Blindness =1.4% of population or 14 million blind persons
- Pregnancies = 21.4% of childbearing age-group women at any point of time or over 40 million pregnant women
- Deliveries/Births = 25 per 1000 population per year or about 68,500 births every day

(estimated from CBHI, WHO,1988, ICMR,1990, NICD,1988, Gupta et.al.,1992, NSS,1987)

The above is a very select profile, which reflects what is expected out of a health care delivery system. Let us take handling of daily morbidity alone, that is, outpatient care. There are 30 million cases to be tackled every day. Assuming that all will seek care (this usually happens when health care is universally available, in fact the latter increases perception of morbidity) and that each GP can handle about 60 patients in a days work, we would need over 500,000 GPs equitably distributed across the country. This is only an average; the actual requirement will depend on spatial factors (density and distance). This means one GP per about 2500 population, this ratio being three times less favourable than what prevails presently in the developed capitalist and the socialist countries. Today we already have over 1,400,000 doctors of all systems (660,000 allopathic) and if we can integrate all the systems through a CME program and redistribute doctors as per standard requirements we can provide GP services in the ratio of one GP per less than 1000 population.

It is evident from the above discussion that the neglect of the public health system is an issue larger than government policy making. The latter is the function of the overall political economy. Under capitalism only a well-developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy (which directly benefit capital accumulation) is more urgent (from the business perspective) than the social sectors, hence the latter get only a residual attention by the state. The policy route to comprehensive and universal healthcare has failed miserably. It is now time to change gears towards a rights-based approach. The opportunity exists in the form of constitutional provisions and discourse, international laws to which India is a party, and the potential of mobilizing civil society and creating a socio-political consensus on right to healthcare. All these have to be bundled into a comprehensive health and healthcare legislation which is able to encompass all the issues and concerns discussed above.

The Legal Route for Right to Health and Healthcare

Global experience clearly shows that countries which have established universal access to healthcare have been able to do it with comprehensive legislation that has organized the healthcare system under a common umbrella and pooled resources to deliver structured and regulated health services to its citizens. Legislation covers all dimensions of health and healthcare so that the issues and concerns highlighted above like access, provision of adequate infrastructure, discrimination, negligence, malpractices, quackery, healthcare

systems, quality standards, occupational and environment health problems, reproductive health issues, violation of rights, allocation of resources, professional conduct, rights of patients, and protection against epidemics etc. can be taken care of. All the existing laws have been formulated in response to a specific situation or an issue. There has never been an attempt to legislate a comprehensive law covering the major aspects of health and healthcare. The latter can only emerge from a comprehensive health policy. Historically India had two opportunities, one in the Bhore Committee Report on the eve of Independence, and the second post Alma Ata when the 1982 National Health policy was formulated. Both these opportunities to translate the policy into law were lost because the approach to health and healthcare was a program based one and not a comprehensive approach to establish universal and non-discriminatory access to healthcare.

Thus as yet in India there is no comprehensive legislation on health and healthcare. What we have are laws which cover selective aspects of health and healthcare and often these violate the principles of universality and non-discrimination. So we have social security laws which protect health interests of a selected class of the workforce like the Factories Act, the ESIS Act and Maternity Benefit Act, laws to deal with healthcare establishments like the Hospital and clinical establishment registration acts of different states, laws to deal with epidemics like the Epidemic Diseases Act, Notifiable Disease Act and the various state Public Health Acts, laws to prevent quackery, professional misconduct and malpractice like the Medical Council of India Act, Organ Transplantation Act, laws to assure quality like the Drugs and Cosmetics Act and the Prevention of Food Adulteration Act, Blood Banks Act, laws to deal with negligence like COPRA, The MTP Act for abortion, the PNDT Act to prevent sex-selective discrimination, laws for environment health like Prevention of Pollution Act, Biological Diversity Act, Hazardous substances Act, laws for occupational health like the Workmen's compensation Act etc. (Can we make an Annexure listing all possible health and health related legislation, preferably with annotations??)

The problem with the existing legislation is that it is piecemeal and addresses its objectives without contextualizing them in the overall context of the human right to health. They suffice to deal with specific situations or for specific persons but they don't have a generic applicability. A review of cases under these various legislations (see section on case laws) indicates the inadequacies of these laws from the perspective of rights. As an interim these laws have served a limited purpose and guaranteed protection when violations take place. These are discussed at length in the subsequent sections dealing with various case laws. However, these laws do not provide a general right to health and healthcare and for the latter to happen all these laws have to be brought under the umbrella of an apex law which mandates the right to health and healthcare. This apex law must be contextualized within the framework of the ICESCR and other international covenants as well as the provision of the directive principles of the Indian Constitution discussed above and must facilitate the organization of the healthcare system into a regulated system which is under a public authority and financed by pooling all resources available in the country. To

support this legislation a constitutional amendment to establish right to health and healthcare must also be put in place.

Comprehensive health legislation is absolutely essential to translate policy into practice. Health legislation reflects and makes explicit the health policy, and decision making, the crucial act of politics, may remain a dead letter if not backed up by legislation (WHO, 1988 a). Thus health legislation becomes an important tool for implementation of health policy and provides the managerial and administrative basis for the development of health systems. It is this latter element that is missing in India due to lack of comprehensive health legislation.

What should then comprehensive health legislation include? At the outset it is important to state that health is a public or social good and hence the role of the state is very critical. Healthcare is a general public concern and hence governments are responsible for assuring it and this is best done through a mandate by law which makes the government accountable for it.

There are two aspects that health legislation has to cover. One is mandating that health care is a right and a specified mix of health services will be assured as per the core content we have discussed in an earlier section. The second aspect pertains to regulation of the larger healthcare system which includes private provision of various health and related services. The first one is the political commitment which translates policy into action and the second is the functional details of how the system will be controlled and made accountable. We have already discussed the first aspect earlier and here we would like to reiterate the importance of universality and non-discrimination as the foundation principles of health legislation which should assure equity in access, especially class, caste, gender, differently-abled, geographical and financial equity. The health legislation will have to also work out the organizational and financing framework for the entire healthcare system[32]. Both public and private healthcare has to be factored into the universal access healthcare system and all finances have to be pooled into a common kitty which is administered and controlled by a multi-stakeholder public authority. The Canada Health Act which mandates public spending for physician and hospital services is one good example to learn from. Through this Act, the federal government ensures that the provinces and territories meet certain requirements, such as free and universal access to insured health care[33]. Apart from this Canada also has other legislation which regulates specific aspects of provisions under the Canada Health Act.

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[32] For a framework to operationalise this see Ravi Duggal, 2004

[33] There are five main principles in the Canada Health Act: **1. Public Administration:** All administration of provincial health insurance must be carried out by a public authority on a non-profit basis. They also must be accountable to the province or territory, and their records and accounts are subject to audits. **2. Comprehensiveness:** All necessary health services, including hospitals, physicians and surgical dentists, must be insured. **3. Universality:** All insured residents are entitled to the same level of health care. **4. Portability:** A resident that moves to a different province or territory is still entitled to coverage from their home province during a minimum waiting period. This also applies to residents which leave the country. **5. Accessibility:** All insured persons have reasonable access to health care facilities. In addition, all physicians, hospitals, etc, must be provided reasonable compensation for the services they provide. (http://laws.justice.gc.ca/en/C-6/233402.html ; accessed 30-3-2006)

The regulatory dimension is the second aspect of healthcare legislation and this as we have seen earlier exists in a piecemeal way. Many of these specific laws would need to be brought in line with the apex legislation and strengthened accordingly. As we will see in the section on case laws this is a very wide arena. Here we will attempt to define the regulatory principles for some critical areas where regulation has to be established and/or strengthened.

The following suggestions on regulation encompass the entire health sector. However, they are not an exhaustive list but only some major important areas needing regulation or where it exists strengthening it.

1.Nursing Homes and Hospitals :

- Setting up minimum decent standards and requirements for each type of unit; general specifications for general hospitals and nursing homes and special requirements for specialist care, example maternity homes, cardiac units, intensive care units etc.. This should include physical standards of space requirements and hygiene, equipment requirements, humanpower requirements (adequate nurse:doctor and doctor:beds ratios) and their proper qualifications etc...
- Maintenance of proper medical and other records which should be made available statutorily to patients and on demand to inspecting authorities.
- Setting up of a strict referral system for hospitalisation and secondary and tertiary care
- Fixing reasonable and standard hospital, professional and service charges.
- Filing of minimum data returns to the appropriate authorities for example data on notifiable diseases, detailed death and birth records, patient and treatment data, financial returns etc..
- Regular medical and prescription audits which must be reported to the appropriate authority
- Regular inspection of the facility by the appropriate authority with stringent provisions for flouting norms and requirements
- Periodical renewal of registration after a thorough audit of the facility

2. Physicians and other medical practitioners :

- Ensuring that only properly qualified persons set up practice
- Compulsory maintenance of patient records, including prescriptions, with regular audit by concerned authorities
- Fixing of standard reasonable charges for fees and services
- Regulating a proper geographical distribution
- Filing appropriate data returns about patients and their treatment
- Provision for continuing medical education on a periodic basis with licence renewal dependent on its completion

3. Diagnostic Facilities :

- Ensuring quality standards and qualified personnel
- Standard reasonable charges for various diagnostic tests and procedures
- Audit of tests and procedures to check their unnecessary use

- Proper geographical distribution to prevent over concentration in certain areas

4. Pharmaceutical industry and pharmacies :

- Allowing manufacture of only essential and rational drugs
- Regulation of this industry must be switched to the Health Ministry from the Chemicals Ministry
- Formulation of a National Formulary of generic drugs which must be used for prescribing by doctors and hospitals
- Ensuring that pharmacies are run by pharmacists through regular inspection by the authorities
- Pharmacies should accept only generic drug prescriptions and must retain a copy of the prescription for audit purposes

5. Health insurance and third party administration:

- Health insurance should be allowed only as a not-for-profit sector
- National and social insurance must be under public authority
- Premiums must be negotiated through a multi-stakeholder mechanism
- Insurance coverage must be comprehensive
- Insurance companies must directly settle claims with hospitals and physicians
- Insurance data must be in public domain
- Individual based exclusions should not be permitted
- Insurance must also cover preventive and promotive healthcare, maternity, dentistry and ophthalmic services

Apart from the above there are other areas which regulation has to cover like patients rights (informed consent, privacy, access to records etc.), complaints redressal, reproductive technologies, organ transplantation, human experimentation, euthanasia, mental health, disabilities etc. Many of these laws exist in some way but they need to be linked and brought in line with the apex legislation which will be formulated within the rights perspective. And finally regulation has very little meaning if there is no audit agency to monitor what is happening.

To conclude, if we want to establish right to healthcare then we have to transcend the policy route and translate it into a legal route within the human rights framework. This is the only way to assure political commitment for right to health and healthcare.

In the subsequent section we present a review of selected case laws which have used existing legal provisions to establish that health and healthcare is a right in one way or another. The review and commentary on these case laws should provide us learnings for our task to formulate comprehensive health legislation for the future. (to add another para on what is covered in case laws or this could also go in the preface which also describes the purpose of this volume)

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Mihir

Right to Health → has been left out.
∴ Govt. health is left.

- Medical negligence
- Occupational health } number of judgements.
So only a few cases laws are taken.

3 streams in developing RT Hcare

→ 1. Rt to Pollution free Envt. (devt. of case law) for general population
- Rt to employees in govt. + ~~org sector~~.
(Mohinder Singh Chawla) health care
Pensions, employees not people in general.
- Rt. of employees in hazardous industries
asbestos case: CESC, CERC.

* Public Hospitals - 'proper care' : Paschim Sharma's case.
* Prisoners - have right to health care :
- S.K. Garg's case: AP - Rt. to health care is a fundamental right.
- Ram Bagga's case → State is not bound to give unlimited health care - contingent upon financial resources.

* Rt. to food → SC: policies are enforceable.
case

II

RIGHT TO HEALTH & PUBLIC HEALTH CARE

A. INTRODUCTION

Article 21 of the Constitution, a fundamental right reads: "No person shall be deprived of his life or personal liberty except through procedure established by law." Till the 1970s by and large the courts had interpreted 'life' literally i.e. right to exist. It was in late 1970s onwards that an expanded meaning started to be given to 'life'. Over the years it has come to be accepted that life does not only mean animal existence but the life of a dignified human being with all its concomitant attributes. This would include a healthy environment and effective health care facilities. Today, therefore, the fundamental right to life is seen in a broader context.

'Right to health' is inseparable from 'right to life', and 'right to medical facilities' as a concomitant of 'right to health' is also part and parcel of right to life. Life is not mere existence but a life of dignity, well-being and all that makes it complete. In a welfare state, the corresponding duty to the right to health and medical facility lies with the State. The 'Directive Principles of State Policy', Chapter IV of the Constitution lays down guiding principles to be followed in formulating its policies. Traditionally these principles unlike the Fundamental Rights were held as not enforceable in courts of law, but in light of the enlarged meaning of 'life', they have assumed an enforceable form.

The relevant provisions of Constitution that cast a duty on State to ensure good health for its citizens are:

Article 38. State to secure a social order for the promotion of welfare of people-

1) 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.
2) State shall, in particular, strive to minimize the inequalities in income, and endeavor to eliminate inequalities in status, facilities and opportunities, not only amongst individuals but also amongst groups of people residing in different areas or engaged in different vocations.

In other words, no person will be deprived of a healthy life because he cannot afford it. State must provide facilities that an economically better off person can afford out of his own pocket.

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.

Section 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."

To begin with, the right to health as a fundamental right grew as an off shoot of the environmental litigation. Undoubtedly right to environment was crucial because a polluted environment affects public health. Pollution free environment as a fundamental right presupposes right to health as a fundamental right. Logically, the explicit recognition of the fundamental right to health should have preceded the fundamental right to good environment. However, the development of jurisprudence in this branch has been reverse. To begin with, right to decent environment was recognized and from that followed the right to public health, health and health care.

Secondly, the right to health care has also been debated by the courts in the context of rights of Government employees to receive health care. A number of observations of the Court concerning the importance of these rights are to be found in cases dealing with denial or restriction of health care facilities for Government employees.

While dealing with the issue of fundamental right to health and health care the Courts have also dealt with specific categories such as under trials, convicts and mentally ill persons. The Courts have recognized that mere imprisonment will not deprive a person of right to health and health care.

B. CASE LAW CONCERNING FUNDAMENTAL RIGHT TO HEALTH AND HEALTH CARE

In one of the earliest public interest litigations handled by the Supreme Court- Municipal Council, Ratlam Vs. Vardhichand & Ors,[1] the Municipal Corporation was prosecuted by come citizens for not clearing up the garbage. Municipal Corporation took up the plea that it did not have money. While rejecting the plea, Justice Krishna Iyer observed: "The State will realize that Article 47 makes it a paramount principle of governance that steps are taken for the improvement of public health as amongst its primary duties."

Finally, in 1991, in C.E.S.C. Ltd. Vs. Subhash Chandra Bose the Supreme Court relied on international instruments and came to the conclusion that right to health is a fundamental right. It went further and observed that health is not merely absence of sickness. It observed:

> "33. *The term health implies more than an absence of sickness.* Medical care and health facilities not only protect against sickness but also ensures stable man power for economic development. Facilities of health and medical care generate devotion and dedication to give the workers' best, physically as well as mentally, in productivity. It enables the worker to enjoy the fruit of his labour, to keep him physically fit and mentally alert for leading a successful

[1] 1980 Cri LJ 1075)

economic, social and cultural life. The medical facilities are, therefore, part of social security and like gilt edged security, it would yield immediate return in the increased production or at any rate reduce absenteeism on grounds of sickness, etc. Health is thus a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. *In the light of Arts. 22 to 25 of the Universal Declaration of Human Rights, International Convention on Economic, Social and Cultural Rights, and in the light of socio-economic justice assured in our Constitution, right to health is a fundamental human right to workmen. The maintenance of health is a most imperative constitutional goal whose realisation requires interaction by many social and economic factors."*

In CERC Vs. Union of India[2] the Supreme Court was dealing with the rights of workers in Asbestos manufacturing and health hazards related to it. The case is discussed in detail in the chapter on occupational health. However, the relevant observations of the Court concerning fundamental right to health are worth noting::

"20. Social justice is dynamic device to mitigate the sufferings of the poor, weak, Dalits, Tribals and deprived sections of the society and to elevate them to the level of equality to live a life with dignity of person. Social justice is not a simple or single idea of a society but is an essential part of complex of social change to relieve the poor etc. from handicaps, penury to ward off distress, and to make their life livable, for greater good of the society at large. In other words, the aim of social justice is to attain substantial! degree of social, economic and political equality, which is the legitimate expectations. Social security, just and humane conditions of work and leisure to workman are part of his meaningful right to life and o achieve self-expression of his personality and to enjoy the life with dignity, the State should provide facilities and opportunities to them to reach at least minimum standard of health, economic security and civilised living while sharing according to the capacity, social and cultural heritage.

23. Article 38(1) lays down the foundation for human rights and enjoins the State to promote the welfare of the 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. Art. 46 directs the State to protect the poor from social injustice and all forms of exploitation. Article 39(e) charges that the policy of the State shall be to secure "the health and strength of the workers". Article 42 mandates that the States shall make provision, statutory or executive "to secure just and humane conditions of work". Article 43 directs that the Slate shall "endeavour to secure to all workers, by suitable legislation or economic organisation or any other way to ensure decent standard of life and full enjoyment of leisure and social and cultural opportunities to the workers". Article 48-A enjoins the Slate to protect and improve the environment. As human resources are valuable national assets for peace, industrial or material production, national wealth, progress, social stability, descent standard of life of worker is an input. Art. 25(2) of the universal declaration of human rights ensures right to standard of adequate

[2] 1995 3 SCC 42

living for health and well being of the individual including medical care, sickness and disability, Article 2(b) of the International Convention on Political, Social and Cultural Rights protects the right of worker to enjoy just and favourable conditions of work ensuring safe and healthy working conditions.

26. The right to health to a worker is an integral facet of meaningful right to life to have not only a meaningful existence but also robust health and vigour without which worker would lead life of misery. Lack of health denudes his livelihood. Compelling economic necessity to work in an industry exposed to health hazards due to indigence to bread-winning to himself and his dependents should not beat the cost of the health. and vigour of the workman. Facilities and opportunities, as enjoined in Article 38, should be provided to protect the health of the workman. Provision for medical test and treatment invigorates the health of the worker for higher production or efficient service. Continued treatment, while in service or after retirement is a moral, legal and constitutional concomitant duty of the employer and the State. Therefore, it must be held that the right to health and medical care is a fundamental right under Article 21 read with Articles 39(c), 41 and 43 of the Constitution and make thelife of the workman meaningful and purposeful with dig-nity of person. Right to life includes protection of the health and strength of the worker is a minimum requirement to enable a person to live with human dignity. The State, be it Union or State Government or an industry, public or private, is enjoined to take all such action which will promote health, strength and vigour of the workman during the period of employment and leisure and health even after retirement as basic essentials to live the life with health and happiness. The health and strength of the worker is an integral facet of right to life. Denial thereof denudes the workman the finer facets of life violating Art. 21. The right to human dignity, development of personality, social protection, right to rest and leisure are fundamental human rights to a workman assured by the Charter of Human Rights, in the Preamble and Arts. 38 and 39 of the Constitution. Facilities for medical care and health against sickness ensures stable manpower for economic development and would generate devotion to duty and dedication to give the workers" best physically as well as mentally in production of goods or services. Health of the worker enables him to enjoy the fruit of his labour, keeping him physically fit and mentally alert for leading a successful life, economically, socially and culturally. Medical facilities to protect the health of the workers arc, therefore, the fundamental and human rights to the workmen.

27. Therefore, we hold that right to health, medical aid to protect the health and vigour of a worker while in service or post retirement is a fundamental right under Article 21, read with Articles 39(e), 41, 43, 48A and all related to Articles and fundamental human rights to make the life of the workman meaningful and purposeful with dignity of person."

Similarly, in **State of Punjab Vs. Mohinder Singh Chawla**[3], the Supreme Court observed:

> "It is now settled law that right to health is an integral to right to life. Government has constitutional obligation to provide the health facilities. If the Government servant has suffered an ailment which requires treatment at a specialised approved hospital and on reference whereat the Government servant had undergone such treatment therein, it is but the duty of the State to bear the expenditure incurred by the Government servant. Expenditure, thus, incurred requires to be reimbursed by the Slate to the employee. The High Court was, therefore, right in giving direction to reimburse the expenses incurred towards room rent by the respondent during his stay in the hospital as an inpatient."

Also, the Andhra Pradesh High Court observed:

> "Protection of the environment is not only the duty of the citizens but also the obligation of the State and its all other organs including the Courts. The enjoyment of life and its attainment and fulfillment guaranteed by Article 21 of the Constitution embraces the protection and preservation of natures gift without which life cannot be enjoyed fruitfully. The slow poisoning of the atmosphere caused by the environmental pollution and spoliation should be regarded as amounting to violation of Article 21 of the Constitution of India. It is therefore, as held by this Court speaking through P.A, Choudary, J., in T. Damodar Rao and others v. Special Officer, Municipal Corporation of Hyderabad, AIR 1987 AP 171, the legitimate duty of the Courts as the enforcing organs of the constitutional objectives to forbid all actions of the State and the citizens from upsetting the ecological and environmental balance. In Virender Gaur v. Slate of Haryana, 1995 (2) SCC 577, the Supreme Court held that environmental, ecological, air and water pollution, etc., should be regarded as amounting to violation of right to health guaranteed by Article 2! of the Constitution. It is trite to state that hygienic environment is an integral facet of the right to healthy life and it would not be possible to live with human dignity without a humane and healthy environment. In Consumer Education and Research Centre v. Union of India, (1995) 3 SCC 42, Kirloskar Brothers Ltd. v. Employees' State Insurance Corporation, (1996) 2 SCC 682= AIR 1996 SC 3261, the Supreme Court held that right to health and medical care is a fundamental fight under Article 21 read with Article 39(e), 41 and 43, In Subhash Kumar v. State of Bihar, AIR 1991 SC 420 = (1991) I SCC 598, the Supreme Court held that right to pollution-free water and air is an enforceable fundamental right guaranteed under Article 21. Similarly in Shantistar Builders v. Narayan Khimalal Totame, (1990) 2 SCJ 10 = AIR 1990 SC 630 = 1990 1 SCC 520, the Supreme Court opined that the right to decent environment is covered by the right guaranteed under Article 21. Further, in Mehta, M.C. v. Union of India, (1987) 4 SCC 463 = AIR 1988 SC 1037, Rural Litigation and Entitlement Kendra v. State of U.P., AIR 1987 SC 359, Subhash Kumar v. State of Bihar (supra), the Supreme Court imposed a

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[3] 1997 2 SCC 83

positive obligation upon the State to take steps for ensuring to the individual a better enjoyment of life and dignity and for elimination of water and air pollution. It is also relevant to notice as per the judgment of the Supreme Court in Vincent Panikurlangara v. Union of India, AIR 1987 SC 990 - (1987) 2 SCC 165, Unnikrishnan, JP v. State of A.P., AIR 1993 SC 2178 - (1993) 1 SCC 645, the maintenance and improvement of public health is the duty of the State to fulfil its constitutional obligations cast on it under Article 21 of the Constitution."[4]

The Allahabad High Court held[5]:

" 5. In our opinion, the allegations in the petition are serious.. The Supreme Court in Consumer Education and Research Centre and others v. Union of India and others. 1995 (3) SCC 42 and in State of Punjab and others v. Mohinder Singh Chawla and others. 1997 (2) SCC 83. has held that the right to health is a part of the right to life guaranteed by Article 21 of the Constitution. It is indeed true that most of the Government Hospitals in Allahabad are in a very bad shape and need drastic improvement so that the Public is given proper medical treatment. Anyone who goes to the Government Hospitals in Allahabad will find distressing sanitary and hygienic conditions. The poor people, particularly, are not properly looked after and not given proper medical treatment. Consequently, most people who can afford it go to private nursing homes or private clinics. There are many complaints that the staff of the Government Hospitals are often in collusion with the Doctors who run private nursing homes. and deliberately do not look after the patients who come to Government Hospitals so that they may be driven to go to private nursing homes, and they often advise patients to go to a particular nursing home. All this needs to be thoroughly investigated. This is a welfare State, and the people have a right to get proper medical treatment. In this connection, it may be mentioned that in U.S.A. and Canada there is a law that no hospital can refuse medical treatment of a person on the ground of his poverty or inability to pay. In our opinion. Article 21 of the Constitution, as interpreted in a series of judgments of the Supreme Court, has the same legal effect."

Violation of Article 21 by State will give rise to a claim under public law remedy.[6] State is also vicariously liable for acts of its agents or police or Government hospitals.

Poonam Sharma v. Union of India[7] dealt with statutory duty of police and government hospitals. Petitioner's husband who had met with an accident was taken in custody by the Police as they suspected him of drunken driving. The deceased had suffered one inch cut on his head and he was taken to a government hospital for first

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[4] T. Ramakrishna Rao Vs. Hyderabad Urban Development Authority decided on 20.7.2001

[5] In S.K.Garg Vs. State of U.P. decided on 21.12.98

[6] There are two kinds of civil remedies, viz., public law and private law remedy. Private law remedy involves action under torts or contract, whereas in the former, the claim is against the State for a wrong committed by it or persons acting under it. Both remedies exist independent of each other. For instance, in an incident of medical negligence by Government doctors, a cause of action may be instituted by invoking writ jurisdiction of SC or HC under Articles 32 & 226, respectively. Simultaneously aggrieved person will also be entitled to pursue civil law remedy in torts or contract against individuals before either Consumer courts or civil courts. (refer chapter on medical negligence)

[7] AIR 2003 Delhi 50

aid. The Government doctor stitched up the wound and prescribed brufen tablets. Thereafter, Police charged him under the Motor Vehicles Act and put him behind bars. At night, deceased complained of severe headache and he was taken back to the same doctor who gave the deceased some more brufen tablets and sent him back without examining him. Next day he was released on bail. When the condition of deceased deteriorated, his relatives took him back to the same hospital. The hospital took X-Rays and CAT scan that showed brain hemorrhage, and he was immediately referred to a specialist hospital but succumbed to his injuries at the time of admission.
Petitioner invoked writ jurisdiction of High Court under Article 226 and sought relief against the alleged negligence on part of the Government Doctor and police that caused the death of Petitioner's husband.
High Court held that the instant case was not of an error of judgment as within a few hours patient was brought back complaining of severe headache yet no further treatment was given. *A citizen of India is entitled to preservation of his life not only at the hands of the police authorities, but also at the hands of the public authorities, which would include hospital authorities having regard to the extended scope of Article 21 of the Constitution. Every doctor at the government hospital having regard to the paramount importance of preservation of human life is under statutory obligation to extend his services with due expertise.* Hence, Respondent was directed to pay Rs.2 lacs as compensation under Public Law for violation of fundamental rights of Petitioner's husband with liberty to file appropriate suit for damages.

In **Ram Datt Sharma's** case[8] the Rajasthan High Court dealt with responsibility of railways in providing health care facilities to its passangers. The complaint was that neither in the trains nor on the platforms were adequate medical facilities provided which caused tremendous hardship to commuters, especially in long distance trains. The Court held that right to health care is a fundamental right of citizens including passangers and made the following directions:

> *"(i) Instructions shall be issued by Railway Board to Zonal Railway to keep reserve a Coupe' of four births in long distance train that shall carry sign board 'MEDICAL FACILITIES' with symbol of Red Cross. Visible symbol of Red-cross shall also be displayed out side the compartment. Team of one Medical Officer, one made nurse and one attendant shall board train and travel in it After a distance of 500 Kms. or as directed by the Railway Board the team already travelled shall be replaced by another team. The Coupe' shall be equipped with Oxygen Cylinder, life saving drugs and injections.*

> *(ii) In every compartment of train, it shall be prominently notified that Medical Compartment is attached with the train to provide medical assistance*

[8] AIR 2005 RAJ 317

to the passengers free of cost by a competent doctor and complaint book is available with the Train- GUARD.

(iii) Due publicity that Medical facilities are available to the passengers in all the long distance trains, shall be given on all the Platforms. This information shall also be displayed on national Television and broadcast on All India Radio. People of Country shall also be made aware through the news papers.

(iv) Chemist facilities shall be provided on the station premises keeping in mind the quantum of passengers traffic.

(v) The Union of India and Railway Board shall ensure compliance of this order within sixty days from today."

C. CASES ON RIGHTS OF GOVERNMENT EMPLOYEES TO RECEIVE HEALTH CARE:

In **State of Punjab v. Mohinder Singh Chawla**[9] the Respondent was suffering from heart ailment which required replacement of two valves in the heart. Since the facility for such treatment was not available in the State hospital, State Medical Board granted permission for treatment in AIIMS, New Delhi. Later the Respondent approached concerned authorities for reimbursement of medical expenditure. The Appellants rejected the claim to the extent of expenditure on room rent paid to the hospital because of a change in the State policy for employees and ex-employees that excluded expenses incurred on diet, stay of attendant and stay of patient in hotel/hospital. Thus, the issue before SC was the extent of State's responsibility to provide medical facilities to its employees. The State justified its policy on the ground that the ancillary expenses saddled it with needless heavy burden that limited its capacity to provide treatment for general patients.

Supreme Court held that rent of room for in-patient is an integral part of expenses incurred on medical treatment, therefore, cannot be excluded. *Though Court agreed that greater allocation was required to be made for general patients, it was State's constitutional obligation to bear the expenses for the government servant while in service or after retirement.*

Surjeet Singh v. State of Punjab[10] dealt with a situation where according to Respondent State's health policy, in circumstances where the state-run hospitals lacked expertise to treat a specific ailment, its employees and ex-employees could receive medical treatment in hospitals other than the Government hospitals specified in the policy for treating such ailment, and they would be entitled to reimbursement. However, such employees and ex-employees were required to make a prior application to a Board constituted to decide upon if the treatment was available in Respondent State hospitals. Such advance notice applied even to emergency cases.
The instant appeal arose out of refusal to reimburse expenditure incurred abroad at the rate of one of the hospital identified under the State Health Policy for open heart

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[9] (1997) 2 SCC 83
[10] (1996) 2 SCC 336

surgery. Appellant's case was that on a personal visit abroad, he suddenly fell ill and had to undergo open heart surgery at a very short notice, therefore, could not comply with the clauses under State health Policy on requisite intimation.

Supreme Court held that Appellant had the right to take steps in self-preservation. He does not have to stand in queue before the Medical Board. The State cannot insist that its employees should be treated only at a recognized Government institution when state policy permits treatment in private hospitals earmarked for it. Therefore, a government employee can claim reimbursement at such rates as are applicable to the identified private hospitals.

In **Devindar Singh Shergil v. State of Punjab**[11] dealt with a retired government employee. The Appellant, a retired government official, who had approached Postgraduate Institute of medical Sciences (PGI), Chandigarh for kidney treatment, was declined admission as no accommodation was available. Due to malignant growth of kidney, Appellant immediately left for UK and got himself treated. Later he filed his claim for reimbursement of the entire amount but the medical Board sanctioned an amount that would have been incurred if the Appellant was treated at PGI, which equaled to Rs. 20,000/-.
Supreme Court dealt with the issue 'as to why the petitioner should not be reimbursed for medical expenses to the extent of the expenditure which may have been involved for his treatment/operation if carried out in any of the recognized institutions/hospitals in India'. Since IIMS was one such recognized hospital under the State Policy, Supreme Court held that Appellant was entitled to reimbursement at AIIMS rate and further, as an admitted fact, if the Appellant would have been treated in India he would have been entitled to reimbursement of expenses on medical consumable, pharmaceutical items, therefore, he would also be entitled to reimbursement of such expenditure. Respondent State was directed to pay Rs.22,000 as per AIIMS rates for surgery and Rs.73,000/- for expenditure incurred on medicines.

In **State of Punjab v. Ram Lubhaya Bagga**[12] though the Supreme Court observed that the State had an obligation to provide health care facilities to government employees and to citizens, the State was obliged to do so only to the extent its financial resources permitted this.

The State Health Policy for its employees and ex-employees promulgated in 1991 provided reimbursement of medical expenses incurred either in earmarked hospitals or at other hospitals, at the rate prevailing in such specified hospitals.[13] This policy imposed heavy financial burden of State and they issued a new policy under which there was no impediment or procedural hurdle in receiving treatment at any hospital but the reimbursement of medical expenses was to be restricted to such rates as fixed by the Director, Health & Family Welfare, Punjab for similar treatment or the actual expenditure, whichever was less. The instant petition was filed challenging the change

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[11] (1998) 8 SCC 552
[12] (1998) 4 SCC 117
[13] In Surjeet Singh case, Appellant was reimbursed at the rates of AIIMS even though he was treated abroad; or in Devindar Singh Shergil case, where the Appellant was reimbursed at the rate prevailing at AIIMS even though there were other hospitals specified in State Health policy that were cheaper than AIIMS

in State policy for reimbursement of medical expenses incurred by its serving and retired employees.

The Appellants justified the change on the ground that under the earlier policy bulk of the budget was spent on a few elites for such treatments like heart ailment etc. to the detriment of a large number of other employees as the State was not in a position to reimburse them out of the remaining funds. Hence the facility of reimbursement of full charge at designated hospitals was withdrawn.

SC held that Court cannot question the propriety of a policy decision unless it is arbitrary and violates any constitutional rights. So far as the constitutional obligation of State, it must provide for basic infrastructure for maintaining and improving public health. *State renders this obligation by opening Government hospitals and health centres, but in order to make it meaningful, it has to be within the reach of its people, as far as possible, to reduce the queue of waiting lists, and it has to provide all facilities for which an employee looks for at another hospital. At the same time no State has unlimited resources to spend on any of its project. That is why it approves its projects to the extent it is feasible. The same holds good for providing medical facilities to its citizens including its employees. Provisions of facilities cannot be unlimited. It has to be to the extent finances permit.* Article 41 of the Constitution also acknowledges the limited means of State to serve the public and states that 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. *Hence, the principle of fixation or rate and scale under the new policy was justified and could not be held as infringing 'right to life'.*

K.P. Singh v. Union of India[14] was a case filed by retired government employees against the procedural difficulties in Central Government Health Scheme (CGHS) for pensioners to receive timely treatment and reimbursement of expenditure incurred on such treatment. The Petitioners grievances were:

For the purpose of reimbursement of claims relating to medicine that were outside the CGHS formulary, CGHS beneficiaries other than retired government employees and freedom fighters could procure such medicines directly from a registered chemist and claim reimbursement on the strength of a filled-in pro forma of the service head of their respective ministry, department or office. While in case of retired beneficiaries under the Scheme, such medicines had to be indented by the CGHS dispensary concerned. The indentation process was tedious and time consuming hence the medicines could not be taken in time.

Secondly, a beneficiary of the Scheme would receive reimbursement only at a rate approved by the CGHS however such rates were not updated from time to time. Further, rates of CGHS did not consider that in some towns or cities, like that of the petitioner, there were no government hospitals therefore, retired employees had no option but to receive treatment at private hospitals that were expensive and a heavy burden on their meager pockets.

SC directed Respondents to issue circulars to the effect that in case of emergency, medicines that are outside the CGHS formulary could be obtained immediately from the local chemist concerned on the basis of an authority slip from the CMO in-charge

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[14] (2001) 10 SCC 167

of the CGHS dispensary. However, SC refused to grant any relief vis-à-vis the rate of reimbursement as it was *not within its power to dictate policy to State*, though it may direct the State to review its rates and issue appropriate directions.

In **Kamlesh Sharma v. Municpal Corporation of Delhi**[15] the case was filed against the order of the Respondent by which it rejected the Petitioner's claim for reimbursement of expenditure incurred on medication for her husband. Petitioner's husband was earlier a Government servant and covered by the State Health Policy and was being treated at one of the hospitals earmarked under the said policy. During the course of treatment certain medicines were urgently required which were out of stock and therefore, were purchased by the Petitioner from outside. Petitioner was not reimbursed for the medicines purchased from outside. Respondent justified the impugned order on the ground that it was government policy to provide medicine to its pensioners but not to reimburse for purchases made from outside. The office order on which Respondents relied read as:
'All medicines etc. including diagnostics facilities as is required for treatment of patients (pensioners and their families) will be provided free of charge at the Hospitals/Dispensaries……..However, in no case reimbursement of expenditure incurred by a pensioner on treatment will be made.'
The policy of Respondent to the extent it refused reimbursement was challenged as being unreasonable and arbitrary, and liable to be struck down as unconstitutional. High Court held the policy to the extent it refuses reimbursement as unconstitutional. However it also clarified that *its order should not be understood as whittling down the right of the Respondents to frame or formulate a policy including one providing restriction or ceiling on reimbursement of expenses as long as the said policy is not violates Articles 14 & 21.*
In other words, Courts cannot adjudicate on the propriety of government policy unless it is discriminatory or violates right to life. Judiciary cannot step into the shoe of Government and issue policies. Court will refuse to entertain matters that are solely filed on the basis that a more beneficial policy could have been issued.

D. CASES ON RIGHTS OF PRISONERS/DETENUS:

In **Rama Moorthy's** case the Court observed that Society has an obligation towards prisoner's health for two reasons: firstly, the prisoners do not enjoy the access to medical expertise that free citizens have. Their incarceration places limitations on such access, choice of physician, modes of taking second opinion, and access to any specialist. Secondly, because of the conditions of their incarceration, inmates are exposed to more health hazards than free citizens. Prisoners therefore, suffer from a double handicap.[16]

In **Marri Yadamma v. State of Andhra Pradesh**[17] the deceased was an under trial who died of 'congestive cardiac failure'. The petition was filed by his spouse alleging negligence on part of the jail authorities and jail doctor in not providing appropriate treatment on time or referring to a specialist to determine the root cause of the ailment.

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[15] Delhi HC dt 3/10/2002
[16] Rama Murthy v. State of Karnataka (1997) 2 SCC 642
[17] AIR 2002 AP 164

The deceased was in the jail for a span of nearly six months during which he complained of abdominal pain, giddiness, vomiting etc. No effort was made to diagnose the cause of the deceased condition. On 25/1/1995 he complained of acute abdominal pain and was admitted from in the jail hospital. On 29/1/1995 he was shifted to a Government hospital where he breathed his last on 30/1/1995. The post-mortem report showed that left and right lungs were congested and pleural cavities were normal, heart was massively thickened and the aortic valves were fibrosed, aoratic opening was dilated and stomach was found empty. The cause of death was noted as due to congestive cardiac failure associated with aortic valve disease.

High Court observed that the condition of the deceased at the time of his death were such that could have developed over a period of time and not immediately. Thus, it is abundantly clear that no care or caution was taken by the Respondents to get the deceased examined by a Surgeon or a specialist, even though he was complaining of ailments very often. Further, High Court expressed doubt over the genuineness of the medical record maintained by the jail hospital. If the cause of death of the deceased was congestive cardiac failure associated with aortic valve, then deceased must have complained about some form of heart ailment one or two months prior to his death. As the jail authorities had suppressed original records the same remained a question. *High Court stated that on arrest prisoner merely loses his right to free movement. His all other rights including right to medical treatment remains intact and it cannot be violated.* The jail authorities had infringed fundamental right of the deceased therefore the State was liable to compensate his widow as a public law remedy for an amount of Rs.2 lacs.

In **Noorunissa Begum v. District Collector, Khammam**[18] the Petitioner's husband died in jail due to negligence on part of jail authorities in providing timely medical care and attention. On an inquiry it was found that few days prior to the death, he had complained of chest pain and on the fatal day when he collapsed there was a delay of nearly four hours to arrange for escort to take him to a government hospital. There was no hospital or medical facility within the jail premises.

Jail authorities defended allegations of negligence in discharge of their duty on the ground that under Andhra Pradesh Prisoners (Attendance in Court) Rules, 1977, no prisoner could be taken out of prison without armed police escort, and that the delay in shifting the deceased to the hospital was due to delay in arranging armed police force escort.
High Court reiterated the law laid down by Supreme Court in Parmanand Katara case wherein it was stated that no state action or provision of law can intervene in ensuring timely treatment a person in need of medical care, and held jail authorities negligent and State liable to pay Rs.1,50,000/- as compensation to the Petitioner.

Further, High Court also directed State to consider the proposal to include Rule 10-A in Andhra Pradesh Prisoners (Attendance in Court) Rules, 1977 that had been pending before it, and decide upon it within a time frame.[19] Rule 10-A read as:

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[18] AP HC dt. 27/6/2001

[19] As a rule, power of judiciary cannot stretch into the arena of legislature. It cannot direct Parliament or state legislature to pass enactment, however, in the instant case High Court acted to the contrary. The fact that the proposal of Inspector-General of Prisons and Director of Correctional Services, Hyderabad was already in existence to insert Rule 10-A, gave legitimacy to the directions of High Court. In the absence of the same and in

'Escort for persons confined in a prison requiring treatment in a hospital outside the prison, and from such hospital to the prison, shall be undertaken by the police. If such a prisoner is admitted as in-patient in any hospital, his custody during the period of such confinement shall be undertaken by the police.'

In **Directorate of Enforcement v. Ashok Kumar Jain**[20] the Court held that the Police is as much under a statutory obligation to preserve the life of persons under its custody by ensuring medical care and treatment, and taking into account the condition of their health. However, the right of such persons cannot be used as shield to hinder police investigation.
In the instant Appeal, documents were recovered from the possession of Respondent that showed there was a gross violation of Foreign Exchange Regulation Act. Respondent sought anticipatory bail to avoid interrogation on the ground that he suffered from serious heart condition and produced medical records to support his plea. High Court passed a conditional order stating that '*in case the Directorate considers custodial interrogation of the Respondent necessary, it should approach the Director, AIIMS to constitute a Board of cardiologists to examine the Respondent, and if the said Board forms an opinion that custodial interrogation is not feasible in that event it will be open to the officials to interrogate him under the care of doctors at AIIMS.*'

Appellant challenged the condition imposed upon it by the High Court. Supreme Court held that High Court was wrong in imposing conditions on the Directorate regarding the manner in which interrogation of the Respondent was to be modulated. "*No doubt investigating officials of the Enforcement Directorate are duty-bound to bear in mind that Respondent has put forth a case of delicate health condition. They cannot overlook it and they have to safeguard his health while he is in their custody. But to say that interrogation should be subject to the opinion of the cardiologists of the AIIMS and that the officials of the Directorate should approach the Director of AIIMS to constitute a Board of Cardiologists to examine the Respondent etc. would, in our opinion, considerably impair the efficient functioning of the investigating authorities under FERA. The authorities should have freedom to chalk out such measures as are necessary to protect the health of the person who would be subjected to interrogatory process. They cannot be nailed to fixed modalities stipulated by court for conducting interrogations.*"

D.K. Basu Vs. State of West Bengal[21] is a landmark case on rights of arrestees. The Supreme Court prescribed a number of guidelines to be mandatorily followed concerning arrested persons. Two of these directions pertained to health. The Court observed:

> "The arrestee should be subjected to medical examination by a trained doctor every 48 hours during his detention in custody by a doctor on the panel of approved doctors appointed by Director, Health services of the concerned State or Union territory, Director, Health Services shall prepare such a panel for all Tehsils and Districts as well."

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consideration of the limitation of judicial review, it is unlikely High Court would have passed such an order.
[20] (1998) 2 SCC 105
[21] AIR 1997 SC 610

E. CASE LAW CONCERNING MENTALLY ILL PATIENTS:

In the case of **Death of 25 chained inmates in Asylum fire in TN., in Re. v. Union of India**[22] the issue of rights of inmates of mental asylum was raised. This petition sought directions for implementation of provisions of Mental Health Act, 1987 to prevent another mishap of the kind in mental asylum in Tamil Nadu.
In light of the provisions of Mental Health Act, Supreme Court issued following directions for its implementation:-

Every State and Union Territory must undertake a district-wise survey of all registered/unregistered bodies, by whatever name called, purporting to offer psychiatric/mental health care. All such bodies should be granted or refused licence depending upon whether minimum prescribed standards are fulfilled or not. In case licence is rejected, it shall be the responsibility of SHO of the concerned police station to ensure that the body stops functioning and patients are shifted to government mental hospitals.

Chief Secretary or Additional Chief Secretary designated by him shall be the nodal agency to coordinate all activities involved in implementation of the Mental Health Act, 1987, the Persons with Disabilities (Equal Opportunities, protection of rights and full participation) Act, 1995 and National Trust for Welfare of Persons with Autism, Cerebral Palsy, mental Retardation and Multiple Disability Act, 1999. He shall ensure that there are no jurisdictional problems or impediments to the effective implementation of the three Acts between different Ministries or Departments. At the Central level, Cabinet Secretary, Government of India or any Secretary designated by him shall be the nodal agency for the same purpose.

The cabinet Secretary, Union of India shall file an affidavit in SC within one month from the date of this order indicating:

a) The contribution that has been made and that is proposed to be made under Section 21 of the 1999 Act which would constitute corpus of the National Trust.
b) Policy of the central Government towards setting up at least one Central Government-run mental hospital in each State and union Territory and definite time schedule for achieving the said objective.
c) National policy, if any framed under Section 8(2)9b) of the 1995 Act.
d) In respect of the States/UT that do not have even one full-fledged State Government-run mental hospital, the Chief Secretary of the State/UT must file an affidavit within one month from date of this Order indicating steps being taken to establish such full-fledged State Government-run mental hospital in the State/UT and a definite time schedule for establishment of the same.
e) Both Central and State Governments shall undertake a comprehensive awareness campaign with a special focus to educate people as to provisions of law relating to mental health, rights of mentally challenged persons, the fact that chaining of mentally challenged persons is illegal and mental patients should be sent to doctors and not to religious places for treatment.

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[22] 2002 3 SCC 31

Every State shall file an affidavit stating:

Whether the state Mental Health Authority under Section 3 of the 1987 Act exists in the State and if so, when was it set up.

If it does not exist, the reason thereof and when such an Authority is expected to be established and operationalised.

The dates of meetings of those Authorities, which already existed, from the date of inception till date and a short summary of the decisions taken.

A statement that the State shall ensure that meetings of the Authorities take place in future at least once in every four months or at more frequent intervals depending on exigency and that all the statutory functions and duties of such Authorities are duly discharged.

The number of prosecutions, penalties or other punitive/coercive measures is taken, if any, by each State under the 1987 Act.

In the case of **Peoples' Union of Civil Liberties v. Union of India**[23] a public interest litigation was filed against the Government for backing out of a project to build a psychiatric hospital-cum-medical college in Delhi. The plan had been approved but when it was found that over Rs. 40 crores would be the expenditure, Delhi Administration expressed its inability to fund such a project and Central Government refused to take its responsibility.

Supreme Court held that setting up of a psychiatric hospital in the capital city was necessary. Once land has been earmarked and on principle a decision taken that hospital should be shifted and part of it should be converted into a teaching institution while the other part should be a hospital, funding should not stand in way of locating such a hospital. It may be difficult to fund such a huge amount in a year unless this is taken up as a continuous project spread over a period the hospital contemplated can certainly be brought into existence. Hence, the Central Government and Delhi Administration were directed to recommence and finish the project.

F. CONCLUSION

Fundamental right to health and health care has been recognized by the Supreme Court. This is a major leap. But there are limitations. First, fundamental rights are available only against the State and not against private individuals. Second, the State is required to enforce this fundamental right subject to financial availability. However, within this framework citizens have been using the fundamental right to get better facilities from State hospitals, cast obligations on State doctors and on custodial institutions. Prisoners and mentally ill have been held to be equally endowed with this right. The growth of environmental litigation in India is premised on the recognition of right to health as a fundamental right.

A negative fundamental right casts an obligation on the State not to act in a manner which would deprive a citizen of her fundamental right. On the other hand, a positive fundamental right would mandate the State to take proactive measures to fulfill its obligation. Time has come for the Courts to recognize that right to health and health care is a positive fundamental right which cannot be contingent upon the financial capacity of the State.

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[23] Decision of the Supreme Court given on 12/11/1991

III

DRUGS & PUBLIC HEALTH

A. INTRODUCTION

- Licencing : important factor in Drugs.

Access to cheap drugs is an essential aspect of right to healthcare. There are two major laws which govern these aspects.

1. Drugs and Cosmetics Act, 1940
2. Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954

Apart from this of course is the Patents Act and its recent amendments which increasingly play an important part in making right to health substantial for the people. Essentially the expectation from the legislation is that it should ensure supply of cheap and sufficient drugs as also protect persons against spurious and harmful drugs.

Universal health care and access to health care requires affordable drugs. Besides, the drugs need to easily available and of good quality. They should neither be spurious or damaged. They should be able to achieve what they claim to be doing. Drug Price Control Orders issued from time to time seek to ensure that prices of essential drugs are kept under check and within easy reach. Unfortunately since the Indian Government zealously undertook the path of liberalization and privatization the Drug Price Control Orders have been whittled down and the prices of many affordable drugs have been allowed to spiral. Challenge to this is pending in the Supreme Court and the outcome is awaited.

Also the Indian Patents Act ensured availability of cheap generic drugs by adopting the product rather than process patent and further having relaxed provisions considering compulsory licensing and import substitution. Of course, since India signed the TRIPS Agreement the Patent Act has been amended to do away with substantially many of these protections. Thus in future cheap generic drugs will become very difficult to access. The changes are too judge the judicial responses to them but looking at the trends of the judiciary it is very likely that the access drugs will be limited.

The other aspect concerns the responsibility of public hospitals in giving free or subsidized drugs to patients. Even here, the State has been over a period been weaning away from its responsibility with reduced investment in healthcare and consequently drugs and increased user charges.

Drugs and Cosmetics Act regulates the quality of drugs, its manufacture, distribution and sale. Quality control in drugs is sought to be ensured through licensing and supervision procedures. A large number of judgments pertain to conditions of licensing and revocation of licenses.

Chp IV deals with the manufacture, sale and distribution of drugs. Section 16 stipulates that for the purpose of the said Chapter, expression 'standard quality' in relation to a drug means that the drug should comply with the standard set out in Second Schedule. Section 17 of the Act defines 'Misbranded drugs'; Section 17-A 'Adulterated drug'; and Section 17-B spurious drugs.

S.17. Misbranded Drug:- for the purposes of this Chapter, a drug shall be deemed to be misbranded-

(a) If it is so coloured, coated, powdered or polished that damage is concealed or if it is made to appear of better or greater therapeutic value than it really is; or
(b) If it is not labeled in the prescribed manner; or
(c) If its label or container or anything accompanying the drug bears any statement, design or device which makes any false claim for the drug or which is false or misleading in any particular.

Section 17A. Adulterated Drugs- For the purpose of this Chapter, a drug shall be deemed to be adulterated-

- *(a) If it consists in whole or in part, of any filthy, putrid or decomposed substances; or*
- *(b) If it has been prepared, packed or stored not under sanitary conditions whereby it may have been contaminated with filth or whereby it may have been rendered injurious to health; or*
- *(c) If its container is composed, in whole or in part, of any poisonous or deleterious substances which may render the contents injurious to health; or*
- *(d) If it bears or contains, for purposes of colouring only, a colour other than one which is prescribed; or*
- *(e) If it contains any harmful or toxic substance which may render it injurious to health; or*
- *(f) If any substance has been mixed there with so as to reduce its quality or strength.*

Section 17B. Spurious Drugs- For the purposes of this Chapter, a drug shall be deemed to be spurious-

- *(a) If it is manufactured under a name which belongs to another drug; or*
- *(b) If it is an imitation of, or is a substitute for, another drug or resembles another drug in a manner likely to deceive or bears upon it or upon its label or container the name of another drug unless it is plainly and conspicuously marked so as to reveal its true character and its lack of identity with such other drug; or*
- *(c) If the label or container bears the name of an individual or company purporting to be the manufacture of the drug, which individual or company is fictitious or does not exist; or*
- *(d) If it has been substituted wholly or in part by another drug or substance; or*
- *(e) If it purports to be the product of manufacture of whom it is truly a product.*

Section 18. Prohibition of manufacture and sale of certain drugs and cosmetics- From such date as may be fixed by the State Government by notification in the official Gazette in this behalf, no person shall by himself or by any other person on this behalf-

- *(a) Manufacture for sale or for distribution, or sell, or stock or exhibit or offer for sale, or distribute-*
  - *i) Any drug which is not of a standard quality, or is misbranded, adulterated or spurious;*
  - *ii) **
  - *iii) Any patent or proprietary medicine, unless there is displayed in the prescribed manner on the label or container thereof the true formula or list of active ingredients contained in it together with the quantities, thereof;*

iv) *Any drug which by means of any statement, design or device accompanying it or by any other means, purports or claims to prevent, cure or mitigate any such disease or ailment, or to have any such other effect as may be prescribed;*

v) *

vi) *Any drug or cosmetic in contravention of any provision of this Chapter or any rule made there under;*

(b) *Sell or stock or exhibit or offer for sale, distribute any drug or cosmetic which has been imported or manufactured in contravention of any of the provisions of this Act or any rule made there under;*

(c) *Manufacture for sale or for distribution, or sell, or stock or exhibit or offer for sale, or distribute any drug or cosmetic, except under, and in accordance with the condition with the conditions of, a licence issued for such purpose under this Chapter*

Provided that nothing in this section shall apply to the manufacture, subject to prescribed conditions, of small quantities of any drug for the purpose of examination, test or analysis:

Provided further that the Central Government may, after consultation with the Board, by notification in the Official Gazette, permit, subject to any conditions specified in the notification, the manufacture for sale or for distribution, sale stocking or exhibiting or offering for sale or distribution of any drug or class of drugs not being of standard quality.

Sections 20 & 21 contemplate appointment of Government Analysts & Inspectors, respectively by the Central and State Government to execute the purposes of the Act. Inspector has various powers including that of inspection, taking samples of any drug and cosmetic, examination of any records, registers or documents et al, and search and seizure.

Section 27 prescribes penalty for manufacture, sale etc., of any drug which is adulterated or spurious or any drug used by any person for or in the diagnosis or prevention of any disease or disorder, which is likely to cause death or is likely to cause such harm to the human body, which would amount to grevious hurt within the meaning of Section 320 IPC, punishable with imprisonment for a term which may extend up to a term of life and with fine.

The other aspect concerns what is known as 'magic remedy' i.e. persons making flimsy claims that they have remedy for a disease which is otherwise not curable or remedies which do not really fall into any known scientifically tested categories.

The Act specifies two kinds of offences: advertisement of drugs for diseases specified in the Act, or rules that are made under the Act, and advertisements that are misleading about the nature, cure and any other material particular of the drug so advertised.

Section 3: Prohibition of advertisement of certain drugs for treatment of certain diseases and disorder

Subject to the provisions of this Act, no person shall take '*any part in the publication of any advertisement*' referring to any drug in terms which suggest or are calculated to lead to the use of that drug for-

(a) procurement of miscarriage in women or prevention of conception in women; or
(b) maintenance or improvement of the capacity of human beings for sexual pleasure; or
(c) correction of menstrual disorder in women; or
(d) diagnosis, cure, mitigation, treatment or prevention of any disease, disorder or condition specified in the Schedule, or any other disease, disorder or condition specified in the Schedule, or any other disease, disorder or condition (by whatsoever name called) which may be specified in the rules made under this Act:
Provided that no such rule shall be made except-
(i) in respect of any disease, disorder or condition which requires timely treatment in consultation with a registered medical practitioner or for which there are normally no accepted remedies, and
(ii) after consultation with the Drugs Technical Advisory Board constituted under the Drugs and Cosmetics Act, 1940 and, if the Central Government considers necessary, with such other persons having special knowledge or practical experience in respect of Ayurvedic or Unani systems of medicines as that Government deems fit.[1]

Section 4: Prohibition of misleading advertisement relating to drugs

Subject to the provisions of this Act, no person shall take any part in the publication of any advertisement relating to a drug if the advertisement contains any matter which-
(a) directly or indirectly gives a false impression regarding the true character of the drug; or
(b) makes a false claim for the drug; or
(c) is otherwise false or misleading in any material particular.

B. Case Law

a. Spurious and Dangerous Drugs

S.R. Pvt. Ltd v. Prem Gupta, Drug Controller (India) New Delhi[2] was a case dealing with ban on spurious drugs. The petition challenged the order of Central Government under S. 26-A of the Drugs and Cosmetics Act, 1940 whereby it banned the manufacture and sale of the fixed dose combination steroids.

Section 26-A of the Act empowers the Central Government to prohibit in public interest the manufacture, sale or distribution of any drug if it is satisfied that the use of such drug is likely to involve any risk to human beings or it does not have the therapeutic value claimed or purported to be claimed in it.

The Act provides for the constitution of 'Drugs Technical Advisory Board' to advice Central and State Government on any matter tending to secure uniformity throughout the country in the administration of the Act. The Board is to comprise of persons with expertise in drugs along with representations from Central and State Government. The ban on fixed dose combinations of steroids was imposed after consultation with the Technical Advisory Board.

The issue before HC was whether the Central Government had acted arbitrarily or the opinion tendered by the Board was arbitrary and without substance. HC held that the advice tendered by the Board consisting of experts, who have special knowledge and

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[1] Section 5 applies to advertisement of magic remedies mutatis mutandis
[2] AIR 1993 P&H 28

experience in respect of different kinds of drugs, and the opinion formed after due exchange of views in itself ensures that the opinion given by the Board has a rational basis and suffices for Central Government to issue notification in exercise of its power under S.26-A of the Act. *When such a high powered body consisting of experts arrives at such a decision after due consideration and exchange of views, we have to presume that the advice tendered is good in the absence of any basis to characterize it as arbitrary. In this case there is no material or basis to discard the opinion formed and the advice tendered by the Board. Therefore, as the Central Government has exercised its power under S. 26A of the Act on the advice tendered by the board, we are unable to agree that the impugned notification is illegal, arbitrary or violates of Articles 14 and 19(g) of the Constitution.*

The Court therefore concluded that when the State acts on the recommendation of an expert body and prohibits a particular drug or combination, the Court will not ordinarily interfere in such a decision.

A similar situation arose in **Laxmikant v. Union of India**[3] where the Central Government in exercise of its powers under Section 33EE of the Act banned in public interest the manufacture and sale of all Ayurvedic drugs licensed as toothpaste/toothpowders containing tobacco.

Appellant contended that they used only 4% of tobacco and there was no conclusive evidence to show that such a minute quantity could pose threat to health, and even members of the Advisory Board under the Act held divergent views on it, therefore, such ban was arbitrary and violated their right to carry on trade.

Supreme Court held that Central Government in consultation with Ayurvedic, Siddha and Unani Drugs Technical Advisory Board, an Expert Body constituted under Section 33D of the Act, had arrived at a conclusion that tobacco contained carcinogenic elements therefore its use should be banned. A similar view was expressed in an International Conference held at AIIMS, New Delhi in collaboration with WHO. Hence, the Court held that even though the ban offends the right to carry on trade, it is justified in public interest and falls under Article 19(6) of the Constitution being a reasonable restriction on right to carry on trade or business.

In **Bharat Biotech International Ltd. V. A.P. Health and Medical Housing and Infrastructure Development Corporation**[4] WHO pre-qualification was made an eligibility criterion for tender for supply of Hepatitis-B drugs. This was challenged as arbitrary and with the intent to exclude competition in favour of one manufacturer. HC evaluated the provisions of Drugs and Cosmetics Act to determine if it provided an efficient machinery to ensure standard quality of drugs or if WHO pre-qualification actually set higher standards, which would justify the impugned decision. High Court concluded that the State had failed to establish that WHO adopts any standards which are higher than the standards adopted by the Indian Law for assessing the quality of the product. It held that the Indian Laws are very stringent in ensuring high standard of drugs but have been futile because of laxity on part of State in enforcing the law. Instead of rectifying the implementation of the Act, State cannot seek shelter in such a manner.

Definition of Drug

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[3] SC dt. 11/4/1997

[4] AP HC dt. 10/12/2002

Cadila Pharmaceuticals Ltd. V. State of Kerela[5] was a case which dealt with definition of the term drug. Under the Indian legal system drugs cannot be manufactured without a license. Licensing provisions are meant for ensuring quality and content. It is in the interest of manufacturers to avoid taking licenses as then anything can be sold without there being quality control. Thus many ingestibles are given fancy names in order to claim that they are not "drugs". Petitioner manufactured EC 350 (Vitamin E & C) capsules and Cecure (Multi-vitamin capsules) which were sold in market through medical shops as 'Dietary supplements'. The issue before the Court was whether vitamin capsules fall under the definition of 'drugs' under the Drugs and Cosmetics Act and therefore, required license.

Section 3(d) of the Act defines Drugs which definition includes-

(i) all medicines for internal or external use of human beings or animals and all substances intended to be used for or in the diagnosis, treatment, mitigation or prevention of any disease or disorder in human beings or animals, including preparations applied on human body for the purpose of repelling insects like mosquitoes;

(ii) such substances (other than food) intended to affect the structure or any function of the human body or intended to be used for the destruction of (vermin) or insects which cause disease in human beings or animals, as may be specified from time to time by the Central Government by notification in the Official Gazette;

(iii) all substances intended for use as components of a drug including empty gelatin capsules; and

(iv) such devices intended for internal or external use in the diagnosis, treatment, mitigation or prevention of disease or disorder in human beings or animals, as may be specified from time to time by the Central Government by notification in the Official Gazette, after consultation with the Board.

Petitioner contended that the vitamin capsules in question were for general well-being, and not a cure or prevention of any disease or disorder. Therefore, it did not fall within 'drugs' within the meaning of S.3(d)(1).

High Court disagreed with the submission of Petitioner that the two products in question are not part of any treatment of disease or disorder. It stated that the vitamin capsules in question were not used by any person as a general dietary supplement. Vitamin deficiency in human beings may result in certain diseases beings. In such cases doctors prescribe these vitamin capsules of a definite dosage which mitigates or prevents such diseases. These vitamins capsules therefore squarely fall within the definition of 'drugs' under the Act.

Similarly, in **Chimanlal v. State of Maharashtra**[6] the issue before the Supreme Court was whether 'absorbent cotton, wool, roller bandages and gauze' are drugs under the Act. Supreme Court held that the definition of 'drugs' in S.3(d) of the Drugs Act is comprehensive enough to cover not only medicines but also substances intended to be used for or in treatment of diseases of human beings. 'Absorbent cotton, wool, roller bandages and gauze' are substances used for or in treatment of disease,

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[5] AIR 2002 Kerela 357

[6] AIR 1963 SC 665

and hence are 'drugs' for the purposes of the Act. *The main object of the Act is to prevent sub-standard drugs, presumably for maintaining high standards of medical treatment. That would certainly be defeated if the necessary concomitants of medical or surgical treatment were allowed to be diluted.*

Sale and Stocking of Drugs

In **Holy Cross Hospital v. State of Kerela**[7] the Petitioner was a charitable hospital that stocked medicines for its patients. The petition challenged the order of Drug Controller enforcing the system of Drugs Licence to Petitioner's hospital. Section 18 of the Act states that sellers, stockiest and persons similarly situated are obliged to secure license before stocking drugs. Charitable hospitals were earlier exempted from this requirement but through an amendment this exemption was withdrawn and this was challenged.

Government of India via its G.S.R. 812(6) dated 14.11.1994 continued the exemption only in favour of registered medical practitioners, and hospitals/dispensaries maintained or supported by Government or local authorities.

The High Court, however, held that the broad classification between private or charitable hospitals and hospitals/dispensaries under the supervision of Government or local medical bodies was valid and there was nothing unconstitutional in requiring private hospitals to get license for stocking drugs.

In the case of **Kasim Bhai v. State**[8] the accused was the owner of a medical shop that was duly licensed. However he was charged with:

i) possession of drugs covered by Schedule H without having a qualified man under whose supervision sale of such drugs could be executed; and
ii) he was found in possession of and exhibiting for sale expired penicillin ointment.

Rule110 Sub-rule 9 of Rule 65 of Drugs and Cosmetics Rules reads 'Substance specified in Schedule H, and preparations containing such substances, shall not be sold by retail except on and in accordance with a prescription of a registered medical practitioner provided that no prescription shall be required for sale or supply to a registered medical practitioner, hospital, infirmary, or an institution approved by an order of a licensing authority.'

High Court held that Sub-rule 9 referred to sale of drugs specified in Schedule H whereas charges against the accused were for storage of such drugs and not for sale of these drugs. Hence he was absolved of his first charge. As regards the second charge, it was contended by the accused that there was nothing on record to show that the Penicillin tubes were kept in the shop or were exhibited there for purpose of sale. High Court however did not accept this defense and held that when a particular medicine is kept in the shop there will be a presumption that it is there for the purpose of sale unless that presumption is rebutted by the accused.

Swantraj v. State of Maharashtra[9] was an important case concerning storage of drugs in transit. The Appellant had a wholesale dealer license to stock drugs at

[7] Kerela HC decided on 25/2/2002
[8] AIR 1956 Allahabad 703

Bombay and a further license to distribute the drugs *through the motor van* throughout the territory of the State of Maharashtra. Appellant booked certain drugs to distribute in the licensed area. The van which was to receive the stock was held up for a few days. The delivery was received by one of the partners of the Appellant-firm who temporarily stored the drugs in the godown of a local drug dealer to load the van as and when it arrived. The charge against the Appellant-firm was that it did not have the license to stock the drugs at the latter place, therefore they acted in contravention of the provision of Drugs and Cosmetics Act, and were liable for punishment under S.27(b).

The issues before the Supreme Court were:

1. Whether temporary deposit of drugs in a place outside Bombay for which place Petitioners had no license to stock goods, amounts to stocking for sale or distribution (for which license is required)?
2. Whether stocking with the purpose of selling the drugs at another and not from the place of stocking requires license? In other words, whether it can be inferred that drugs stocked are stocked for sale?

Supreme Court interpreted Rules 61 & 62 so as to draw the conclusion that the Rules specify the forms that may be issued and the content and purpose thereof. There is no scope of reading anything into it. The Rules do not cover storage in transit. *Storage in transit must also be licensed so that medicines do not suffer in the process.*

The Appellant pleaded that license should not be insisted upon for every place of make-shift storage in far-flung areas. Supreme Court stated that the paramount purpose of regulation through licensing is to set in motion vigilant medical watch over maintenance of the standard quality of drugs and medicines and verification of its expiry date and spuriousness of the products. If godowns, temporary stores ad depots can remain unlicensed, they escape official attention and can deteriorate into pool of dubious or deceptive drugs harmful to society. Every place where storage for sale is made must be licensed.

The second issue was whether goods stored in transit will be considered at stocked for sale. Supreme Court held in the affirmative after relying on the *'Doctrine of mischief'* which states that such interpretation of a statute must be upheld that serves its purpose even if by doing so some persons' interest is wrongly affected so that mischief by those who would use any other judicial interpretation to serve their purpose in contravention to the general object of the statute is avoided.

SC thus concluded:

1) Licences under Rules 61 & 62 proviso will extend to grant of licences for wayside depots or 'emergency stores' or 'vehicles', but every storage for sale must have license.
2) License permitting sale by a vehicle cannot automatically cover cases of 'emergency storage' or storage in transit. The words of Section 18(c) & Rule 62 are mandatory being plain and admitting no exceptions.
3) Applying the mischief rule of interpretation, storage even though for a short spell or on ad hoc basis and without intent to sell at that place but as a part of the sale business comes within the scope of 'storage for sale' in Section 18(c) & Rule 62.

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[9] (1975) 3 SCC322

In **Sagar Medical Hall** v. **State of Bihar**[10] a petition was filed against the order of State Government restraining the Regional Licensing Authorities from issuing or renewing license for wholesale and retail sale of drugs. State Government's justification for its policy decision was that the ban on issuance of wholesale and retail drug license was a temporary measure to prevent spurt of spurious drugs. There were adequate drug stores to meet public need. A mushrooming of drug stores would lead to decline in turnover and loss, which would cause drug stores to sell spurious drugs to sustain themselves.

Petitioners contended that license cannot be refused when all the conditions attached to it have been complied with. The Act does not impose any such ban or gives power to impose such a ban.

Rule 64 provides for conditions subject to which licence shall be granted or renewed.

HC held that grant and renewal of drug is governed by statutory rules and nowhere do such rules provide that the license can be declined or renewal refused on the ground that in the opinion of the State Government the number of shops are sufficient to meet demand of public. Thus, executive decisions of the State cannot override the statutory provisions. Growth of drug stores is to cater the needs of public. State cannot regulate grant of license because they cannot efficiently control the menace. The State Government has an entire department to control and prevent sale of spurious drugs.

Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954

The purpose of this Act is to prevent danger of self-medication and inducement to take drugs for certain specific disease, condition or disorder, by advertising its alleged magical properties or healing power.

In **Hamdard Dawakhana** v. **Union of India**[11] the constitutionality of the Act was challenged before the Supreme Court on the ground that its violates the freedom to speech and expression under Article 19(1)(a).[12]

Supreme Court upheld the Constitutionality of the Act and stated that *'An advertisement is no doubt a form of speech but its true character is reflected by the object, for the promotion of which it is employed. It assumes the attributes and elements of the activity under Art. 19(1)(a) which it seeks to aid by bringing it to the notice of public. When it takes the form of a commercial advertisement which has an element of trade or commerce, it no longer falls within the concept of freedom of speech, for the object is not propagation of ideas, social, political or economic, or furtherance of literature or human thought, but the commendation of the efficacy, value and importance of certain goods.*

It cannot be said, therefore, that every advertisement is a matter, dealing with freedom of speech nor can it be said that it is an expression of ideas. In every case one has to see what is the nature of the advertisement and what activities falling under the Article 19(1), it seeks to further.

The advertisements prohibited by S.3 of the Act relates to commerce or trade and not to propagation of ideas, and advertising of prohibited drugs and commodities of which the sale in not in public interest, cannot be speech within the meaning of freedom of speech and would not fall within Art/. 19(1)(a). As the main purpose and

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[10] (CWJC) Patna HC dt. 7/12/01

[11] AIR 1960 SC 554

[12] Sections 3(d) & 8 were also challenged for giving unhindered power to the executive under the Act, and both were held ultra vires. In 1963 Parliament rectified the flaws.

true intent and aim, object and scope of the Act is to prevent self medication or self-treatment and for that purpose advertisements commending certain drugs and medicines have been prohibited, it cannot be said that this is an abridgement of the Petitioner's right to free speech.'

In [13]**State of Karnataka** v. **R.M.K. Sivasubramanya Om**[14] Drug Inspector raided the hotel room where the Respondent was staying pursuant to an advertisement published in a local paper, and seized drugs used to treat tuberculosis and sexual rigour and literature relating to these drugs. The advertisement read as:

'all diseases of any nature and how-long-standing
they may be are well attended to with utmost care.
To restore, regain and to retain vim, vigour and vitality,
use our 73 years very popular fully vitaminised
special invigorative nervine tonic for all.
Amazatone with Ton Ton Oil
Cost per set Rs.147/-
Medicines are available for all diseases.
Consult the Siddha Hakeem'

High Court opined that for a person to be liable under S.3 three ingredients are required, namely,

i) Accused should have taken part in publication of an advertisement
ii) Advertisement should relate to or should have reference to a drug.
iii) Such drug should be suggested as cure for diseases, condition or disorder specified under S.3.

Since the contravention of S.3 is made punishable, it should be construed strictly. High Court held the Respondent as not guilty for followings reasons:

i) It was not proved that Accused himself had authorized the publication of the advertisement.[15] The Advertisement Manager of the local paper in his deposition stated that though the advertisement in question was published on behalf of the Accused but it was not made clear who authorized the Manager to publish on behalf of the Accused.[16]
ii) There was no evidence to show that he had taken the seized drugs outside his hotel room for the public to see. There was no evidence to show that the accused had sent the literature or bottles outside for distribution. The material available on record merely pointed to the fact that the Drug Inspector had seized the articles from the possession of the accused when he was in his hotel room.
iii) 'Amazatone' is a special invigorative nervine tonic useful for all and will help to restore, regain and retain vim, vigour and vitality, it is nowhere even obliquely stated that it is a cure for impotence or that it helps the maintenance or improvement of the capacity of human beings for sexual pleasure. There was also no reference to Tuberculosis.

[13] S.6 prohibits import or export of any document containing advertisements of such nature as specified in Ss. 3, 4 & 5

[14] 1978 CRI.L.J. 853 (Karnataka HC)

15 S.9

[16] ibid para 13. The Advertisement Manager earlier in his statement before police had admitted that the advertisement was published at the behest of the Accused. The Manager retracted his statement by deposing that he had signed certain the statement without reading it. The Court expressed that the advertisement was not sufficient to hold the Accused guilty.

Dr. Yash Pal Sahi v. **Delhi Administration**[17] was a case where the Appellant was the proprietor of a Homeopathic hospital and publisher of a journal named 'Homoeopathic Doctor'. In a sting operation carried out by the Respondent, Appellant was asked to send copies of the said journal and a list of medicines printed by it. This was sent. The list of medicine had a note stating 'for the use of medical practitioners alone'.

Appellant's case was that he was protected under S.14(1)(c). Rule 6 of the Rules framed under the Act prescribe that:

'All documents containing advertisements relating to drugs, referred to in clause (c) of Sub-section (1) of Section 14, shall be sent by post to a registered medical practitioner or to a wholesale or retail chemist...Such documents shall bear on top, printed in indelible ink a conspicuous manner, the words 'For use only of registered medical practitioners or a hospital or a laboratory.'

As the list bore the words printed in indelible ink 'For the use of registered medical practitioners' he had complied with the provisions of law.

Supreme Court held that the person to whom the list of medicine was sent was not a medical practitioner and the Appellant did not even verify his profession before sending such a list. Therefore, Appellant's case did not fall under S.14(1)(c) and was guilty under S.3.

In **Zaffar Mohammad** v. **State of West Bengal**[18] the advertisement in question that was published in a local paper was as follows:

New life, New vigour, New spirit, New wave.
If you want a cure, see today well known, world famous experienced
registered Physician. Special diseases such as oldness in youth,
all sorts of **defects in nerves**, or weakness, laziness
are treated with full responsibility,
with new methods, new machines of science
and electric treatment and are cured permanently.....

'Disorders of the nervous system' is Item No.14 of the Schedule to the Act, hence the issue was whether the treatment and machines referred to in the advertisement were drugs for S.3 to apply.

Supreme Court held that *any article, other than food, which is intended to affect or influence in any way any organic function of the body of a human being is a 'drug' within the meaning of S.2(b)(iii). The so-called 'machines of science' or of 'electric treatment' whose magically curative properties were advertised in a newspaper by the Appellant to cure nervous diseases, and designed according to advertisement to confer on mankind the blessings of new life and new vigour, are 'articles' intended to influence the organic function of the human body. A machine is a tangible thing which can both be seen and felt and as such it answers the description of an 'article' within the meaning of S.2(b)(iii) of the Act.* Such advertisement was therefore not permitted and the accused had committed an offence.

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[17] (1963) 5 SCR 582
[18] AIR 1976 SC 171

C. CONCLUSIONS

Health care laws relating to drugs deal with two aspects. (i) Accessibility to drugs; and (ii) quality of drugs. As regards quality of drugs, there are sufficient provisions in the law to control the quality through licensing, supervision and provision of standards. Misleading advertisements are also prohibited. Most of the litigation concerning drugs has been on these aspects, though overwhelmingly by manufacturers and traders rather than by consumers.

On the other hand, legal provisions concerning affordability and accessibility to drugs are very few and even these have been whittled down over a period. Also, not much litigation has taken place on these issues but some of the Petitions concerning drug price control and similar issues are pending before the Courts and one needs to keep an eye on them to discern the trend.

IV OCCUPATIONAL HEALTH AND SAFETY & RIGHT OF WORKERS TO HEALTH

A. INTRODUCTION

There are four laws which have been enacted dealing with health care for workers. Factories Act, 1948 prescribes safety conditions for manufacturing processes. Workmen's Compensation Act deals with compensation to workers who suffer injuries at the place of work and suffer from specified occupational diseases. Employees' State Insurance Act, 1948, apart from dealing with compensation also is concerned with access to free medical care for employees. This includes setting up of dispensaries, hospitals and panel doctors whom the employees can approach. Maternity Benefit Act is concerned with providing paid medical leave to pregnant women workers coupled with certain other benefits. Apart from these general laws, certain specific Acts have been passed which also deal to a certain extent with the health care for workers. These include the Beedi and Cigar Workers Act, Mines Act, etc.

Prior to 1920s, it was believed that an employee by entering into a contract with the employer undertakes the risks involved in employment and therefore cannot hold the employer liable if he suffers from any injury or disease related to employment. But since 1920s, when the Employers Liability Act was enacted it was recognized that because of the unequal relationship between employer and employee no such presumption can be made. All these laws also recognize that it is the responsibility of the employer to provide safe work environment for employees. Over the years the laws have been amended to bring in more and more detailed safety provisions for employees. Of course, especially the safety laws are implemented more in their breach.

Most of these Enactments are more than 50 years old and obviously a large amount of litigation has taken place on these issues. Especially the Workmen's Compensation Act and ESI Act have been much used by employees who suffer from employment related injuries and diseases. An overwhelming amount of litigation has been concerning whether a particular injury or disease is employment related or not. Questions such as when an employee gets heart attack at work place, can it be called employment related injury or when an employee is traveling from home to work and meets with an accident can it be called an employment related injury have been agitated widely. Similarly, issues concerning extent of injury and occupational disease have also been subject matter of a large amount of litigation. But it is not the scope of this book to go into these aspects.

In this Chapter we will look at some other aspects mainly those flowing from the Supreme Court's assertion of workers having a fundamental right to work in healthy environment. Some aspects of these fundamental rights have already been dealt with under the Chapter on fundamental right to health care and the present Chapter will deal with some of the remaining aspects.

Many of these laws have their foundation in the Constitution or certain International Instruments.

Article 38(1) of the Constitution lays down the foundation for human rights and enjoins the State to promote the welfare of the 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.

Article 46 directs the State to protect the poor from social injustice and all forms of exploitation.

Article 39(e) charges that policy of the State shall be to secure 'health and strength of the workers.'

Article 42 mandates that the States shall make provision, statutory or executive 'to secure just and humane conditions of work.'

Article 43 directs that the State shall endeavour to secure to all workers, by suitable legislation or economic organization or any other way to ensure decent standard of life and full enjoyment of leisure and social and cultural opportunities to the workers.

Article 25(2) of the Universal Declaration of Human Rights promises right to standard of adequate living for health and well-being of the individual including medical care, sickness and disability.

Article 2(b) of the International Covenant on Political, Social and Cultural Rights protects the right of worker to enjoy just and favourable conditions of work ensuring safe and healthy working conditions.

As regards health care, both Factories Act and ESI Act deal with it to a certain extent. Apart from making provisions concerning health and safety at work place, s. 45 of the Factories Act mandates every factory to have first aid boxes. For every 150 workers there should be at least one first aid box. Such first aid box is to be in charge of a person who holds a certificate in first aid from the State Government. Besides, every factory having more than 500 workers is required to have an ambulance room and prescribed medical and nursing staff. Each State Government has its own rules under the Factories Act. For instance, Rule 76 of the Maharashtra Factories Rules prescribes a detailed list of the items which are required to be in a First Aid Box. There is a further sub division depending on whether the Factory is using mechanical power or not. Rule 78 prescribes that in every factory which employs more than 500 workers the Ambulance Room must be in charge of a qualified medical practioner along with at least one qualified nurse.

Similarly, in what are classified as hazardous processes, Section 41C of the Factories Act provides that any employee must be medically examined before he is employed in such process and should be medically examined once every year during the time he is in employment and even after the cessation of his employment for such period as may be prescribed. Rule 73X of the Maharashtra Factory Rules also prescribe that every factory involved in hazardous process must have at least one fully equipped ambulance van.

Similarly, the ESI Act, provides for medical care to the registered employees in cases not just of accidents and occupational diseases but also in cases of ordinary illnesses. The scheme extends to the families of the employees.

B. CASE LAW

Asbestos case

In **Consumer Education & Research Centre v. Union of India**[1] the Supreme Court was concerned with rights of employees in the Asbestos manufacturing industry. It was a public interest litigation filed concerning conditions of work and health affects on workers.

In this very crucial decision the Supreme Court held that the right to health of a worker is an integral facet of meaningful right to life to have not only a meaningful existence but also robust health and vigour without which worker would lead life of misery. Lack of health denudes his livelihood. Compelling economic necessity to work in an industry exposed to health hazards should not be at the cost of the health and vigour of the workman. Facilities and opportunities, as enjoined in Article 38, should be provided to protect the health of the workman. Provision for medical test and treatment invigorates the health of the worker for higher production or efficient service. The Court further held that *continued treatment, while in service or after retirement is a moral, legal and constitutional concomitant duty of the employer and the State. Therefore, it must be held that the right to health and medical care is a fundamental right under 21 read with Article 39(c), 41 and 43 of the constitution to make life of the workman meaningful and purposeful with dignity of person.* Right to life includes protection of the health and strength of the worker and is a minimum requirement to enable a person to live with human dignity. *The State (Central & State) government or an industry, public or private, is enjoined to take all such action which will promote health, strength and vigour of the workman during the period of employment and leisure and health even after retirement as basic essentials to live the life of health and happiness.*

The Supreme Court went on to observe that the right to human dignity, development of responsibility, social protection, right to rest and leisure are fundamental human rights to a workman assured by the Charter of Human Rights, in the Preamble and Arts. 38 & 39 of the Constitution. Health of the worker enables him to enjoy the fruit of his labour, keeping him physically fit and mentally alert for leading a successful life, economically, socially and culturally. *Medical facilities to protect health of the workers are, therefore, the fundamental and human rights of the workmen.*
The Court also held that in an appropriate case, Court would give directions to the employer, be it the State or its undertaking private employer to make the right to life meaningful; to prevent pollution of the work place; protection of the environment; protection of the health of the workman or to preserve free and unpolluted mater for the safety and health of the people. This was an important observation because ordinarily, under its Constitutional jurisdiction the Supreme Court gives directions only to State authorities and not to private individuals or employers.

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[1] AIR 1995 SC 922

The employer is vicariously liable to pay damages in case of occupational diseases, here in this case asbestosis. The Employees State Insurance Act and Workmen's Compensation Act provide for payment of mandatory compensation for the injury or death caused to the workman while in employment. The Act does not provide for payment of compensation after cessation of employment, it therefore becomes necessary to protect such persons f4rom the respective dates on cessation of their employment.

The Court observed:

"The Employees State Insurance Act and Workmen's Compensation Act provide for payment of mandatory compensation for the injury or death caused to the workman while in employment. Since the Act does not provide for payment of compensation after cessation of employment, it becomes necessary to protect such persons from the respective dates of cessation of their employment till date. Liquidated damages by way of compensation are accepted principles of compensation."

The Court, while allowing the Petition, said:

> "All the industries are directed
>
> (1) to maintain and keep maintaining the health record of every worker upto a minimum period of 40 years from the beginning of the employment or 15 years after retirement or cessation of the employment whichever is later;
> (2) the Membrane Filter test to detect asbestos fibre should be adopted by all the factories or establishments on a par with the Metalliferrous Mines Regulations, 1961 and Vienna Convention and rules issued thereunder;
> (3) All the whether covered by Employees State Insurance Act or Workmens Compensation Act or otherwise are directed to copulsarily insure health coverage to every worker;
> (4) .....
> (5) The Union and all the State Governments are directed to consider inclusion of such of those small scale factory or factories or industries to protect health hazards of the workers engaged in the manufacture of asbestos or its ancilliary products;
> (6) The appropriate inspector of factories in particular of the State of Gujarat, is directed to sent all the workers, examined by ESI hospital concerned, for re examination by the National Institutie of Occupational Health to detect whether all or any of them are suffering from asbestosis. In case of positive finding that all or any of them are suffering from occupational health hazards, each such worker shall be entitled to compensation in a sum of rupees one lakh payable by the factory or industry or establishment concerned within a period of three months from the date of certification by the National Institute of Occupational Health."

In **Rajangam, Secretary, Dist. Beedi Worker's Union v. State of Tamil Nadu**[2] the issue concerned conditions of work of employees in Beedi manufacturing and allied industries. A large number of children are employed in this work.

The Supreme Court passed the following directions:

1. .....
2. Tobacco manufacturing is indeed health hazardous. Child labour in this trade should therefore be prohibited as far as possible and employment of child labour should be stopped either immediately or in a phased manner to be decided by the State Governments but within a period not exceeding three years from now. The provisions of Child Labour (Prohibition & Regulation) Act, 1986 should be strictly implemented.
3. The Beedi Workers Welfare Cess Act, 1976 and the Beedi Workers Welfare Fund Act, 1976 which contain beneficial provisions should be implemented in the true spirit and since they are legislations of the Central Government, the machinery of the Central Government should be made operational in the area.
4. ....
5. ....
6. In view of the health hazard involved in the manufacturing process, every worker including children, if employed, should be insured for a minimum amount of Rs 50,000 and the premium should be paid by the employer and the incidence should not be passed on to the workman."

Bandhu Mukti Morcha v. **Union of India**[3]

PIL was filed against employment of children below 14 years of age in Carpet industry in Uttar Pradesh and in most cases the children were forced into labour. The petitioner sought directions for total prohibition on employment of children below 14 years of age and directions to the Respondents to give them facilities like education, health, sanitation, nutritious food, etc. It was also contended that employment of children in any industry or in a hazardous industry violated Art. 24[4] of the Constitution and derogatory to the mandate contained in Articles 39(e) & (f) & 45 of the Constitution read with the Preamble.

Judgement:

The imperatives of Directive principles of State policy, particularly, Articles 45, 39 (e) & (f), 46 read with the Preamble, Article 21, 23 and 24 of the Constitution enjoins upon State to ensure socio-economic justice to the child and their empowerment, full growth of their personality- socially, educationally and culturally- with a right to leisure and opportunity for development of the spirit of reform, inquiry, humanism and scientific temper to improve excellence- individually and collectively. In specific the State has the responsibility to formulate policy to protect children of tender age from abuse (Art. 39(e)); to provide opportunities and facilities for their development in a healthy manner and in conditions of freedom and dignity and protect their childhood and youth against exploitation and moral and material abandonment (Art. 39(f)); free and compulsory primary education for all children (Art. 45); and prohibit

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[2] SC dated 19/11/1991

[3] (1997) 10 SCC 549

[4] Art 24 Prohibition of employment of children in factories, etc:- No child below the age of 14 shall be employed in any factory or mine or engaged in any other hazardous employment.

employment of the children below the age of 14 in any factory or mine or any hazardous employment (Art.24).

Child labour is a social phenomenon with its genesis in poverty and cannot be completely eradicated except by social changes even though it violates the right of the child to a meaningful life, leisure, food, shelter, medical aid and education. Total banishment of employment may drive the children and mass them up into destitution and other mischievous environment, making them vagrant, hard criminals and prone to social risks etc. Thus progressive elimination of employment of children below the age of 14 years would be required.

Education is one such way of creating an opportunity for a better life. The Convention on the Rights of the Child also emphasized the importance of education for children. Article 28 provides:

(a) Make primary education compulsory and available free to all;

(b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need,

(c) Make higher education accessible to all on the basis of capacity by every appropriate means;

(d) Make educational and vocational information and guidance available and accessible to all children;

(e) Take measures to encourage regular attendance at schools and the reduction of drop-outs rates.

Article 27(1) provides that the state parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

Article 31(1) recognizes the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.

Article 32 which is material for the purpose of this case reads as under:

(1) State parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

(2) State parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, State parties shall in particular:

a) Provide for a minimum age or minimum ages for admission to employment;

b) Provide for appropriate regulation of the hours and conditions of employment;

c) Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

Thus, SC gave the directions to Central Government to convene a meeting of Ministers concerned of the respective State Governments and their Principal Secretaries holding Departments concerned within two months of the receipt of this Order, to evolve principles of policies for progressive elimination of employment of children below the age of 14 years in all employments governed by the respective enactments mentioned in MC Mehta Case; and to evolve such steps consistent with the scheme laid down in M.C. Mehta case, to provide:

(1) Compulsory education to all children either by the industries themselves or in coordination with it by the State Government to the children employed in the factories, mine or any other industry, organized or unorganized labour with such timings as is convenient to impart compulsory education, facilities for secondary, vocational profession and higher education;
(2) Apart from education, periodical health check-ups;
(3) Nutrient food etc.; &
(4) To entrust the responsibilities for implementation of the principles

Bonded labourer

Bandhua Mukti Morcha v. Union of India[5] concerned the issue of release of bonded labourers especially from stone quarries from Haryana.
The SC appointed a Committee to inquire into the conditions of the workers at such stone quarries. The Committee's report stated that the due to a large number of stone crushing machines operating at the site, the air was laden with dust making it difficult to breathe. Workers were forced to work and were not allowed to leave the stone quarries. They did not even have pure water to drink and were living in jhuggies with stones piled one upon the other as walls and straw covering at the top which did not afford any protection against sun and rain and which were so low that a person could hardly stand inside them. A few workers were suffering from tuberculosis. Workers were not paid compensation for injuries caused due in accidents arising in the course of employment. There were no facilities for medical treatment or schooling for children. The Court held:

> *"It is the fundamental right of everyone under Article 21 to live with human dignity, free from exploitation. This right to live with human dignity enshrined in Article 21 derives its life and breath from the Directive Principles of State Policy and particularly clauses (e) & (f) of Article 39 & Articles 41 & 42 and at least, therefore, it must include protection of the health and strength of workers, men and women, and the children of tender age against abuse, opportunities and facilities for children to develop in a healthy manner and in conditions of freedom and dignity, educational facilities, just and humane conditions of work and maternity relief. These are the minimum requirements which must exist in order to enable a person to live with human dignity and neither the Central nor the State Government has the right to take any action which will deprive a person of the enjoyment of these basic essentials. Since the Directive Principles of State Policy contained in clause (e) & (f) of Articles 39, 41 & 42 are not enforceable in a court of law, it may not be possible to compel the State through the judicial process to make provisions by statutory enactment or executive fiat for ensuring these basic essentials which go to make up a life of human dignity but where legislation is already enacted by the State providing these basic requirements to the persons, particularly belonging to the weaker section of the community and thus investing their right to live with basic human dignity, the State can certainly be obligated to ensure observance of such legislation, for inaction on the part of the State in securing implementation of such legislation would amount to denial of protection under Article 21, more so in the context of Article 256*

[5] AIR 1984 SC 802: (1984) 3 SCC 161

which provides that the executive power of every State shall be so exercised as to ensure compliance with laws made by the Parliament & any existing laws which apply in that State. In ASIAD CONSTRUCTION WORKERS CASE[6] *another Bench of SC had expressed that the State is under a constitutional obligation to see that there is no violation of the fundamental right of any person, particularly when he belongs to the weaker section of the community and is unable to wage a legal battle against a strong and powerful opponent who is exploiting him. The Central Government is therefore bound to ensure observance of various social welfare, and labour laws enacted by Parliament for the purpose of securing to the workmen a life of basic human dignity in compliance with the Directive Principles of State Policy.*

The State of Haryana must therefore ensure that mine lessees or contractors, to whom it is giving its mines for stone quarrying operations, observe various social welfare and labour laws enacted for the benefit of the workmen. This is a constitutional obligation which can be enforced against the Central Government and the State of Haryana by a writ petition under Article 32.[7]"

The Supreme Court also issued various directions to the State and Central Governments and some of the important directions concerning health are the following:

1. The Central Government and the Government of Harayan will immediately take steps for the purpose of ensuring that the stone crusher owners do not continue to foul the air and they adopt either of two devices, namely, keeping a drum of water above the stone crushing machine with arrangement for continuous spraying of water upon it or installation of dust sucking machine and a compliance report in regard to this direction shall be made to this court on or before 28th February 1984.
2. The Central Government and the Government of Haryana will immediately ensure that the mine lessees and stone crusher owner start supplying pure drinking water to the workmen on a scale of at least two litres for every workmen by keeping suitable vessels in a shaded place at conveniently accessible points and such vessels shall be kept in clean and hygienic condition and shall be emptied, cleaned and refilled every day and the appropriate authorities of the Central Government and the Government of Haryana will supervise strictly the enforcement of this direction and initiate necessary action if there is any default.
3. The Central Government and the Government of Haryana will immediately direct the mine lessees and the stone crusher owners to start obtaining drinking water from any unpolluted source or sources of supply and to transport it by tankers to the work site with sufficient frequency so as to be able to keep the vessels filled up for supply of clean drinking water to the workmen and the Chief Administrator, Faridabad Complex will set up the points from where the mine lessees and the stone crusher owner can, if necessary, obtain supply of potable water for being carried by tankers.
4. The Central Government and the State Government will ensure that conservancy facilities in the form of latrines and urinals in accordance with the

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[6] People's Union v. union of India (1982)2 SCC 235
[7] p.183 para 10

provisions contained in Section 20 of the Mines Act, 1950 and Rules 33 to 36 of the Mines Rules 1955 are provided.

5. The Central Government and the State Government will take steps to immediately ensure that appropriate and adequate medical and first aid facilities as required by Section 21 of the Mines Act, 1952 and Rules 40 to 45-A of the Mines Rules 1955 are provided to the workmen.
6. The Central Government and the Government of Haryana will ensure that every workman who is required to carry out blasting with explosives is not only trained under the Mines Vocational Training Rules, 1966 but also holds first aid qualification and carries a first aid outfit while on duty as required by Rule 45 of the Mines Rules, 1955.
7. The Central Government and the State Government will immediately take steps to ensure that proper and adequate medical treatment is provided by the mine lessees and the owners of the stone crushers to the workmen employed by them as also to the members of their families free of cost and such medical assistance shall be made available to them without any cost of transportation or otherwise and the doctor's fees as also the cost of medicines prescribed by the doctors including hospitalization charges, if any, shall also be reimbursed to them.
8. The Central Government and the State Government will ensure that the provisions of the Maternity Benefit Act, 1961, the Maternity Benefit (Mines & Circus) Rules, 1963, and the Mines Creche Rules, 1966, where applicable in any particular stone quarry or stone crusher are given effect to by the mine lessees and stone crusher owners.
9. As soon as any workman employed in a stone quarry or stone crusher receives injury or contracts disease in the course of his employment, the concerned mine lessee or stone crusher shall immediately report this fact to the Chief Inspector or Inspecting Officers of the Central Government and/or the State Government and such Inspecting Officers shall immediately provide legal assistance to the workman with a view to enabling him to file a claim for compensation before the appropriate Court or authority and they shall also ensure that such claim is pursued vigorously and the amount of compensation awarded to the workman is secured to him.
10. The Inspecting Officers of the Central Government as also of the State Government will visit each stone quarry or stone crusher at least once in a fortnight and ascertain whether there is any workman who is injured or who is suffering from any disease or illness, and if so, they will immediately take all necessary steps for the purpose of providing medical and legal assistance.
11. If the Central Government and the Government of Harayana fail to ensure performance of any of the obligations set out in clauses 11, 13, 14 & 15 by the mine lesses and stone crusher owners within the period specified in those respective clauses, such obligation or obligations to the extent to which they are not performed shall be carried out by the Central Government and the Government of Harayana.

In the case of Mangesh Salodkar Vs. Monsanto Chemicals of India Ltd. (Writ Petition No. 2820 of 2003 decided by the Bombay High Court on 13th July, 2006), the issue concerned conditions of work at the plants run by Monsanto Ltd. The Company manufactured pesticides and it was alleged that a particular worker suffered from brain haemorrage because of the work environment. He survived but suffered major

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illnesses. He was paid Rs. 3 lakhs by the Company towards medical expenses but he filed a Petition in the High Court. The Court initially appointed a Commission headed by a retired judge of the High Court. The Commission in turn summoned documents from Factory Inspectorate and asked certain experts to go into the conditions of work of the Factory. Medical examination was also undertaken of some of the workers. During the pendency of the matter, the dispute between workers and employer was resolved as the employer agreed to pay additional Rs. 17. 80 lakhs to the concerned employee and Rs. 7.40 lakhs to some of the other employees who were affected. The Commission accordingly filed a report before the High Court. Since the dispute between employer and employees was resolved the Court was not called upon to determine that aspect. However, the Court did go into some other aspects concerning rights of employees to a safe work place, etc.

To begin with, the Court held that the workers had a fundamental right to health at their work place. In addition it observed:

"As this case demonstrates, the absence of updated medical records results in a virtual denial of access to justice. In the absence of information, factory workers and all those who espouse the cause of workers cannot realistically attempt to redress the systemic failure on the part of the regulated industry to maintain regulatory standards."

The Court issued various directions including the following:

> "(iv). The medical examination of workers which is to be conducted under Section 41E of the Factories Act, 1948 should be such as would enable an identification of diseases and illnesses which are a likely outcome of the process and material used in the factory;
>
> (v). Copies of medical records of workmen must be handed over to them as and when medical examinations are conducted and the appropriate government will consider the issuance of suitable directions mandating the permanent preservation of medical records in the electronic form by factories engaged in hazardous processes;
>
> (vi). In respect of factories involved in hazardous processes, safety and occupational health surveys as required by Section 91A should invariably be carried out at the time of renewal of licenses, apart from other times."

C. CONCLUSION

Right to safe working environment has been recognized since nearly 80 years. Over the years it has expanded to include newer areas. To begin with it was only a recognition in principle. This was followed by a recognition that if an injury was suffered at the workplace the employer was liable to pay compensation. Subsequently this was expanded to even occupational diseases. Over the years the modalities and procedures which are required to fulfill this right have been recognized. This includes regular medical examination, handing over medical reports to the workers, frequent inspection of the work premises. Apart from health, certain health care aspects of the workers have also been recognized. These include the provisions under the ESI Act

for giving free medical treatment to registered employees and under the Factories Act for providing regular check up, first aid kits and in certain circumstances also ambulance rooms and vans.

On paper these laws appear very effective. Even otherwise, to a limited extent for the organized work force they do provide certain amount of succour. Even the Government employees have a number of schemes and provisions concerning medical benefits and care. But by and large they have been ineffective in dealing with the unorganized sector. To begin with, these laws do not apply to small scale industries. Also, implementation of these laws in many of the establishments to which they apply is also difficult. For instance, if the employer has not deducted or deposited the ESI contribution, the employee becomes disentitled to avail of the benefit. Similarly, many ocuupational diseases are not covered by the Act and at times it has become difficult to prove in courts that a disease occurred because of employment at a particular place. Courts role has also not been laudatory especially in recent times. For instance, in 2006, the Supreme Court held that a casual workman is not entitled to benefit of Workmen's Compensation Act.

MEDICAL NEGLIGENCE

A. INTRODUCTION

Negligence has since centuries been recognized as a tort i.e. a civil wrong for which the remedy is compensation in monetary terms. This is true of any negligence, not just medical negligence. Medical negligence is a sub species of this tort which falls within the larger species of professional negligence. Medical negligence, like other forms of negligence, is under our law, as under many other legal systems also a criminal offence for which a doctor can even be imprisoned. This chapter briefly looks at all aspects of medical negligence under the Indian law.

Before we go into what constitutes medical negligence it is necessary to look at the various remedies available under the Indian law in case of medical negligence. Broadly, there are three remedies available:

Filing a civil suit for damages or a complaint before the consumer court for compensation. This is essentially a civil remedy where the relief sought is compensation for injuries suffered. The law followed is what is known as the "common law" concerning negligence which is not based on any statute or legislation but is the judge made law over centuries both in England and in India. Civil suits are difficult to pursue for two reasons: first, the expenses including the court fees are very high and two, the delay can be very long. Before the Consumer Protection Act, 1985 was enacted one saw very little medical negligence litigation due to these reasons. But since the enactment of the Consumer Protection Act the cases against doctors have gone up dramatically partly because it is a much cheaper remedy and partly because relatively it is a quicker remedy.

Filing a case before the Medical Council. A case against a doctor can be filed before the Medical Council of the concerned system of medicine. The Medical Councils do not have the power either to award compensation or to imprison the doctor. Its powers are confined to warning a doctor, suspending or revoking his license. Besides, by and large the perception has been that the medical councils tend to protect their members.

Filing a criminal case of negligence. The main section under which a criminal case is filed against doctors is Section 304B of the Indian Penal Code which deals with causing death due to rash and negligent act. The punishment is two years imprisonment or fine or both. Similarly, S.336 of the Penal Code provides that it is an offence to endanger the human life or personal safety of others through a rash or negligent act. The punishment is three months imprisonment or fine of Rs. 250 or both. S. 337 and 338 of the Indian Penal Code make it an offence to cause simple hurt or grievous hurt through rash or negligent act. The punishment can be upto six months of imprisonment or fine upto Rs. 500 or both for simple hurt and punishment upto 2 years or fine upto Rs. 1000 or both for causing grievous hurt.

All the three remedies can be resorted to simultaneously.
But what will amount to medical negligence? And is there any difference between how the civil law defines negligence and how the criminal law defines negligence. Till 2004 it was generally believed that though the civil law and criminal law provide

for different remedies what constitutes negligence under both these laws is the same. However recent decisions of the Supreme Court have taken a different view.

Following are the three essential components of negligence:

> The existence of a duty to take care, which is owed by the defendant to the complainant;
>
> The failure to attain that standard of care, prescribed by the law, thereby committing the breach of such duty;
>
> Damage, which is both causally connected with such breach and recognized by the law, has been suffered by the complainant.

This is the ordinary legal meaning of negligence. But for professionals such as medical practitioners an additional perspective is added through a test known as the Bolam test which is the accepted test in India. In the case of *Bolam Vs. Friern Hospital Management Committee*[1] the Queens Bench Division of the British Court held:

> "(W)here you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham Omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill ...It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art."

As set out in the judgment of the Supreme Court in the case of *Jacob Mathew Vs. State of Punjab*[2]

> "Two things are pertinent to be noted. Firstly, the standard of care, when assessing the practice as adopted is judged in the light of the knowledge available at the time (of the incident), and not at the date of trial. Secondly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used.
>
> A mere deviation from normal professional practice is not necessarily evidence of negligence. Let it also be noted that a mere accident is not evidence of negligence. So also an error of judgment on the part of the professional is not negligence per se."

In this decision the Supreme Court also observed that for inferring negligence on part of a professional including a doctor additional considerations apply. "A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed."

Finally, while dealing with negligence the Supreme Court made the following observations:

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[1] 1957 2 ALL ER 118
[2] 2005 6 SCC 1

"A professional may be held liable for negligence on one of the two findings: either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess. The standard to be applied for judging whether the person charged has been negligent or not would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices."

B. CRIMINAL NEGLIGENCE

As regards criminal liability of medical practitioners, Supreme Court in a recent judgment[3] curtailed criminal proceedings against medical negligence to incidents of *gross* negligence. It held that a medical practitioner cannot be held punishable for every mishap or death during medical treatment. '*No criminal liability should be attached where a patient's death results from error of judgment or an accident. Mere inadvertence or some degree of want of adequate care and caution might create civil liability but would not suffice to hold him criminally liable.*'[4] The degree of medical negligence must be such that it shows complete apathy for the life and safety of his patient as to amount to a crime against the state. The issue has been more elaborately dealt with in the case of Jacob Mathew discussed above.

In Suresh Gupta's case, the patient died while he was being operated for nasal deformity, a minor operation without much complexity. The medical experts of the prosecution testified that the cause of death was due to the failure of the Appellant in introducing a cuffed endotracheal tube of proper size to prevent aspiration of blood from the wound in the respiratory passage. SC held that even if is assumed that the Appellant was negligent, he'll not be criminally liable as the alleged act was not grossly negligent. At the most he was liable in tort for damages but not for imprisonment under the criminal law.

The court expressed concern that if the liability of doctors is unreasonably extended to criminal liability thereby exposing them to the risk of landing themselves in prison for alleged criminal negligence then the repercussion would be that the doctors would be worried about their own safety rather than administering treatment to the best of their ability. The Court felt that this would adversely affect the society at large and shake the mutual confidence between the doctor and the patient.

Even where gross negligence is alleged, a prima facie case must be established before a Magistrate at the first instance as was pointed out in **Dr. Anand R. Nerkar v. Smt Rahimbi Shaikh Madar**[5]

> '... *it is necessary to observe that in cases where a professional is involved and incases where a complainant comes forward before a Criminal Court and levels accusations, the consequences of which are disastrous to the career and reputation of adverse party such as a doctor, the court should be slow in entertaining the complaint in the absence of the complete and adequate material before it. It is always open to the learned magistrate to direct an*

[3] Dr. Suresh Gupta v. Govet. Of NCT of Delhi (2004) 6 SCC 422
[4] p. 429, para 21
[5] 1991(1) Bom. C. R. p. 629

enquiry through the police so that all relevant aspects of the case are looked into before process is issued.... the duty cast on the trial Magistrate under Section 202 of the Criminal procedure Code is not to be understood as being confined to ascertain as to whether the complainant and the witnesses have mechanically averred that the accused has committed an offence, but I presupposes that judicial mind will apply itself to the case made out as a whole and conclude as to whether there I sufficient justification to hold that an offence has been committed. The establishment of a prima facie case, therefore, indicates that on the face of the record all ingredients that would constitute the commission of an offence are before the court. Where there exist serious lacunae in the case made out and where the possibilities and probabilities of an adverse conclusion are remote, it would not be justified in holding that a prima facie case has been made out.'

So far so good. But what the Supreme Court did in Jacob Mathew's case was to hold that ingredients of criminal negligence were more rigorous than those of civil negligence. In addition to the ingredients of civil negligence for establishing criminal negligence "*it shall have to be found that the rashness was of such a degree as to amount to taking a hazard knowing that the hazard was of such a degree that injury was most likely imminent... Where negligence is an essential ingredient of the offence the negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment....criminal negligence is the gross and culpable neglect or failure to exercise that reasonable and proper care and precaution to guard against injury..*"
The Supreme Court also gave guidelines for prosecuting doctors:

A private criminal complaint should not be entertained unless the complainant has produced prima facie evidence in the court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence.

The investigating officer, before proceeding against a doctor, should obtain an independent medical opinion preferably from a doctor in government service qualified in that branch of medical practice.

The accused doctor should not be arrested in a routine manner unless his arrest is necessary for furthering investigation or for collecting evidence or unless the investigating officer feels satisfied that the doctor will abscond.

This judgment in fact amounts to a stretched interpretation of the words of the legislation and placing doctors on a higher pedestal when the law itself does not make any such distinction.

C. JURISDICTION OF CONSUMER COURTS:

Medical negligence gives rise to civil and criminal liability. We have already mentioned that as regards civil wrongs, aggrieved person can claim compensation either through a civil suit or a complaint lodged with consumer forum. Since the enactment of Consumer Protection Act, 1985 there has been a significant rise in medical negligence cases being filed. In one sense, the passing of this law has given a boost to consumers for approaching courts in respect of negligence. Before we go into substantial aspects of medical negligence it is important to see how the Courts have

interpreted the Consumer Protection Act and its jurisdiction. Doctors have raised a number of concerns regarding the applicability of Consumer Protection Act. Wide ranging issues from applicability of the Act to medical practitioners, the nature of medical services which would be covered by the Act, the nature of consumers (i.e. patients) who would be covered by the Act have been litigated.

Indian Medical Association v. V.P. Shantha[6] finally settled the issue as to whether Consumer Protection Act applied to medical practitioners, hospitals and nursing homes. The Court held that proceedings under Consumer Protection Act are summary proceedings for speedy redressal and the remedies are in addition to private law remedy. The issue was whether patients are consumers under the Consumer Protection Act and could they claim damages for injury caused by negligence of the doctor, hospital or nursing home?

Apart from submitting that patients could not be classified as consumers under the Consumer Protection Act, the Medical Association argued the following points which are important to briefly reproduce:

> Deficiency in service, as defined under the Act, means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained under any law or has been undertaken to be performed by a person in pursuance of a contract or otherwise in respect to any service.[7] Thus, deficiency is ascertained on the basis of certain norms relating to quality, nature and manner of performance, and since medical services cannot be judged on the basis of any fixed norms, therefore, practitioners are not covered under the definition of 'services'.
>
> Only such person can fairly and justly decide on medical malpractice cases who are themselves qualified in medical field as they will be able to appreciate the complex issues involved in such cases. The District Forum comprises of President who is or was a District Judge and the other two members shall be persons having adequate knowledge or experience of, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration. Similarly State Commission and National Commission comprise of two members who are concerned with economics, law, commerce, accountancy, industry, public affairs or administration, while the President shall be a person who is or was a judge of a High Court and Supreme Court, respectively. It was submitted that as the members of the Forum are not qualified to deal with medical malpractice claims hence medical practitioners should be exempted from the ambit of the Act.
>
> Medical malpractice claims involve complex issues that will require detailed examination of evidence, deposition of experts and witnesses. This is contrary to the purpose of summary proceedings involving trial by affidavits, which is to provide speedy results. Hence Consumer Forum should not adjudicate medical malpractice cases.
>
> If the medical practitioners are brought within the purview of the Act, the consequences would be a huge increase in medical expenditure on account of insurance charges as well as tremendous increase in defensive medicine, that medical practitioners may refuse to attend to medical emergencies and their will

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[6] (1995) 6 SCC 651
[7] Section 2(1)(g)

be no safeguards against frivolous and vexatious complaints and consequent blackmail.

The Supreme Court, however, rejected all these arguments and held -

The Act defines 'consumer' as any person who *hires* or *avails* of any services for a *consideration* which has been paid or promised or partly paid and partly promised under any system of deferred payment and includes any *beneficiary* of such services other than the person who hires or avails of the services for the consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person.[8]

'Service' means service of *any description* which is made available to *potential users and* includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, boarding or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information, but does not include rendering of any service *free of charge* or under a *contract of personal service*.

Supreme Court observed that all services are included other than those that are provided for free or under a contract of service.

The next question was as to by what parameters deficiency in services of medical practitioners, hospitals or nursing homes should be ascertained. Section 14 enumerates the relief that can be granted for deficiency in service. Sub-section 1(d) provides compensation for any loss or injury suffered by a consumer due to *negligence* of the opposite party. A determination of deficiency in services has, therefore, to be made by applying the same test as is applied in an action for damages for negligence. The test is the standard of medical care a reasonable man possessing same skills and expertise would employ under same circumstances. A medical practitioner need not exhibit extraordinary skills.

As regards the expertise of the member of the consumer forum to adjudicate on medical malpractice cases the Supreme Court observed that the object of the Act is to have members who have required knowledge and experience in dealing with problems relating to various fields connected with the object and purpose of the Act, which is to protect the interest of the consumers. Also as person who is well versed in law and has considerable judicial or legal experience heads all the forum, it will ensure that the deliberation on cases will be guided by legal principles. To say that the members must have adequate knowledge or experience in the field to which the complaints are related would lead to impossible situation. If the jurisdiction is limited to the area of expertise of its members then complaints relating to large number of areas will be outside the scope of the Act as the two members in the District Forum have experience in two fields. The problem will arise vertically as at particular times in State Commission there may be members having experience in fields other than that of members of District Forum, would this imply that the State Commission will be ousted of its Appellate jurisdiction in such complaints. The intention of the legislature is to ensure that the members have the aptitude to deal with consumer problem. It is for the parties to place the necessary material before the forum to deliberate upon. It cannot therefore, be said that since the members of the Consumer Dispute Redressal Agencies don't posses knowledge and experience in medicine, they are incapable of dealing with medical malpractice cases.

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[8] Section 2(1)(d)(ii)

Appellant had contended that medical malpractice cases involved complicated question of facts that are not fit for summary trials, hence such cases should be kept outside the purview of the Act. Supreme Court observed that in some cases complicated questions requiring recording of evidence of experts may arise but it is not so in all cases. There are many cases where deficiency of services is due to obvious faults for instance, removal of wrong limb or performance of an operation on the wrong patient or without looking into the out-patient card injecting drug to which the patient is allergic or use of wrong gas during of an anesthetic or during surgery leaving inside the patient swabs or other foreign object during surgery. Such issues arising in complaint can be easily established and speedily disposed off by the consumer courts. In complaints involving complicated question of facts that require recording of evidence of experts, the consumer forum can ask the complainant to approach civil court for appropriate relief. The Act clearly states that its provision is in addition to and not in derogation of he provisions of any law for the time being in force.

The Supreme Court drew the following conclusions:

Services rendered to patient by medical practitioner (except where the doctor renders service free of charge to every patient or under a contract of personal service), by way of consultation, diagnosis and treatment, both medical and surgical, would fall within the ambit of services as defined in Section 2(1)(o) of the Act

The fact that medical practitioners belong to the medical profession and are subject to the disciplinary control of the Medical Council of India and /or State medical Councils would not exclude the services rendered by them from the ambit of the Act.

Services rendered by a medical officer to his employer under the contract of employment is not 'service' under S. 2(1)(o) for purposes of the Act

Services rendered at private or Government hospital, nursing home, health centres and dispensaries for a fee are 'services' under the Act while services rendered free of charge are exempted. Payment of a token amount for purposes of registration will not alter the nature of services provided for free.

Services rendered at a Government or a private hospital, nursing home, health centres and dispensaries where services are rendered on payment of charges to those who can afford and free to those who cannot is also 'service' for the purposes of the Act. Hence in such cases the person who are rendered free services are 'beneficiaries' under S. 2(1)(d) thereby 'consumer' under the Act.

Services rendered free of charge by a medical practitioner attached to a hospital/ nursing home or where he is employed in a hospital/nursing home that provides free medical facilities, is not 'services' under the Act.

Where an insurance company pays, under the insurance policy, for consultation, diagnosis and medical treatment of the insurer then such insurer is a consumer under S. 291)(d) and services rendered either by the hospital or the medical practitioner is 'service' under S. 2(1)(o). Similarly where an employer bears the expenses of medical treatment of its employee, the employee is consumer under the Act.

The remedy under Consumer Protection Act is in addition to civil remedy and it cannot be denied to a consumer merely on the ground that either the facts are too complicated or the complainant's claim is unreasonable.

In **Charan Singh v. Healing Touch Hospital,**[9] Appellant had brought a claim of Rs. 34 lacs for removal of his one kidney without his consent during the course of the operation, which resulted in loss of job and huge expenses for his treatment and upkeep. National Commission dismissed his complaint on the reasoning that his claim was excessive, exaggerated and unrealistic. This was because a consumer is required to approach the District, State or National Commission directly depending on the compensation claimed.

> *'..the complainant was drawing a salary of Rs. 3000 plus allowances... This is his allegation, which is not admitted by the opposite party. Even if we accept his contention is correct and even I we accept that as a result of wrong treatment given in the Hospital he has suffered permanent disability, the claim of Rs. 34 lacs made by the complainant is excessive. We are of the view that this exaggerated claim has been made only for the purpose of invoking the jurisdiction of this commission... '*

Supreme Court opined that the quantum of compensation is at the discretion of the Forum irrespective of the claim. The legislative intent behind the Act is to provide speedy summary trial and the Commission should have taken the complaint to its logical conclusion by asking the parties to adduce evidence and rendered its findings on merits. The Court further held,

While quantifying damages, Consumer Forums are required to make an attempt to serve the ends of justice so that compensation is awarded, in an established case, which not only serves the purpose of recompensing the individual, but which also at the same time aims to bring about a qualitative change in the attitude of the service provider.

It is not merely the alleged harm or mental pain, agony or physical discomfort, loss of salary and emoluments etc. suffered by the Appellant which is in issue- it is also the quality of conduct committed by the Respondents upon which attention is required to be founded in a case of proven negligence. (para 13, p. 673)

In another case[10] Supreme Court observed that in matters involving complicated questions of fact that require recording of evidence, the consumer forum has the discretionary power to direct the complainant to approach civil court for appropriate reliefs. Nevertheless, the procedure provided in the Act is adequate vis-à-vis civil suit to decide medical malpractice cases involving complicated questions of law and fact. For instance affidavits of experts including doctors can be taken as evidence. Thereafter, if cross-examination is sought for by the other side and the Commission finds it proper, it can easily evolve a procedure permitting a party who intends to cross-examination by putting certain questions in writing and those questions could also be replied to by such experts including by doctors on affidavit. In case where stakes are very high and still a party intends to cross-examine such doctors or experts, there can be video conference or asking questions by arranging telephonic conference and at the initial stage this cost should be borne by the person who claims such videoconference. Further, the Commissioner appointed by it at the work place can undertake cross-examination. For avoiding delay the District Forum or commissions can evolve a procedure of levying heavy cost where a party seeks adjournment on one or the other ground.

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[9] (2000) 7 SCC 668

[10] Dr. JJ Merchant v. Shrinath Chaturvedi (2002) 6 SCC 635

D. CASE LAW ON CIVIL NEGLIGENCE

The substantial aspects of civil liability in negligence cases have by and large remained the same over decades with a few additions. Indian civil law on negligence essentially is the judge made common law followed in England since centuries. The main principles have been as laid out in introduction to this chapter. This section looks at the application of these principles in concrete situations.

In **Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole**[11] patient had died due to shock when the Appellant attempted reduction of fracture without taking elementary caution of giving anesthesia. In the light of the surrounding circumstances it was held that the Appellant was negligent in applying too much of force in aligning the bone. Supreme Court held that doctors have the discretion to choose the course of treatment to be given and such discretion is relatively large in case of emergency. Nevertheless, doctor owes his patients a duty of care in deciding whether to undertake the case, the line of treatment to be adopted and a duty in administering that treatment. When a doctor gives medical advice and treatment, he impliedly undertakes that he is possessed of skill and knowledge for the purpose. And in executing his duty he must employ reasonable degree of skill, knowledge and care.
The Supreme Court also cited with approval the observations in Halsbury Laws of England in its Vol. 30 which states that whether or not he is a registered medical practitioner, such a person who is consulted by a patient owes him certain duties, namely

- duty of care in deciding whether to undertake the case;
- duty of care in deciding what treatment to give;
- duty of care in his administration of that treatment; and
- duty of care in answering a question put to him by a patient in circumstances in which he knows that the patient intents to rely on his answer.

A breach of any of these duties will support an action for negligence by the patient.[12]

Bombay High Court held that in a claim against medical negligence it is not sufficient to show that the patient suffered in some way but it has to be proven that the suffering or death of the patient was the result of negligence on part of the doctor.
In **Philips India Ltd. v. Kunju Punnu**[13] Bombay High Court held that in an action for negligence against a doctor, the plaintiff has to prove:

that the defendant had a duty to take reasonable care towards the plaintiff to avoid the damage complained of ;
that there was a breach of duty on the part of the defendant; and
that the breach of duty was the real cause of the damage complained of and such damage was reasonably foreseeable.

In the instant case the deceased was an employee of the Appellant. He approached the resident doctor of the company complaining of digestive problem and was treated accordingly. After a week he returned this time complaining of fever, cold and headache. Within 4-5 days he was brought in with high fever and was kept in the company's dispensary for observation. In the evening when the doctor found red

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[11] AIR 1969 SC 128
[12] Vol. 30 Fourth Edition, p.31 para 34
[13] 1975 M. L.J. 792

pigmentation his body he advised pathological test and was taken in a nursing home of a specialist who treated him for bacteraemia. He approved of the treatment given by doctor. Later it was discovered that the deceased was suffering from small pox that had caused his death.

The issue before the court was whether the doctor was negligent as he failed to diagnose small pox. Court held that a mistaken diagnosis is not necessarily negligent diagnosis. A practitioner can be liable if his diagnosis is so palpably wrong as to prove negligence, in other words, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part regard being had to the ordinary levels of skills in the profession. In the instant case there was no evidence to show that when the patient was taken to the company doctor any doctor of ordinary skill and competence could have diagnosed the disease of the patient as small pox or treated him for small pox. There was no epidemic of small pox at that time to induce the defendant doctor from carrying on test for the same. On the other hand, expert evidence showed that fulminating small pox could have occurred within 24 or 36 hours with no outward manifestations at all and that appearances were very indefinite with no findings on which to base a certain diagnosis. Thus, the defendant doctor was held to be not negligent.

In some circumstances, however, negligence may be attributed to a medical practitioner without proof of direct nexus between injury and conduct of the practitioner. In **Poonam Verma v. Ashwin Patel**[14] Respondent No. 1 was a registered Homeopathy Doctor who prescribed allopathic medicine for viral fever which as then prevalent in Appellant's locality. The condition of Appellant's husband deteriorated and he was admitted in Respondent No.2, a nursing home, for pathological tests and diagnosis. The deceased was treated for two days and as his condition did not improve he was shifted to another hospital where he died within hours of admission. In appeal the Supreme Court set up an ad hoc medical board to determine the cause of death. Board concluded that it was impossible to determine the true cause of the death. Therefore, claims against Respondent No.2 hospital were set aside but Respondent No.1 was held negligent on the ground that he was a homeopathic doctor and was not qualified to administer any other system of medicine. Respondent No.1 was held to be negligent per se.

Black's Law Dictionary defines 'negligence per se' as-

> *'Conduct, whether of action or omission, which may be declared and treated as negligence without any argument or proof as to the particular surrounding circumstances, either because it is in violation of a statute or valid municipal ordinance, or because it is so palpably opposed to the dictates of common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule, the violation of a public duty, enjoined by law for the protection of person or property, so constituted.'*

Also known as the Doctrine of Res ipsa Loquitur (things speaks for itself). The doctrine is attracted *'...when an unexplained accident occurs from a thing under the control of the defendant, and medical or other expert evidence shows that such accidents would not happen if proper care were used, there is at least evidence of negligence 'for a jury'.*[15]

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[14] (1996) 4 SCC 332

[15] Street on Torts (1983) 7th Ed.

It may be mentioned that now under the Judgment in Jacob Mathew's case (ibid) Supreme Court has held that the doctrine of Res Ipsa Loquitor is not applicable in criminal cases. Of course it continues to be applicable in civil cases.
Even so, the present judgment seems to be incorrect, in the context of the long line of precedents on negligence. In this case, the cause of death was not attributed to the treatment. Thus there was no causal link established between the treatment and the death. In absence of this, punishing a doctor for negligence does not fit within the law. The Court could have of course directed the homeopathy doctor to be prosecuted and his registration to be cancelled for practicing allopathic medicine. The Court have also directed the doctor to pay a fine which could then have been ordered to have been paid to the heirs of the deceased. But having come to the conclusion that there was no causal link between treatment and injury (in this case death) the doctor could not have been punished for negligence.

In **Shyam Sunder Vs. State Of Rajasthan,**[16] the doctrine of res ipsa loquitur was again discussed. The normal rule is, that it is for the plaintiff to prove negligence, but, in some cases, considerable hardship is caused to the plaintiff, as the true cause of the accident is not known to him, but is solely within the knowledge of the defendant who caused it. The plaintiff can prove the accident but cannot prove how it happened (so as) to establish negligence on the part of the defendant. This hardship is sought to be avoided, in certain cases, by invoking the principle of res ipsa loquitur, where the thing is shown to be under the management of the defendant or his servants, and the accident is such, as, in the ordinary course of things, does not happen if those who have the management use proper care, then it affords reasonable evidence, in the absence of an explanation by the defendant, that the accident arose from want of care.
[Scott Vs. London & Catherine Docks, (1965) 3 H&C 596 quoted in 'Shyam Sunder Vs. State of Rajasthan', AIR 1974 SC 896]
In **Jasbir Kaur v. State of Punjab**[17] Petitioner's newborn child's eye was gauged out by a cat that crept into the ward where he was kept. The infant was kept in a separate room under the charge of Petitioner's relatives, as there was a shortage of cots. It was urged by the Respondent Government hospital that the incident took place because of Petitioner's relatives, negligence in leaving the child alone. The Court applied the doctrine of res ipsa loquitur and held the hospital and State negligent. The safety and protection was under the control of the Hospital and such an incident would have not in the ordinary course of things but because of the negligence of the Hospital.

Another landmark judgment wherein liability was established on the basis of doctrine of res ipsa loquitur is **Achutrao Haribhau v. State of Maharashtra**[18]. In this case Respondent doctors left a mop inside the abdomen of the deceased during the sterilization operation that caused pus formation and peritonitis. Though the mop was removed but expired soon after the second operation. However, Appellant failed to prove that negligence of respondent Doctor in leaving the mop inside her abdomen had caused the death of the deceased. Supreme Court held that 'without doubt formation of pus was due to the mop left in the abdomen, and it was the pus formation that caused all the subsequent difficulties. The negligence in leaving the mop in the deceased's abdomen during the first operation led, ultimately, to her death.

[16] AIR 74 SC 876
[17] AIR 1995 P&H 278
[18] (1996) 2 SCC 634

Negligence is thus writ large in this case. In a case like this the doctrine of res ipsa loquitur clearly applies. Under these circumstances, and in the absence of any valid explanation by the Respondent which would satisfy the Court that there was no negligence on their part, it must be held that the deceased died due to negligence of respondent no.2 & 3. The Supreme Court observed:

> *"The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care ad competence, judged in the light of the particular circumstances of each case, is what law requires. A person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way. He is also not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, even though a body of adverse opinion also existed among the medical men.*
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> *"An error of judgment may not necessarily amount to negligence. It will depend on the nature of the error. If such an error of judgment would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that (such) a man, acting with ordinary care, might have made, then it is not negligence."*

In **Vinitha Ashok v. Lakshmi Hospital**[19] Appellant's uterus was removed because of excessive bleeding during a surgery for termination of pregnancy that was discovered to be cervical pregnancy. Appellant alleged that had a sonography been performed the nature of pregnancy would have been determined and she would not have had her uterus removed. Supreme Court observed that there was difference of opinion among medical experts on whether ultra sonography could determine cervical pregnancy. The Appellant showed no symptoms of cervical pregnancy and there was no reason for the Respondent doctor to suspect that and resort to a different course of treatment. In Kerela removal of uterus was recommended for tackling excessive bleeding in case of cervical pregnancy, and in the instant case Respondent had to resort to it save Appellant's life. Supreme Court, thus, held that the course adopted by Respondent doctor was reasonable and although the risk involved might have called for further investigation, Respondent doctor's view cannot be dismissed as being illogical. Difference of opinion amongst experts on procedure adopted by a doctor cannot be called negligence if the procedure adopted is commonly in practice in an area.

In **State of Tripura Vs. Amrita Bala Sen**[20] the Division Bench of Gauhati High Court was concerned with a case where 2 persons who were admitted to a Government hospital for cataract operation lost one eye each due to the operation. A Writ Petition was filed directly in the High Court by these two persons claiming compensation from the State. The Division Bench found that the facts were quite clear and negligence of the doctors was apparent on the face of the record. The Court therefore directed the State to pay to each of these persons compensation of Rs. 60,000/- with interest. The State argued that the concerned individuals should be asked to file a civil suit in local courts (which would have been time consuming and

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[19] (2001) 8 SCC 731
[20] 2005 1 GLR 7

also expensive) rather than approaching the High Court directly. But the Court negatived this contention and held that when the facts were clear, there was no need for the High Court in cases of state negligence to ask the complainants to go through long winded legal proceedings and the High Court itself could direct compensation.

In **S. Mittal V/s State of U.P.**[21] the Court was concerned with negligence in eye camps. An eye camp was organised for extending expert ophthalmic surgical treatment to patients of a particular place in UP. The operated eyes of several patients were, however, irreversibly damaged, owing to post-operative infection of the "intra ocular cavities of the eyes", caused by normal saline used at the time of surgery. A public interest litigation was filed, praying (apart from other reliefs) for compensation to victims of the negligence in arranging the eye operations. The Supreme Court directed the State Government to pay Rs. 12,500 compensation to each victim (in addition to Rs.5,000 already paid). The Supreme Court, observed that
(a) It was no defence, that the treatment was gratuitous or free.
(b) State Government would be liable for negligence in such activities.

In the case of **Achutrao Haribhau Khodwa Vs. State Of Maharashtra**[22], a patient had undergone a sterilisation operation in a Government hospital. The patient developed high fever and abnormal pain; and, though her condition deteriorated, no step was taken to ascertain the cause of her ailment. When the patient's condition became serious, the doctors re-opened the abdomen. A mop (towel), (left inside the peritoneal cavity during the previous operation) was removed and the abdomen was closed, after draining out the collected pus. The patient ultimately died. The Supreme Court held that once death by negligence in a Government hospital is established, the State is liable to pay compensation.

In **Philips India Ltd. V/s Kanju Pannu**[23],
It was held by the Bombay High Court that the doctor was not negligent on the facts. What was important was that the Court laid down that the duty cast on the company's doctor, in respect of the company's employee, is not higher or lower than the duty of an average doctor towards hispatient.

In **Spring Meadows Hospital Vs. Harjot Ahluwalia,**[24] a child patient was treated for seven days in the Spring Meadows Hospital (Noida) for typhoid. The consultant physician prescribed "Chioromphenical injunction", but the unqualified nurse misread it as "chloroquine" and indented, for the purchase of injection, "Lariago" (i.e. chloroquine). She injected chloroquine 5 mg IV, which was at least 3-1/2 times of the normal paediatric dose. The patient suffered irreversible brain damage. Treatment for 21 days in AIIMS, New Delhi , did not help. The patient was compelled to live in a vegetative state.

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[21] 1989 3 SCC 223
[22] 1996 2 SCC 634
[23] AIR 75 BOM 306
[24] AIR 1998 SC 1801

The National Consumer Commission, whose judgment was confirmed by the Supreme Court, came to the conclusion, that the attending doctor was negligent, as he allowed an unqualified nurse to administer the injection, even though the consultant doctor had advised administration by the attending doctor himself.
The hospital and the nurse were jointly and severally liable. The Court ordered the following compensation in the case:
(a) Rs. 12.5 lakhs to the child (Rs. 10 lakhs compensation, plus Rs. 2.5 lakhs forequipment).
(b) Rs. 5 lakhs to the parents, for mental agony.
The Supreme Court further held that when a young child is taken to a hospital and treated by the hospital, then -
(a) the child's parents would come within the definition of "consumer" [section 2 (1) (d) (ii)]; and
(b) the child also becomes a "consumer", being a beneficiary of such services.
[Even where the patient is a married daughter, the parents who are required "to spend for her treatment, are also "consumers", **Rajaram S.Parale Vs. Dr. Kalpana Desai**[25]]

State Of Haryana VS. Santra[26] relates to negligence in sterilization, resulting in the birth of an unwanted child.
A mother of seven children underwent sterilization at a Government hospital under the scheme launched by the State Government (Haryana). The hospital authority issued a certificate that the operation was successful. However, after the operation, she conceived and gave birth to a daughter. The evidence established that only her right fallopian tube had been operated upon and the left fallopian tube had not been touched.
It was held that the doctor who had performed the operation had acted in the most negligent manner and, further, that the State was vicariously liable for the doctor's negligence. The following points need to be noted concerning this judgment of the Supreme Court:

(a) The claim in the above case arose, not from mere failed sterilization, but for negligent failure of sterilization.
(b) The judgment also clarifies, that running a hospital for the treatment of the general public is a welfare activity. It is not a "sovereign function", conferring immunity from tort liability.
(c) However, it seems (from material not quoted in the judgement) that the operating doctor had clearly stated that the left tube was inoperable. This seems to have escaped the court's attention.

[25] 1998 3 CPR 398 (BOM)
[26] 2000 1 CPJ 53 (SC)

C. CONCLUSION

The cases of medical negligence are rising rapidly especially in the consumer courts. However it has been observed that getting fellow doctors to testify even in cases which are self evident is a very difficult task. With the recent decisions of the Supreme Court in matters concerning criminal negligence, it is going to be more and more difficult for doctors to be prosecuted under the criminal law.

Majority of the successful cases have been those where the Courts are not required to go into complicated medical evidence. They have repeatedly held that a doctor is liable only if the line of treatment prescribed by him was not a recognized method altogether. A few cases concerning informed consent are now coming up before the Courts but it is yet to be settled as to what constitutes 'informed consent'.

VI

MEDICAL PRACTICE

A. INTRODUCTION

Not every person who has studied medicine has a right to practice medicine. Not every degree or diploma qualifies a person to claim that he has studied medicine. Medical profession is governed by various Central and State Acts that prescribe standard of education and practice in the interest of public and to maintain high standard of the profession. Thus, to be eligible to practice there must be absolute adherence to the provisions of concerned Acts.

Since medical practice is part of the concurrent list of the Constitution, both Central as well as State Governments can pass laws concerning medical practice. Ordinarily if the State law conflicts with the Central law, the Central law will prevail. In respect of all systems of medicine Central as well as State laws have been passed. The Medical Council Act, 1956 regulates modern system of medicine; the Indian Medicine Central Council Act, 1970 regulates Indian systems of medicine including Ayurveda, Sidha and Unani systems of medicine and the Homoeopathic Central Council Act, 1973 regulates practice of homoeopathic medicine. In respect of each of these branches of medicines most of the State Governments have also passed laws. All these laws have schedules which list the qualifications and degrees and diplomas which would entitle practitioners to practice a particular branch of medicine. Thus, Medical Council Act, 1956 gives a list of degrees and diplomas which are recognized for practicing allopathic medicine. Similarly, say the Maharashtra Medical Practitioners Act prescribes additional list of degrees and diploma which would are available in Maharashtra and which would also entitle practitioners to practice allopathic medicine. Medical Councils are set up at both Central and State levels, which apart from other functions also sets the standards for medical ethics and parameters of medical malpractice.

One of the major issues which the Courts have had to deal with is the one concerning cross practice. Can an Ayurvedic practitioner give allopathic drugs and vice versa. The common sense answer would be no. But a large part of the primary health care sector is run by those practitioners who are registered under the Ayurvedic system but have done what is known as integrated medicine i.e. they have studied some amount of allopathic system. The other issue concerns practice of those system of medicines which are not ordinarily recognized as the mainstream branches. These and similar issues have been raised in the Supreme Court and the High Courts in the last few years.

B. Case Law

In **Poonam Verma** v. **Ashwin Patel** [1] the Supreme Court made its famous observation:

> *'A person who does not have the knowledge of a particular system of medicine but practices in that system is a quack and a mere pretender to medical knowledge or skill, or to put it differently, a charlatan.'*

[1] (1996)4 SCC 332

The Court went onto observe that no person can practice a system of medicine unless he is registered either under Indian Medical Register or State Register to practice that system of medicine; and only such persons are eligible for registration who possess the recognised degree as specified under the concerned Central and State Act. The mere fact that during the course of study some aspects of other system of medicine were studied does not qualify to practice those other systems.

In this case, Respondent was a registered homoeopathy doctor but he prescribed allopathic medicines to Appellant's husband. His defense was that he had received instructions in modern system of medicine (allopathy), and after the completion of his course, he had worked as Chief Medical Officer at a well-known Allopathic clinic.

Supreme Court observed that a registered homoeopathic practitioner could practice homoeopathy only. Further the Court opined that 'physiology and anatomy is common in all systems of Medicines and the students belonging to different systems may be taught physiology and anatomy together, but so far as the study of drugs is concerned, the pharmacology of all systems is entirely different. Therefore, merely because the anatomy and physiology are similar does not entitle a person who has studied one system of medicine to treat patients under another system.'

Hence it was held that Respondent was registered to practice homoeopathy only. He was under a *statutory duty* not to enter other systems of medicine. He trespassed into a prohibited field and was liable to be prosecuted under Section 15(3) of the Indian Medical Council Act, 1956. His conduct also amounted to an *actionable negligence* for any injury caused to his patients in prescribing allopathic drugs.

In **Mukhtiar Chand (Dr.) v. State of Punjab** [2] the primary question before the Supreme Court was as to 'who can prescribe allopathic medicines?' Drugs and Cosmetics Act & Rules state that drugs can be sold or supplied by a pharmacist or druggist only on the prescription of a 'registered medical practitioner' who can also store them for treatment of his patients. Rule 2(ee) defines 'registered medical practitioner' as a person-

'i) holding a qualification granted by an authority specified or notified under Section 3 of the Indian Medical Degrees Act, 1916, or specified in the Schedules to the Medical Council Act, 1956; or

ii) registered or eligible for registration in a Medical Register of a State meant for the registration of persons practicing the modern scientific system of medicine (excluding the homoeopathic system of medicine); or

iii) registered in a Medical Register (other than a register for the registration of homeopathic practitioner) of a State, who although not falling within sub-clause (i) or sub-clause (ii) is declared by a general or special order made by the State Government in this behalf as a person practicing the modern scientific system of medicine for the purposes of the Act.'

In 1967 State Respondent issued a notification under Clause (iii) of Rule 2(ee) whereby those vaids and hakims who had been registered under certain specified State Acts, viz., East Punjab Ayurvedic and Unani Practitioners Act, 1949; PEPSU Ayurvedic and Unani Practitioners Act; and Punjab Ayurvedic & Unani Practioners Act, 1963, governing practice in Indian medicine were declared as 'medical

[2] (1998)7 SCC 579

practitioner' for the purposes of Drugs and Cosmetics Act. Even though notification allowed ayurvedic practitioners to prescribe allopathic medicines, yet State authorities restrained them from doing do hence began the course of litigation. High Court held the notification as ultra vires the provisions of Rule 2(ee)(iii) and also contrary to Indian Medical Council Act, 1956 and accordingly dismissed the writ petition. Indian Medical Council Act provides qualification and registration of medical practitioners to practice allopathic medicine. Through this petition Appellants sought to reinforce their right to prescribe allopathic medicine on the strength of the Notification and restrain State authorities from interfering with such a right. Similar issues also arose in various other High Courts and finally all the cases reached the Supreme Court.

Supreme Court observed on a plain reading of Rule 2(ee) that clause (i) & (ii) covered medical practitioners registered to practice allopathic medicine, while clause (iii) covered persons who are registered in a State Medical Register other than for practicing modern system of medicine and homeopathy, and through a State Government declaration held eligible to practice modern system of medicine for purposes of the Drugs Act.

The Court further observed that Rule 2(ee) only defines the expression 'registered medical practitioners' and does not provide as to who can be registered. Therefore, the Court read the notification in consonance with laws regulating and permitting medical practice.

As a rule medical practitioner can practice in that system of medicine for which he is registered as a medical practitioner. Under the Indian Medical Council Act, 1956 there are two types of registration: under 'State Medical Register' and 'Indian Medical Register'. Section 15(2) states that only such persons can practice allopathic medicine in State who are enrolled in any State Medical Register. Section 15(1) provides that qualifications specified in the Schedules of the Act shall be sufficient for enrollment in State Medical Register. However, such qualification is not a necessary pre condition for registration. 'State Medical Register' is a contradistinction to 'Indian Medical Register' and is maintained by the State Medical Council constituted under any State law that regulates the registration of medical practitioners. It is thus possible that in a State, the law governing registration may enable a person to be enrolled on the basis of qualifications other than the 'recognized medical qualification'. On the other hand, 'recognized medical qualification' is a perquisite for enrollment in Indian Medical Register. To summarise, persons holding 'recognized medical qualification' cannot be denied registration in any State Medical Register, but the same cannot be insisted upon for registration in a State Medical Register. Further, a person registered in a State Medical Register cannot be enrolled on the Indian Medical Register unless he possesses 'recognized medical qualification'.

The Indian Medicine Central Council Act, 1970 has made a similar distinction between 'State Register' and 'Central Register of Indian Medicine'. Section 17 provides the recognized medical qualification for enrollment in State Register, and that no person other than those who are enrolled either on the State register or Central Register of Indian Medicine can practice Indian medicine. Section 17(3) carves out exception to the above stated prohibition and protects, inter alia-

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Privileges including the right *to practice any system of medicine which was conferred by or under any State law relating to registration of practitioners of Indian*

Medicine for the time being in force, on a practitioner of Indian Medicine who was enrolled on a State register of Indian Medicine.

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Thus, a harmonious reading of Section 15 of the 1956 Act and Section 17 of 1970 Act leads to the conclusion that a medical practitioner of Indian Medicine who is enrolled on the State Register of Indian Medicine or the Central Register of Indian Medicine can practice modern scientific medicine only if he is also enrolled on a State Medical Register within the meaning of Section 15(2) of the 1956 Act.

Supreme Court held that benefit of Rule 2(ee) and the notifications issued there under would be available in those States where the privileges to practice any system of medicine is conferred upon by the State law for the time in being in force, under which medical practitioners of Indian Medicine are registered in the State.

Lastly, Appellants urged that integrated courses in ayurvedic medical education includes to an extent the study of modern scientific system of medicine. The right to practice a system of medicine is derived from the Act under which a medical practitioner is registered; whereas the right which the holders of a degree in integrated courses of Indian Medicine are claiming is to have their prescription of allopathic medicine honoured by a pharmacist or a chemist under the Pharmacy Act and Drugs Act. Supreme Court held that right to prescribe drugs is a concomitant of the right to practice a system of medicine. Appellants cannot claim such a right when they do not possess the requisite qualification for enrollment in the State Medical Register.[3]

Akhtar Hussain Delvi (Dr.) v. State of Karnataka [4] dealt with a situation quite opposite to the earlier cases. Here, a registered allopathic medical practitioner sought the right to prescribe drugs and medicines of ayurvedic origin, which had been accepted by professionals practicing allopathic medicine pursuant to clinical and other tests. The High Court observed that under Indian Medicine Central Council Act, 1970 only such persons have right to practice Indian medicine who either possess medical qualifications specified in Second, Third or Fourth Schedule of the Act or are enrolled in the State Register of Indian medicine. The Petitioner neither had acquired such a qualification nor passed qualifying examination under the concerned State Act, therefore, was not entitled to prescribe ayurvedic medicine.

Allopath cannot prescribe ayurved.

Standard of education

The Medical Councils constituted under different Central and State Acts are sole statutory body under their respective Acts that regulate the course of admission, standard of education and quality of practice. Provisions made by Medical Council in exercise of such powers can neither be transgressed by any authority nor are subject to judicial review unless the Act itself provides certain exceptions and confers or delegates any power to any other authority.

Can MBBS do cardiac Surgery? Silent

Basavaraj M. v. Karnatak State Pharmacy Council [5]

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[3] Even if a non-allopathic medical practitioner does not have the right to practice allopathic medicine, he can prescribe allopathic medicine that are sold across the counter for common ailment. (p. 597 para 41)

[4] AIR 2003 Karnataka 388

[5] AIR 2001 Karnataka 239

The Karnataka State Government conducted a job-oriented Diploma in Pharmacy Vocational Courses from 1993 to 1995 under the Centrally Sponsored Scheme of providing vocational courses at secondary education level. The course was not recognized by Pharmacy Council of India, a statutory body constituted under Pharmacy Act, 1948 to determine the course, to regulate admission, standard and examination. Petitioners' grievance was that they had been denied registration on the basis of Diploma Certificate that was granted by the State Government. Under Pharmacy Act, 1948 only such persons are eligible for registration who have passed the approved examination or posses qualification that has been approved under Section 14 or is registered as Pharmacist in another state. High Court held that since Pharmacy Council of India was the sole authority governing the standard of education and practice in pharmacy, State Government was not competent to run such a course without proper and due approval from it. If a course is run without the requisite approval of the statutory body then certificates or diplomas received are not valid and will not entitle persons like the Petitioners to claim registration. It is of no consequence whether State Government or any authority acting under it has granted such diplomas.

Delhi Pradesh Registered Medical Practitioners v. Director of Health, Delhi Admn. Services[6] was a Petition filed against the decision of the Indian Medicine Central Council constituted under the Indian Medical Central Council Act, 1970 denying recognition to the degree in Indian medicine awarded by Hindi Sahitya Sammelan after 1967. Appellants' case was that:

1. The Institution in question was very old and reputed, and on the basis of degrees awarded by it large number of practitioners in the discipline of Ayurveda had been registered in various States including Delhi and have been successfully practicing in the discipline of Ayurveda.
2. In the absence of proper medical facilities available to a large number of poorer sections of society, the ban on practitioners who were providing medical services to the needy and poor people was wholly unjustified.

Supreme Court, however, refused to review the decision of the Indian Medical Central Council merely on the basis of above submission as it fell within the realm of policy decision of constitutional functionaries who had the requisite knowledge and expertise to take such decisions. Thus, the Degrees were not recognized.

→ Grey year in cross practice?
→ B.A.M.S. have internship homeopaths - no

UNLICENSED PRACTITIONERS

In **State of Tamil Nadu Vs. M.C. George**[7] decided by the Tamil Nadu High Court the Petitioner was a hereditary practitioner of Siddha medicine. Since mid 1960s he was practicing Siddha medicine after learning it from his father and was very popular with his villagers. In 1981 the Tamil Nadu Government issued a Notification asking people who were practicing Indian system of medicine to register themselves. The

[6] (1997)11 SCC 687

[7] W.A. No. 108 of 2005 and W.A.M.P. No. 153 of 2005

Decided On: 24.03.2005

Petitioner delayed the matter and was not granted registration. He challenged this in the High Court. The Division Bench said that the Petitioner did not have any need to register himself since under the Indian Medicine Central Council Act, if a person was practicing Indian medicine at the commencement of the Act for a period of five years, he had a right to continue practicing Indian medicine. As a result, the Court held that the Petitioner could continue to practice Siddha medicine without registration. It needs to be noted of course, that this right is only for those who were already practicing Indian medicine for five years at the time of commencement of the law and not the subsequent entrants.

The Court also observed:

> *"9. Before dealing with the facts of this case, it may be mentioned that in our country, like in other countries, since ancient times medicine has been practiced and a medical system has been evolved. We had renowned medical practitioners like Sushrut and Charak who are internationally known. In fact, no society can get along without medical practitioners. In every society some people fall sick and get diseases, thus requiring medical treatment. In our country, the Siddha, Ayurveda and Unani systems were evolved, which were traditionally indigenous systems of our country. Medical practitioners of these systems would often pass all their medical knowledge to their children or disciples and often this knowledge was kept secret from others. Thus, this knowledge was passed on from generation to generation, but it was only given to the children or the devoted disciples and kept secret from others. Many of the treatments in our indigenous medical systems are very effective and there is no reason why we should not utilize the wisdom of our ancestors.*
>
> *10. In our opinion, we should encourage indigenous systems of medicines, though with scientific discrimination and after experimentation. However, it is also important that quackery should be suppressed, because it is also true that quackery is widely prevalent in our country, as poor people often cannot afford the fees of qualified doctors. Hence, a balance has to be maintained."*

In **Private Medical Practitioners Association of A.P. Vs. State of Andhra Pradesh**[8] the State Government issued a notification prohibiting all unlicensed practitioners from practicing medicine. This was challenged by the Association representing the unlicensed practitioners in the High Court. The contention was that they were mainly practicing in rural areas and were of great help to the poor villagers. The High Court however dismissed their Petition holding that unless a person has the qualifications prescribed under one of the medical laws he does not have the right to practice medicine.

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[8] W.P. 15410 of 1995 decided by the AP High Court on 8.4.2002

In the case of **Electropathy Medicos of India Vs. State of Maharashtra**[9] the College was conducting a three year course in Electropathy which was a branch of medicine contended to be different from Homeopathy, Ayurveda and Allopathy. The State Government had issued a notification directing that such a course is not recognized and no degrees or diplomas could be offered. This was challenged. The Petitioners contended that Electropathy was founded in the 19th Century in Italy and provided a sound system of medical practice. The High Court however rejected this and ordered:

> *"i) The petitioner-society is directed to close down all courses in electropathy/ electro-homoeopathy forthwith.*
>
> *ii) The petitioner-society is directed not to grant affiliation and/or recognition to any college or institution.*
>
> *iii) The petitioner-society is hereby directed to refund the fees received from the students admitted by the petitioner-society for its 3 years diploma courses as well as one year diploma course with interest at the rate of 18% p.a. within 3 months.*
>
> *iv) The State Government is directed to close down all institutions in the State holding the course in electropathy or electro-homoeopathy and to take action against the electropathy practitioners in accordance with the provisions of the Maharashtra Medical Practitioners Act, 1961."*

A similar case concerning Electropaths and Electrohomeopaths happened in U.P. In the case of **Electro Homeopthic Practitioners Association of India**[10] a Division Bench of Allahabad High Court was asked to permit Electrohomeopaths to continue to carry on their profession. The Court rejected this contention and held that unless a system of medicine was recognised by the Legislature it could not be allowed to continue. Upon this, the Association claimed that its members were not practising medicine. The Court, while rejecting this contention held:

> *"23. Shri U. K. Shandilya. learned sr. counsel for the appellants then submitted that the members of the petitioner's Association are not practising medicine, and hence they cannot be debarred from practice. We cannot agree. Chambers English Dictionary defines medicine to mean "the art or science of prevention and cure of disease." Thus, medicine is that knowledge which is used for curing the aliment of the human body. Since the petitioners claim that their activities are aimed at curing the ailment of the human body there can be no doubt that they claim to be practising medicine. It is of course a different*

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[9] decided by Bombay High Court on 13.8.2001
[10] 2004 4 AWC 3148

matter that their claim has not been accepted by the expert committee appointed by the Central Government."

The Court directed the State to restrain the practice or teaching of Electro

Homeopathy throughout the State.

In the case of **D.K.Joshi Vs. State of U.P.**[11] **a** public interest litigation was filed demanding that the State Government should take steps to stop unqualified practitioners from practicing in Agra and surrounding areas. The Court felt that adequate steps were not taken by the administration and issued directions in respect of the entire state of U.P. as follows:

"6. The Secretary, Health and Family Welfare Department, State of U.P. shall take such steps as may be necessary to stop carrying on medical profession in the State of U.P. by persons who are unqualified unregistered and in addition shall take followings steps:

(i) All District Magistrates and the Chief Medical Officers of the State shall be directed to identify, within a time limit to be fixed by the Secretary, all unqualified/unregistered medical practitioners and to initiate legal actions against these persons immediately.

(ii) Direct all District Magistrates and the Chief Medical Officers to monitor all legal proceedings initiated against such persons;

(iii)The Secretary, Health and Family Welfare Department shall give due publicity of the names of such unqualified/unregistered medical practitioners so that people do not approach such persons for medical treatment.

(iv) The Secretary, Health and Family Welfare Department shall monitor the actions taken by all District Magistrates and all Chief Medical Officers of the State and issue necessary directions from time to time to these officers so that such unauthorised persons cannot pursue their medical profession in the State."

In the case of **Charan Singh Vs. State of U.P.**[12] the Allahabad High Court was concerned with practitioners having degrees from unrecognized colleges. This arose as a follow up of the D.K. Joshi case above cited. The Court came down heavily on these practitioners and held that they had no right to practice. Similarly, it also ordered the State Government to close down such institutions. Besides this, the Court repeated the directions earlier issued by it meant for ensuring that only registered medical practitioners practice in the State. Towards this the Court directed:

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[11] C.A. No. 2016 of 1996 decided by the Supreme Court on 25.4.2000
[12] AIR 2004 ALL 373

(1) All the Hospitals, Nursing Homes, Maternity Homes, Medical Clinics, Private Practitioners, practising medicine and offering medical and ***health care*** *services, Pathology Labs, Diagnostic Clinics; whether run privately or by firms, Societies, Trusts, Private limited or Public limited companies, in the State, shall register themselves with Chief Medical Officer of the District where these establishments are situate, giving full details of the medical facilities offered at these establishments, the names of the registered and authorised medical personnel practising, employed or engaged by them, their qualifications with proof of their registrations, the Para Medical staff employed or engaged and their qualifications, on a form (for each category) prescribed by the Principal Secretary, Medical Health and Family Welfare, Government of U. P. The prescribed pro forma with true and accurate information shall be submitted, supported by an affidavit of the person providing such medical services of the person incharge of such establishment, sworn before Notary Public. The required information shall be submitted for registration, by al these persons, on or before 30-4-2004.*

(2) The principal Secretary, Medical Health and Family Welfare, U. P. shall publish the information requiring all the persons to obtain registrations, along with the directions given in this order, and the prescribed pro forma, in all leading newspapers of the State, at least three times, in the month of February, 2004.

(3) Any change or addition in the particulars submitted shall be notified within thirty days and that the registrations shall be renewed every year before 30th April of the year.

(4) On and from 1-5-2004, all those persons who have not furnished the information and obtained registration with the Chief Medical Officers of the District, shall be taken to be practising unauthorised and that the Chief Medical Officers, shall scrutinize and forthwith report the matter to the Superintendent/Senior Superintendent of Police of the District with information to this Court, to conduct raids and to seal the unauthorised premises/establishments. All the authorised persons/establishments, who fail to obtain registration will have liberty to apply only to this Court to explain the delay and to seek permission to continue with their medical practice/profession.

(5) All those medical practitioners who desire to offer medical services in the State, in future, shall be required to submit the details in the aforesaid pro forma for registration as above with the Chief Medical Officer of the district before they start medical practice.

(6) All the institutions/establishments/ colleges awarding medical degree in the State shall apply and get themselves with the Principal Secretary Medical Health and Family Welfare, U. P. with full particulars of their authorization to confer such degrees/certificates, on or before 30-4-2004.

(7) The news papers and magazines, published in Uttar Pradesh, are restrained from publishing advertisements by and from unauthorised medical

practitioners, publishing their claims of quick and magical remedies. They shall require these persons to give proof of their qualifications and registrations. The breach shall be taken to aid and obviate illegal activities violative of Magic Remedies (Objectionable Advertisement) Act, 1954, and other relevant legislation's.

(8) The Principal Secretary, Medical Health and Family Welfare, it is directed, to ensure that no medical officer in the Government Service is posted beyond three years in any District, and that all para medical staff serving in the Primary Health Centre/Community Health Centre/District Hospitals and other hospitals run by Government of U.P. for more than five years shall be transferred from that centre/hospital. Any doctor in employment of State Government offering their services to the unauthorised medical practitioners shall face immediate disciplinary action by the State Government, and shall be prosecuted for aiding and abetting such unauthorised practice.

In the case of **Shri Sarjoo Prasad Vs. State of Bihar**[13] the Patna High Court was concerned with the right of practice of Occupational Therapists/ Physiotherapists. To begin with, after studying the literature in detail the Court held that Occupational/ physiotherapy is a recognized form of medical practice. However, the Court further observed that unless the concerned qualification finds a place in the Schedule to the Medical Council Acts and the holders of the qualifications are registered under that Act, they have no right to practice modern scientific medicine or prescribe allopathic drugs.

C. CONCLUSIONS

India is a place where various systems of medicine are practiced. The Legislature however recognizes the 5 main systems, namely Allopathy, Ayurvedic, Unani, Siddha and Homeopathy. In order to practice medicine, practitioner has to have a recognized qualification from a recognized institute. In all other cases, practice of medicine is prohibited.

The Courts have mainly been concerned with cross practice and practice of certain non recognized systems of medicine. Cross practice has by and large not been allowed though there are certain exceptions. Similarly, uniformly the Courts have uniformly come down against unrecognized degrees or qualifications granted by unrecognized institutions. The Courts have also refused to recognize other systems of medicine such as electorpathy, etc.

One issue which has been constantly coming up especially in States like Maharashtra concerns registered practitioners of other States. In states like Bihar, a certificate for practicing medicine is permitted even without any formal qualifications if one is able to satisfy certain basic criteria. A number of persons from Maharashtra, for instance, go to Bihar and get these Certificates and start practicing medicine in Maharashtra. Such practice has been challenged in Maharashtra and the cases are pending in Court. But it is very likely that the Courts will frown upon such practice and will not allow such medical practitioners.

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[13] 2003 1 BLJR 686

Mihir

CHAPTER

VII

EMERGENCY HEALTH CARE

A. INTRODUCTION

Following questions repeatedly confront doctors, patients as well as activists.

- Are doctors and hospitals bound to attend to emergency patients?
- Is the obligation same for Government hospitals and private hospitals?
- What if the case is a police case? Should the police formalities be first completed before attending to a patient?
- What if the patient or his relatives do not have money to bear expenses for the treatment?

We read about and hear of many cases where emergency patients suffer as they are sent from one hospital to another without being admitted. Many times private hospitals refuse to admit medico legal emergency cases and ask them to approach public hospitals.

In India, there is no law that deals specifically with duty to provide medical treatment in emergency cases. Emergency health care like public health facilities falls in the shadow of Article 21. In other words, where there is refusal to treat an emergency case, petitioner can initiate legal proceedings for compensation for violation of his right to life. Supreme Court has held that failure to provide timely medical care amounts to violation of fundamental right to life.

In reference to emergency cases, Supreme Court is more definite on the nature and extent of duty of State. State is under an absolute liability to provide medical facilities in such circumstances, and financial inability or lack of infrastructure is no justification to evade such liability. Whenever State fails to discharge its constitutional obligation, aggrieved party may approach either Supreme Court or High Court under Articles 32 or 226, respectively as a public law remedy. Court may also be moved by a public-spirited person or organization as Supreme Court in number of judgments has said that the traditional concept of 'locus standi' does not strictly apply to Public Interest Litigation.[1] Supreme Court & High Courts also have the power to convert a letter concerning any issue of public importance into a PIL suo moto (at its own initiative).

So far as duty of private medical practitioners and private hospitals are concerned, in the ordinary course of practice, they have a right to decide whether to undertake a case or not.[2] However, Supreme Court while deciding upon delay in treatment of medico-legal cases by Government hospitals has said that even private hospitals

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[1] One of the basic principles of law is that only such a person can approach the court who is directly affected by chain of events which gives rise to the legal proceedings. Thus, at the admission stage aggrieved party must establish its 'Locus standi'. If such a party fails then the matter is held not maintainable, i.e., court has the jurisdiction to try the matter but will not because the party claiming relief does not have right to claim such relief.

[2] 'When a patient consults a doctor, the doctor owes him certain duty, viz., a duty of care in deciding whether to undertake the case and a duty of care in deciding what treatment to give. A breach of any of these duties gives a right of action for negligence to the patient.' Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole AIR 1969 SC 128

cannot refuse treatment in a medico-legal case. But the question is if a private hospital refuses treatment then which forum is to be approached. Article 21 of the Constitution dealing with right to life is normally not available against private parties. Consumer courts and civil courts deal with tortuous liability of doctor or hospital, i.e., negligence in treatment. In emergency cases if the hospital refuses to treat a patient it can definitely amount to negligence in performing duties and consumer court or civil courts can be approached.

However, the under the Code of Medical Ethics drawn up by the Medical Council with the approval of the Central Government, it has been said:

> "10. Obligations to the sick:
>
> Though a physician is not bound to treat each and every one asking his services except in emergencies for the sake of humanity and the noble traditions of the profession, he should not only be ever ready to respond to the calls of the sick and the injured, but should be mindful of the high character of his mission and the responsibility he incurs in the discharge of his ministrations, he should never forget that the health and the lives of those entrusted to his care depend on his skill and attention. A physician should endeavour to add to the comfort of the sick by making his visits at the hour indicated to the patients.
>
> 13. The patient must not be neglected:
>
> A physician is fee to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant. No provisionally or fully registered medical practitioner shall wilfully commit an act of negligence that may deprive his patient or patients from necessary medical care."

Of course, there will continue to be a number of gray areas. For instance, if a patient suffers a heart attack in the clinic of a general practitioner to what extent is the general practitioner liable to treat such a patient. It appears that in such a case the general practitioner would be required to give ordinary care and treatment to a patient but will not be expected to treat like a heart specialist. Or while traveling in an aircraft if a passenger suffers a stroke, is a doctor co passenger obliged to treat him? These are areas on which still there is no clarity. In the absence of a specific law, there is also not likely to be clarity on every area since the law develops depending on the cases which come up before the court and such development is very erratic and uneven.

B. IMPORTANT CASE LAW

I. OBLIGATION TO PROVIDE EMERGENCY HEALTH CARE

Paschim Banga Khet Mazdoor Samity v. State of W.B.[3]

> *'Providing adequate medical facilities is an essential part of the obligation undertaken by the State in a welfare state. The Government discharges this obligation by running hospitals and health centres. Article 21 imposes an obligation on the State to safeguard right to life of every person. Preservation of human life is thus of paramount importance. Government hospitals run by the state and the medical officers employed therein are duty-bound to extend medical assistance for preserving human life. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21'* (para 9)

Is it only for emergency?

The issue before Supreme Court was the legal obligation of Government to provide facilities in government hospitals for treatment of persons who had sustained serious injuries and required immediate medical attention. In the instant petition, Petitioner who had suffered brain hemorrhage in a fall from the train was denied treatment at various Government hospitals because of non-availability of beds.

The Petitioner was given first aid in a Primary health centre and referred to a certain specialized State hospital for better treatment. At the specialized hospital, Petitioner was examined and X-rays of his skull were taken which showed his condition as serious and immediate admission for further treatment was recommended. However, he was not admitted as there were no vacant beds and was referred to another specialized hospital. There also he was not admitted are there were no vacant beds. After doing the rounds of three more State specialized hospitals, Petitioner was admitted in a private hospital and incurred expenditure disproportionate to his means. He had to spend Rs. 17,000 for his treatment.

Respondent Government justified its action on the ground that the petitioner could not have been kept on floor of a hospital or trolley because such arrangement of treatment was fraught with grave risks of cross-infection and lack of facility for proper post-operative care. The Respondent State further stated that State hospitals cater to the need of poor and indigent patients as of the total number of beds maintained by the state government all over the State, 90% are free beds for treatment of such patients.
During the pendency of the case, the State Government appointed an enquiry committee to investigate the matter. It concluded, -

> 'Even in excess of the sanctioned beds some patients are kept on the trolley-beds in the morning and that even if it is dangerous to keep a patient with head injuries on a trolley-bed he could very well be kept for the time being on the floor and could be transferred to the cold ward, as the situation demanded, temporarily. In the instant case, the Emergency Medical officer concerned should have taken some measure to admit the petitioner and he is, therefore, responsible for non-admission in the said hospital. In a situation of this kind, the Superintendent of the hospital should take some measures to give

[3] (1996)4 SCC 37

guidelines to the respective medical officers so that a patient is not refused admission when his condition is grave...

The Emergency Medical Officer should have contacted the superior authority over the telephone if there was any stringency as to the beds available and admit the patient in spite of the total sanctioned beds not having been available. The Superintendent should have given guidelines to respective medical Officers for admitting serious cases under any circumstances and thus in a way the Superintendent was responsible for this general administration.'

Various recommendations made by the Enquiry Committee were adopted by the State Government and following directions were issued by the West Bengal State Government to health centres/OPD/Emergency Departments of hospitals in dealing with patients:

1. Proper medical aid within the scope of the equipments and facilities available at the Health Centres and hospitals should be provided to such patients and proper records of the treatment given should be maintained and preserved. The guiding principle should be to ensure that no emergency case is denied medical care. All possibilities should be explored to accommodate emergency patients in serious condition.

   To avoid confusion Admission/Emergency Attendance Registers shall contain a clear recording of the following information:

   a) name, age, sex, address, disease of the patient by the attending MO;
   b) date and time of attendance/examination/admission of the patient; and
   c) whether and where the patient has been admitted, transferred, referred;

   Further, there should be periodical inspection of the arrangement by the Superintendent and responsibility fixed for maintenance and safe custody of the registers.
2. Emergency Medical Officers will get in touch with Superintendent/Deputy Superintendent/Specialist Medical Officer for taking beds on loan from cold wards for accommodating such patients as extra-temporary measures.
3. Superintendents of hospitals will issue regulatory guidelines for admitting such patients on internal adjustments amongst various wards and different kinds of beds including cold beds and will hold regular weekly meetings for monitoring and reviewing the situation.
4. If feasible, such patients should be accommodated in trolley-beds and, even, on the floor when it is absolutely necessary during the exercise towards internal adjustments as referred to above.

The Enquiry Committee made certain other suggestions which were also accepted by the State Government:

1. A central Bed Bureau should be set up which should be equipped with wireless or other communication facilities to find out where a particular emergency patient can be accommodated when a particular hospital finds itself absolutely helpless to admit a patient because of physical limitations. In such cases the hospital concerned should contact immediately the Central Bed Bureau which will communicate with other hospitals and decide in which hospital an emergency serious patient is to be admitted.
2. Some casualty hospitals or trauma units should be set up at some points on regional basis.

3. The intermediate group of hospitals, viz., the district, sub-division and the State general hospitals should be upgraded so that a patient in a serious condition may get treatment locally.

Apart from directions of the Respondent State and the recommendation of Enquiry Committee, Supreme Court made some additional recommendations:

1. Adequate facilities at the Primary Health Centres where the patient can be given basic treatment and his condition stabilized.
2. Hospitals at the district and Sub-divisional level are to be upgraded so that serious cases can be treated there.
3. Facilities for giving specialist treatment are to be increased and having regard to the growing need, it must be made available at the district and sub-divisional level hospitals.
4. In order to ensure availability of bed in an emergency at State level hospitals, there should be a centralized communication system so that the patient can be sent immediately to the hospital where bed is available in respect of the treatment which is required.
5. Proper arrangement of ambulance should be made for transport of a patient from the primary health centre to the district hospital or sub-divisional hospital to the State hospital.
6. Ambulance should be adequately provided with necessary equipment and medical personnel.

Supreme Court observed that though for implementation of the above directions financial resources would be required but at the same time it cannot be ignored that it is the constitutional obligation of State to provide adequate medical services to the people. The Court also observed: "In the context of the constitutional obligation to provide free legal aid to a poor accused this Court has held that the State cannot avoid its constitutional obligation in that regard on account of financial constraints. (Khatri II v. State Of Bihar). These observations will apply with equal, if not greater, force in the matter of discharge of constitutional obligation of the State to provide medical aid to preserve human life. In the matter of allocation of funds for medical services the said constitutional obligation of the State has to be kept in view." The Court held that it was necessary that a time-bound plan for providing these services should be chalked out keeping in view the recommendations of the Committee as well as the requirements for ensuring availability of proper medical services in this regard as indicated by us and steps should be taken to implement the same.

This case arose out of an incident in West Bengal. Other States were not parties to the case. Also, the Committee was concerned with West Bengal and the directions were also given by the West Bengal Government. **The Supreme Court, however, observed that other States, though not parties, should also take necessary steps in the light of the recommendations made by the Committee, the directions contained in the Memorandum of the Government of West Bengal dated August 22, 1995 and the further directions given in the Judgment. Thus all the directions referred to above, would be equally applicable to other States in the country.** Besides, Union of India was a party to these proceedings. The Court observed that since it was the joint obligation of the Centre as well as the States to provide medical services it is expected that the Union of India would render the necessary assistance in the improvement of the medical services in the country on these lines.

The Court also ordered that the Petitioner be paid Rs. 25,000/- as compensation.

Labonya Moyee Chandra v. State of West Bengal[4]

The instant case reflected the lack of seriousness of State in executing its duties and the implementation of the directions and recommendations in Paschim banga Khet Mazdoor Samity case.[5]

Appellant was an old woman residing in a village near the city of Burdwan who was denied admission in SSKM, a state hospital on account of non-availability of bed even though her condition was recorded as critical. This hospital was also involved in the earlier case of Pashim Banga Khet Mazdoor Samity.

Appellant suffered severe chest pain and difficulty in breathing, the local doctor examined her, diagnosed heart block and recommended immediate hospitalization. Appellant was taken to Burdwan where she was shown to Burdwan Medical College hospital (BMCH) who referred her to cardiology department of Seth Sukhlal Karnanl Medical College (SSKM) in Calcutta or any other State hospital having cardiology department as they didn't have the said facility. At SSKM, RMO referred Appellant to the Cardiology Department who informed her that there were no vacant beds and referred her back to the RMO. Appellant instead was admitted in a private hospital were she under went an operation and a permanent pacemaker was implanted.

There were two issues before the Supreme Court: firstly, whether Appellant was brought to SSKM hospital in a critical state, and secondly, whether the Appellant was refused admission and 'turned out at night'.

The Supreme Court considered following evidence to conclude that Appellant indeed was in a critical state:

1) The prescription of the local doctor recorded that patient was unconscious, suffering from convulsion and frothing from mouth. He diagnosed complete heart block condition (stockes-adams). Stockes-adams is a medical term to designate occasional transient cessation of the pulse and loss of consciousness, especially caused by heart block. *'The condition of such patient must be critical.'* Accordingly the local doctor advised urgent hospitalization, and prescribed oxygen inhalation and medication.

2) Discharge certificate of BMCH described her condition as 'complete heart block' and referred her to a State hospital with cardiology department.

3) The endorsement of the cardiology RMO on the outdoor Emergency Department ticket of SSKM hospital also described her as suffering from 'Complete heart block' with S.A. Attack. This clearly showed that Appellant's condition was not stable as alleged by the State.

As regards the second issue, Supreme Court held that though the SSKM hospital did not turn her out it was not for her to bear with the jostling between the two departments when she was in a critical state. It was the responsibility of the doctor in charge of the Cardiology Department who examined her, to ensure that a bed was made available in any of the department so that she could be accommodated in the Cardiology Department as and when vacancy arose.

Supreme Court observed that despite the directions issued by it and the State Government in Pashcim Banga Khet Mazdoor Samiti there had been no compliance of the same. Appellant was denied treatment in BMCH on ground of lack of proper facility. This was despite the specific direction in Mazdoor Samiti case to upgrade facilities and to set up specialist treatment in District level hospitals. "*Clearly State*

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[4] SC decided on 31/7/1998

[5] ibid

Government has not taken any follow up action to ensure that recommendations are implemented." There was no 'centralised communication system' set up with the help of which BMCH could have referred Appellant to a hospital that had vacant beds before setting her off on a long journey in a critical state. The 'admission register' maintained by SSKM hospital was not as per the guidelines set out in the Mazdoor Samiti case. The entries were haphazardly and irresponsibly made. It did not describe the medical condition of the Appellant although a column had been provided for it. The inquiry report submitted by SSKM hospital to Court did not show that there was no possibility of arranging bed for the Appellant. It was silent about the occupancy of beds in other departments.

In the light of above circumstances and lapses on part of State and government hospital to implement the recommendations in Pashim Banga Mazdoor Khet Samiti case, Supreme Court held the state liable to compensate Appellant for the cost of pace-maker assessed at Rs.25,000/-. Further, State Government was directed to take follow up action on the implementation of the recommendations under the earlier case.

II. MEDICO LEGAL CASES

Parmanand Katara v. Union of India[6]

Police formalities cannot come on the way

The instant petition was filed by a human right activist seeking directions against Union of India that every injured citizen brought for treatment should be instantaneously given medical aid to preserve life and thereafter the procedural criminal law should be allowed to operate in order to avoid negligent death and in event of breach of such direction, apart from any action that may be taken for negligence, appropriate compensation should be admissible. The Petitioner had appended to the writ petition a report titled 'Law helps the injured to die' published by Hindustan Times that told the story of a hit-n-run case where the victim was denied treatment by the nearest hospital and asked to approach another hospital situated 20 km away that was authorized to handle medico-legal cases. The victim succumbed to his injury on way to the other hospital.

There were three issues before Supreme Court:

First, whether there are any legal impediments that hindered timely treatment in medico-legal cases;

Second, the nature of duty of Government, Government hospitals & Police in medico-legal cases; and

Last, whether private hospitals could refuse to treat medico-legal cases?

Medical Council of India in its affidavit stated that though doctors are not bound to undertake every case but they can not refuse emergency case on humanitarian grounds and the noble tradition of the profession necessitates this. The affidavit stated that the doctors were reluctant to undertake medico-legal cases because of unnecessary harassment by Police during the course of investigation and trial. MCI urged that doctors attending medico-legal cases should be indemnified under the law from any action by the Government/police authorities so that it is conducive for doctors to perform their duties. Criminal procedure should be amended so that injured persons may be treated immediately without waiting for police report or completion of police formalities. The Indian Evidence Act should also be amended so that diary maintained by doctors in regular course of their work is admissible as evidence for the purposes of the medico-legal cases instead of their presence during trial to prove the same.

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[6] AIR 1989 SC 2039

A report of the Committee headed by the Director General of Health Services was filed. It had taken the following decisions:

> "1. Whenever any *medico-legal* case attends the hospital, the medical officer on duty should inform the Duty Constable, name, age, sex of the patient and place and time of occurrence of the incident, and should start the required treatment of the patient. It will be the duty of the Constable on duty to inform the concerned Police Station or higher police functionaries for further action.
>
> Full medical report should be prepared and given to the Police, as soon as examination and treatment of the patient is over. *The treatment of the patient would not wait for the arrival of the Police or completing the legal formalities.*
>
> 2. Zonalisation as has been worked out for the hospitals to deal with medico-legal cases will only apply to those cases brought by the Police. The *medico-legal* cases coming to hospital of their own (even if the incident has occurred in the zone of other hospital) will not be denied the treatment by the hospital where the case reports, nor the case will be referred to other hospital because the incident has occurred in the area which belongs to the zone of any other hospital. The same police formalities as given in para 1 above will be followed in these cases.
>
> *All Government Hospitals, Medical Institutes should be asked to provide the immediate medical aid to all the cases irrespective of the fact whether they are medico-legal cases or otherwise.* The practice of certain Government institutions to refuse even the primary medical aid to the patient and referring them to other hospitals simply because they are *medico-legal cases is not desirable*. However, after providing the primary medical aid to the patient, patient can be referred to the hospital if the expertise facilities required for the treatment are not available in that Institution."

The Union Government, filed its affidavit and denied that there was any legal impediment in criminal procedural law to hinder treatment in emergency cases. The affidavit mentioned, " there are no provisions in the Indian Penal Code, Criminal Procedure Code, Motor Vehicles Act etc. which prevent Doctors from promptly attending seriously injured persons and accident case before the arrival of Police and their taking into cognisance of such cases, preparation of F.I.R. and other formalities by the Police."

Supreme Court, agreeing with this, held that –

> *'There is no legal impediment for a medical professional when he is called upon or requested to attend to an injured person needing his medical assistance immediately. The effort to save the person should be the top priority not only of the medical professional but even of the police or any other citizen who happens to be connected with the matter or who happens to notice an incident or a situation.*
>
> *Preservation of human life is of paramount importance. That is so on account of the fact that once life is lost, the status quo ante cannot be restored as resurrection is beyond the capacity of man. The patient whether he is innocent person or liable to be punished under the laws of the society, it is the*

obligation of those who are in charge of the health of the community to preserve life so that innocent may be protected and the guilty may be punished. Social laws do not contemplate death due to negligence to tantamount to legal punishment. A doctor at the Government hospital positioned to meet the State obligation is, therefore, duty bound to extend medical assistance for preserving life. ***Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life.*** *No law or State action can intervene to avoid delay the discharge of the paramount obligation case upon the members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with discharge of this obligation cannot be sustained and must, therefore, give way..... ...Zonal regulations and classification cannot operate as fetters in the process of discharge of the obligation and irrespective of the fact whether under instructions or rules, the victim has to be sent elsewhere or how the police shall be contacted, the guidelines indicated in the 1985 decision of the Committee on Forensic Medicine (set up by the Ministry of Home Affairs of the Government of India) are to become operative".*

Supreme Court Legal Aid Committee v. State of Bihar[7]

The responsibility to provide immediate medical treatment to an injured person in a medico-legal case extends even to the police. Thus, where the deceased who was lynched by the mob for attempting to rob passengers of train, died because of negligence of the police in taking him to a hospital on time and also for the inhuman manner in which he was tied and dumped in the vehicle, the Court held that it amounted to violation of right to life and the State was bound to pay Rs.20,000/- as compensation for the loss of life.

- Is there any direct case directing Pvt. hospitals?

- Is it only for accidents any or emergency ? like heart attack)

Poonam Sharma v. Union of India[8]

In another case pertaining to the liability of police and Government hospital in medico-legal case, Petitioner's husband met with an accident while driving in allegedly drunken state. The police took him to Government hospital for check up where the doctor on duty stitched up an inch cut on his scalp and gave him brufen tablets. Later the deceased was taken into custody and charged for drunken driving under Motor Vehicles Act, 1988. In the night the deceased complained of severe headache and the police took him to the same doctor who again prescribed brufen tablets. During the night the condition of the deceased deteriorated. Next day his family bailed him out and took him to another hospital were he succumbed to brain hemorrhage.

High Court observed that in case of head injury, it is elementary that an extra care is required to be taken. Such extra care is required to be taken, particularly in medico-legal cases. In medico-legal cases, the doctor as also the police authorities are under statutory obligation not only to see that injuries suffered by a person who has been brought to the hospital be properly taken care of. Every doctor at the Government hospital having regard to the paramount importance of preservation of human life is statutorily obliged to extend his services with due expertise.

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[7] (1991) 3 SCC 482

[8] AIR 2003 Delhi 50

The instant case was not of an error in clinical judgment. Within a few hours, the patient was brought back complaining of severe headache. Despite that no further treatment was given and he was asked to take brufen tablets only. Thus, in light of the facts and circumstances of the case and that the deceased was only 30 years old drawing a salary of Rs.3,000/- per month, High Court ordered Rs. 2 lacs as compensation to the Petitioner.

C. CONCLUSION

The Courts have now been recognizing that the State and State run medical institutions have the obligation to provide medical care in cases of emergency. This cannot be contingent upon adequate infrastructure, etc. In the Paschim Banga Case, the Court ordered Central Bed Bureaus to be set up as also upgraded facilities in district and sub district hospitals. Of course these have not been widely implemented. But groups working on health can definitely file Public Interest Litigations in High Courts for implementation of these orders in their respective states.

It is to be noted that though the responsibility of the State and government hospitals is well provided by a radical interpretation of the Constitution, there is no definite corresponding legal duty imposed on private hospitals and practitioners to treat emergency cases. The above judgments focus on the duty of State and government hospitals. In this regard, the Counsel for the Petitioner in Paschim Banga Khet Mazdoor Samity case[9] made few interesting suggesting drawing from the legal position in USA. It was urged that the denial of treatment should be specifically made a cognizable offence and further it should also be made actionable as a tort.[10] In US it was found that private hospitals were turning away uninsured, indigent person in need of urgent medical care and these patients were often transferred to, or dumped on public hospitals and the resulting delay or denial of treatment had sometimes disastrous consequences. To meet this situation US Congress has enacted the *Consolidated Omnibus Budget Reconciliation Act, 1986* (for short COBRA) to prevent the practice of dumping of patients by private hospitals. By this Act all hospitals that receive medical care benefits and maintain emergency rooms are required to perform two tasks before they may transfer or discharge any individual: (i) the hospital must perform a medical screening examination of all prospective patients, regardless of their ability to pay; (ii) if the hospital determines that the patient suffers from an emergency condition, the law requires the hospital to stabilize his condition. It cannot transfer or discharge an unstabilized patient unless the transfer or discharge is appropriate as defined by the statute. COBRA also imposes penalty on hospitals and physicians who negligently violate its provisions. In addition, the individual who suffers personal harm as a direct result of the refusal to treat has a right to pursue civil action against the defaulting hospital.
In respect of medico legal cases, the Courts have now categorically laid down that treatment cannot wait for legal papers to be prepared.

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[9] ibid

[10] In civil law, liability of doctor arises when there is a duty of care, a breach of such duty and consequential injury. The duty is not absolute which implies that a doctor need not treat all those who approach him. He has right to refuse. He is liable for harm caused only to those whom he undertakes to treat.

VIII ENVIRONMENT AND HEALTH CARE

A. INTRODUCTION

The right to healthy, clean and pollution free environment has its origin in the human right to health. The logic being that in order for a healthy body one needs clean environment. Of course, there are a number of other reasons for the need of good environment, namely conservation of natural resources, maintaining bio diversity and protecting wild life. But in the context of individual human beings the right to clean environment is very much linked to the right to health.

As already set out in the earlier chapters, in India, the judicial recognition of the fundamental right to healthy environment preceded the recognition of right to health. A large chunk of public interest litigation in the last 20 years has revolved around environmental issues and there are hundreds of cases decided by the Apex Court concerning all facets of environment. In this Chapter, we are confining ourselves mainly to those judicial decisions, which touch upon right to health care and not merely right to health.

B. CASE LAW

[1]Municipal Council *Ratlam v. Vardichand* and others, is a crucial case because for the first time the Supreme Court prescribed that in matters concerning public health financial inability was no ground for State authorities to carry out their duties. The Apex court held that, '.....*A responsible Municipal Council constituted for the precise purpose of preserving public health and providing better finances cannot run away from its principal duty by pleading financial inability. Decency and dignity are non-negotiable facets of human rights and are a first charge on local self-governing bodies. Similarly, providing drainage system – not pompous and attractive, but in working condition and sufficient to meet the needs of the people – cannot be evaded if the municipality is to justify its existence.....*'

Precedent in the history of PIL

> Ratlam is a town in the State of Madhya Pradesh. The town had the Ratlam Municipal Council, as its local self governing body. The situation of sanitation in Ratlam was pathetic as the drains overflowed. In ward no 12, new road, Ratlam there was litter which dirtied the area and also created a lot of stink. The discharge from the alcohol plant on the road added to the woes of the citizens.
>
> The municipality was oblivious to its obligation towards human well-being and was directly guilty of breach of duty and public nuisance and active neglect. The sub-Divisional Magistrate, Ratlam, was moved to take action under Section 133 CrPC to abate the nuisance by ordering the municipality to construct drain pipes with flow of water to wash the filth and stop the stench. The magistrate found the facts proved, made the direction sought and scared by the prospect of prosecution under Section 188 IPC, for violation of the order under Section 133 CrPC, the

[1] AIR 1980 Supreme Court 1622

municipality rushed from court to court till, it reached the Apex Court as the last refuge of lost causes.

The Sessions Court held the order as unjustified but the High Court of Madhya Pradesh upheld the order of the Divisional Magistrate, Ratlam.

The Municipal Council, Ratlam argued that though it was their statutory obligation to build proper drains, there was financial inability. The Court held that, 'The plea of the municipality that notwithstanding the public nuisance financial inability validly exonerates it from statutory liability has no juridical basis. The criminal procedure code operates against statutory bodies and others regardless of the cash in their coffers, even as human rights under Part III of the Constitution have to be respected by the State regardless of budgetary provision. Likewise, Section 123 of the Act has no saving clause when the municipal council is penniless. Otherwise, a profligate statutory body or pachydermic governmental agency may legally defy duties under the law by urging in self-defence a self-created bankruptcy or perverted expenditure budget. That cannot be.'

The Supreme court also held that it was not just a matter of health of a private individual but the helath, safety and convenience of public at large was at stake.

The Supreme Court while passing the judgment in this matter partially modified the order of the magistrate and also asked the Municipal Council, Ratlam to carry out the following orders,

'1. We direct the Ratlam Municipal Council (R1) to take immediate action, within its statutory powers, to stop the effluents from the Alcohol Plant flowing into the street. The State Government also shall take action to stop the pollution. The sub-Divisional Magistrate will also use his power under Section 133 CrPC, to abate the nuisance so caused. Industries cannot make profit at the expense of public health. Why has the magistrate not pursued this aspect ?

2. The Municipal Council shall, within six months from today, construct a sufficient number of public latrines for use by men and women separately, provide water supply and scavenging service morning and evening so as to ensure sanitation. The Health Officer of the Municipality will furnish a report, at the end of the six-monthly term, that the work has been completed. We need hardly say that the local people will be trained in using and keeping these toilets in clean condition. Conscious cooperation of the consumers is too important to be neglected by representative bodies.

3. The State Government will give special instructions to the Malaria Eradication Wing to stop mosquito breeding in Ward 12. The sub-Divisional Magistrate will issue directions to the officer concerned to file

a report before him to the effect that the work has been done in reasonable time.

4. The municipality will not merely construct the drains but also fill up cesspools and other pits of filth and use its sanitary staff to keep the place free from accumulations of filth. After all, what it lays out on prophylactic sanitation is a gain on its hospital budget.

5. We have no hesitation in holding that if these directions are not complied with the sub-Divisional Magistrate will prosecute the officers responsible. Indeed, this Court will also consider to punish for contempt in case of report by the sub-Divisional Magistrate of willful breach by any officer.'

The court also held that the State should be guided by the paramount principle of Art. 47 of the Constitution of India which states that, improvement of public health should be one of the primary duties of the state.

The Bombay High court in [2]**Citizens Action Committee, Nagpur vs. Civil Surgeon, Mayo (General) Hospital, Nagpur and Ors**, put in detail the responsibilities of the Municipal Corporation, in marinating the civic hospital and the other basic amenities in the city. The high court in its order stated that, *'We cannot but emphasis that the hospitals have their own role to play. Hospitals are the necessities of modern life and they have to respond to the needs of any growing city. Hardly any option can be speedy out or any excuse permissible so as to afford an alibi when the matters concern the authorities would bestow urgent attention on every facet of the problem of public health and effectively ……'*

Basic amenities

The citizens Action Committee approached the Nagpur bench of the Bombay High Court asking the court to intervene as the over all condition of the civic amenities such as roads, sanitation and public health was deteriorating considerably.

The Court issued notice to all the concerned authorities and asked them to file their say. Two fact finding reports of the citizens were also given to the court. The court largely based its finding on the reports and the affidavits filed by the citizens.

One of the main problems was regarding the 3 hospitals that were being run by the state. The overcrowding in all the hospitals had reached dangerous levels. The trespassers and visitors also burdened the hospitals. Even the staff of the hospitals was housed in poor conditions and they were living in unhygienic conditions.

[2] AIR 1986 Bom 136

The court held that as per Art. 47 of the constitution of India it is the duty of the state to provide for proper facilities for public health.

The court set up an Investigative and Remedial Measures Suggestive Committee (I. R. M. S. C.) to look into the matter.

The High Court of Madhya Pradesh in [3]**Hamid vs. State of M.P.** held that the citizens have right to clean and safe drinking water. The court stated that, '*Under Article 47 of the Constitution of India, it is the responsibility of the State to raise the level of nutrition and the standard of living of its people and the improvement of public health. It is incumbent on State to improve the health of public providing unpolluted drinking water. Slate in present case has failed to discharge its primary responsibility. It is also covered by Article 21 of the Constitution of India and it is the right of the citizens of India to have protection of life, to have pollution free air and pure water……*'. The court also held the state liable to pay for the damages caused by the consumption of the polluted water.

Hamid Khan a lawyer filed a petition before the high court of the Madhya Pradesh, regarding the quality of water supplied through the hand pumps in the district of Mandla. The water being supplied contained high amount of fluoride causing damage to lot of people in terms of damages like, skeletal flurosis and dental flurosis.

The high court held that, 'Under Article 47 of the Constitution of India, it is the responsibility of the State to raise the level of nutrition and the standard of living of its people and the improvement of public health. It is incumbent on State to improve the health of public providing unpolluted drinking water. Slate in present case has failed to discharge its primary responsibility. It is also covered by Article 21 of the Constitution of India and it is the right of the citizens of India to have protection of life, to have pollution free air and pure water……'

The court also held that the people affected due to the contaminated water should be treated at the expense of the state. The court further held that in cases where surgery is required, it should be done at the state expense.

The State was also directed to close down the hand pumps which had excessive amount of fluoride and a proper and safe drinking water facility should be put in place.

The Allahabd High court in [4]**Kaamlavati vs. Kotwal and others**, ordered the brick klin owners to follow the norms laid down by the government very strictly and also ordered the government to set up a fund for the modernization of the brick kilns as the traditional brick klins were causing a lot of air pollution.

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[3] 1996
[4] 2000

C. CONCLUSION

In the hundreds of cases dealing with environment, our Courts have not really dealt so much with right to health care but right to health and the impact of environment on health. While dealing with environmental issues the Supreme Court has developed a number of innovative doctrines such as "polluter pays", "public trust", "reversal of burden of proof", "preventive principle", "trangenerational equity", etc. However, none of them directly deal with health care. It is important now for the Courts to look not just at the harmful effects of environmental pollution but also the issue of health care related to it and the responsibility of the polluters not just to stop the pollution but to ensure health care for those affected.

Indirect ref:

- M.C. Mehta → only speaks of Taj
- Sriram fertilisers → greenbelts around hazardous industries
- Vehicular pollution —
- Bhopal or other ~~gas~~ state level cases.

Principles evolved:

Polluter pays

Transgenerational equity

IX CONCLUSIONS

Last two decades have seen a phenomenal rise (compared to the earlier decades) on litigation concerning health of individuals and also communities and society at large. An obvious off shoot of these developments has been litigations concerning health care. Till the early 1980s judicial response to health related issues in India was essentially centered around cases of medical negligence. Even these cases were few and far between.

There were two developments in the 1980s which led to a marked increase in health related litigation. First was the establishment of consumer courts which made it cheaper and speedier to sue doctors for medical negligence. Second, the growth of public interest litigation and one of its off shoots being recognition of health and health care as a fundamental right.

PUBLIC INTEREST LITIGATION, FUNDAMENTAL RIGHT AND ITS CONSEQUENCES

The Public interest litigation movement in India started in late 1970s. This movement, had and has as its basis the enforcement of fundamental rights guaranteed under the Constitution of India. Any citizen could trigger off the judicial mechanism by claiming violation of fundamental rights, either of himself or of other individuals or of citizenry at large. Fundamental rights existed even before late 1970s. The real push for the PIL movement came from an expanded interpretation of the fundamental right to life which is enshrined in Article 21 of the Constitution. This reads:

> *"No person shall be deprived of his life or personal liberty except through procedure established by law."*

Till the 1970s by and large the courts had interpreted 'life' literally i.e. right to exist. It was in late 1970s onwards that an expanded meaning started to be given to the word 'life'. Over the years it has come to be accepted that life does not only mean merely animal existence but the life of a dignified human being with all its concomitant attributes. This has been interpreted to include a healthy environment and effective health care facilities.

As already mentioned in the Chapters above, to begin with, the right to health as a fundamental right grew as an off shoot of the environmental litigation. Pollution free environment as a fundamental right presupposes right to health as a fundamental right. Logically, the explicit recognition of the fundamental right to health should have preceded the fundamental right to good environment. However, the development of jurisprudence in this branch has been reverse. To begin with, right to decent environment was recognized and from that followed the right to public health, health and health care. Even while dealing directly with right to health, the first issues concerned employees' health.

EMPLOYEES' RIGHT TO HEALTH

It was in 1991, in **C.E.R.C. Ltd. Vs. Subhash Chandra**[1] the Supreme Court placed reliance on international instruments and declared that right to health is a fundamental right. It went further and observed that health is not merely absence of sickness and observed:

> "33. *...In the light of Arts. 22 to 25 of the Universal Declaration of Human Rights, International Convention on Economic, Social and Cultural Rights, and in the light of socio-economic justice assured in our Constitution, right to health is a fundamental human right to workmen. The maintenance of health is a most imperative constitutional goal whose realisation requires interaction by many social and economic factors."*

In **CERC Vs. Union of India**[2] the Supreme Court was dealing with the rights of workers in Asbestos manufacturing and health hazards related to it. It observed:

> "27. Therefore, we hold that right to health, medical aid to protect the health and vigour of a worker while in service or post retirement is a fundamental right under Article 21, read with Articles 39(e), 41, 43, 48A and all related to Articles and fundamental human rights to make the life of the workman meaningful and purposeful with dignity of person."

Similarly, in **State of Punjab Vs. Mohinder Singh Chawla**[3], dealing with rights of Government employees to health care, the Supreme Court observed:

> "It is now settled law that right to health is an integral to right to life. Government has constitutional obligation to provide the health facilities. If the Government servant has suffered an ailment which requires treatment at a specialised approved hospital and on reference whereat the Government servant had undergone such treatment therein, it is but the duty of the State to bear the expenditure incurred by the Government servant. Expenditure, thus, incurred requires to be reimbursed by the State to the employee."

RIGHT TO HEALTH- GENERALLY

In **Virender Gaur v. State of Haryana,** 1995 (2) SCC 577, the Supreme Court held that environmental, ecological, air and water pollution, etc., should be regarded as amounting to violation of right to health guaranteed by Article 21 of the Constitution. In **Kirloskar Brothers Ltd. v. Employees' State Insurance Corporation**[4], the Supreme Court held that right to health and medical care is a fundamental fight under Article 21 read with Article 39(e), 41 and 43. It is also relevant to notice as per the judgment of the Supreme Court in **Vincent Panikurlangara v. Union of India,** AIR 1987 SC 990 - (1987) 2 SCC 165, "In a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health."

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[1] AIR 1992 SC 573
[2] 1995 3 SCC 42
[3] 1997 2 SCC 83
[4] (1996) 2 SCC 682

But having recognized that right to health and health care is a fundamental right what follows? Fundamental rights are generally available only against the state. They prescribe the obligations of the State. In a poverty ridden country like India, does it mean that the State must provide free medical health care facilities to all? In a situation where there is increasing privatization of health care systems, where the annual budget for health is reducing, where the cost of health education is growing exponentially this seems very unlikely. No Court has yet said that the State is bound to provide free medical care to all the citizens.

QUALITY OF HEALTH CARE

The other aspect would of course be the quality of health care provided by the State. Infrastructure in not just primary health care centers but even in government run hospitals in metropolitan cities is crumbling. These institutions are plagued by lack of enough beds, sufficient medicines and other similar problems. The Courts including the Supreme Court have not adequately dealt with this aspect. They have mainly been concerned with pious declarations of health being a fundamental right and peripharal and not so peripharal issues such as rights of government employees to be treated in government hospitals, emergency medical care and the like.

But in a case dealing with bad infrastructure in public hospitals the

Allahabad High Court held[5]:

> *" It is indeed true that most of the Government Hospitals in Allahabad are in a very bad shape and need drastic improvement so that the Public is given proper medical treatment. Anyone who goes to the Government Hospitals in Allahabad will find distressing sanitary and hygienic conditions. The poor people, particularly, are not properly looked after and not given proper medical treatment. Consequently, most people who can afford it go to private nursing homes or private clinics. ...All this needs to be thoroughly investigated. This is a welfare State, and the people have a right to get proper medical treatment. In this connection, it may be mentioned that in U.S.A. and Canada there is a law that no hospital can refuse medical treatment of a person on the ground of his poverty or inability to pay. In our opinion. Article 21 of the Constitution, as interpreted in a series of judgments of the Supreme Court, has the same legal effect."*

Statutory duty of police and government hospitals

In the case of **B. Poonam Sharma v. Union of India**[6], the Court held that *every doctor at the government hospital having regard to the paramount importance of preservation of human life is under statutory obligation to extend his services with due expertise.* Hence, Respondent was directed to pay Rs.2 lacs as compensation under Public Law for violation of fundamental rights of Petitioner's husband.

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[5] In S.K.Garg Vs. State of U.P. decided on 21.12.98

[6] AIR 2003 Delhi 50

In Marri Yadamma v. State of Andhra Pradesh[7], the High Court stated that on arrest a prisoner merely loses his right to free movement. His all other rights including right to medical treatment remains intact and it cannot be violated.

EMERGENCY HEALTH CARE

One of the major issues concerning health care has been the obligation of doctors to provide emergency health care.
In the case of **Paschim Banga Khet Mazdoor Samity v. State of W.B.**[8] the Supreme Court observed that providing adequate medical facilities is an essential part of the obligation undertaken by the State in a welfare state. And the failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21.

It is to be noted that though the responsibility of the State and government hospitals is well provided by a radical interpretation of the Constitution, there is no definite corresponding legal duty imposed on private hospitals and practitioners to treat emergency cases. The judgments mainly focus on the duty of State and government hospitals.

Medico-legal cases:
In **Parmanand Katara v. Union of India**[9] Supreme Court, held that –

> *'There is no legal impediment for a medical professional when he is called upon or requested to attend to an injured person needing his medical assistance immediately. The effort to save the person should be the top priority not only of the medical professional but even of the police or any other citizen who happens to be connected with the matter or who happens to notice an incident or a situation.*
>
> ***Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life.*** *No law or State action can intervene to avoid delay the discharge of the paramount obligation case upon the members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with discharge of this obligation cannot be sustained and must, therefore, give way..... ..... "*

CONDITIONS OF EMPLOYMENT OF HEALTH CARE PROFESSIONALS

In **C.L. Venkata Rao Vs. Govt. of Andhra Pradesh**[10] the Andhra Pradesh High Court was concerned with the issue of strikes by doctors and facilities in medical hospitals. The Court relied on the Medical Regulations framed under Section 20-A read with Section 33(m) of the Indian Medical Council Act, 1956. Regulation No. 2 in Chapter-2 lays down the duties of physicians to their patients. Regulation No. 2.4 lays down:

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[7] AIR 2002 AP 164
[8] (1996)4 SCC 37
[9] AIR 1989 SC 2039
[10] 2005 6 ALD 327 decided on 23.8.2005

"provisionally or fully registered medical practitioner shall not willfully commit an act of negligence that may deprive his patient or patients from necessary medical care."

Chapter-7 of these Regulations deals with misconduct and the acts of commission or omission on the part of a physician, which construe misconduct. Regulation No. 7.1 deals with violation of the Regulations. Regulation No. 7.24 lays down that:

"If a physician posted in a medical college/institution both as teaching faculty or otherwise shall remain in hospital/college during the assigned duty hours. If they are found absent on more than two occasions during this period, the same shaH be construed as a misconduct if it is certified by the Principal/Medical Superintendent and forwarded through the State Government to Medical Council of India/ State Medical Council for action under these Regulations."

On the basis of these two provisions, the Division Bench came to the conclusion that doctors do not have a right to strike. However, since the strike had been withdrawn the Court directed that no action be taken against striking doctors.

The second issue which the Court dealt with concerned provision of emergency health care services in case doctors go on strike. High Court directed the State Government to have an emergency plan ready in case doctors go on strike including opening up military and similar hospitals for common people during the strike. The Court exhorted private hospitals to provide free treatment to poor patients in case of strike by Government doctors.

The third issue was the one raised by doctors. They had argued that the Government hospitals did not have enough facilities. This included problems concerning lack of availability of drugs, inadequate teaching doctors, etc. The High Court appointed a committee to go into these aspects and submit a report to the Government.

Seenath Beevi Vs. State of Kerala[11] was concerned with conditions of service of nurses in hospitals. The Kerala High Court was faced with a situation where the nurses in some of the Taluka hospitals complained that they were required to perform 14 hours of duty for six days in a week and asked the Court to direct the Government to have nurses in three shifts of 8 hours each. The State contented that this would cause tremendous financial strain to it. To begin with, the Court observed:

"Facts stated in the Writ Petition, uncontroverted as they are, go to show that the work of a Nurse, especially in the Government Hospitals, is extremely arduous in nature. The sum and substance of the submission of the learned counsel is that attending such duties continuously for long hours is harmful to the physical as well as mental health of the Nurse, unsafe to the patient and likely to cause deleterious consequences."

[11] 2003 3 KLT 788

The Court, after referring to various decisions of the Supreme Court, reaffirmed that right to decent working conditions is part of fundamental right to life. It further observed:

> *"Therefore it can safely be held that rationalisation of working hours to make it just, unreasonable and humane is the constitutional obligation of the State. Right to have such conditions of work is an integral part of the right to life under Article 21 of the Constitution."*

The Court ordered that nurses must not be forced to work for more than 8 hours a day and financial stringency is no ground for the State to abdicate this responsibility. The Court's final order had the following directions:

> *"(i) There shall be a declaration that compelling the petitioner to be on duty continuously for 14 hours a day for 6 days consecutively in a week is illegal and unconstitutional.*
>
> *(ii) The respondents are directed to introduce 3 shift duty system in the Government Hospital, Thirroorangadi, immediately and redress forthwith the grievance of the petitioner.*
>
> *(iii) It is made clear that in the light of the declaration above made to the effect that the impugned action of the respondents is illegal and unconstitutional, the prevailing system of assigning duty for 14 hours continuously to the petitioner and other nursing staff shall not be continued. It follows that the respondents shall take expeditious steps to introduce 3 shift duty system for the nursing staff in all the hospitals."*

The Supreme Court and the High Courts have been intervening in a much more active manner in the last few years on the issue of health and health care. But again, unless they start looking into the impact of patents and drug price control as also the obligations of private hospitals, the effect is bound to be limited. Besides, there is an increasing need to look at the obligations of private hospitals. The Bombay and Delhi High Courts have already started looking into this issue, but unless there is a national level focus on the responsibilities of private health care providers the impact of judicial decisions is likely to be very marginal. There is definitely a need for a Central Legislation which lays down responsibility of the State to provide cheap, accessible and quality health care to all Indians.

Mihir Desai

Annexure : Acts and Laws related to Health.

HEALTH RELATED LEGISLATION IN KARNATAKA

NAVEEN I. THOMAS

September 2003

COMMUNITY HEALTH CELL
Society for Community Health Awareness, Research & Action (SOCHARA)
Bangalore, India

Introduction

If the number of laws a land possessed were an indicator of a law-abiding society, India would have been highly ranked among the nations of the world. However, the mere possession of laws and other legal instruments do not ensure a law-abiding society, instead it just adds to the notion of lawlessness (more the laws, more will be the incidents of violations). However, legislations and legal instruments provide an avenue, which could be harnessed by an aware and vigilant civil society to ensure order and social justice.

The need for a vigilant and pro-active civil society has become all the more necessary in view of legislations and decisions increasingly being taken at a global level, way beyond the reach of local communities and very often, even national governments. The World Trade Organisation (WTO) negotiations is a case in point, where nations and continents are subdued into agreeing to norms and agendas that are very often set by powerful Trans-National Corporations (TNCs). However, WTO is not the only mechanisms for remote access and control of national resources and economies. Aid and loan given by industrialized nations and multi-lateral organisations like the World Bank to less-industrialized nations, are often means of coercing them to budge to the machination of powerful vested interests. The governments of the less-industrialized nations have repeatedly failed to stand up to such devices. In such a scenario, it is important for the civil society to be pro-active and work towards strengthening the existing spaces available for people to have access and control over their resources.

Much has been written about the impact of globalization on health. Even the National Health Policy 2001 makes a note of the threats faced by people due to globalization. However sadly, the Government action has been to reduce it's spending on health, even while taking the LPG (liberalization, privatization and globalization) route. More than 80% of health spending is already in the private sector. The opening up of the health sector under the General Agreement of Trade in Services (GATS) could see further changes in the health care scenario in the country.

There is a dire need to explore different ways in which health of the people can be secured. Prioritization of health spending, increasing the health budget and strengthening the policy and legal environment are a few of the ways, in which this can be achieved. Strengthening the policy and legal environment helps people to stake a claim to health and health care as a right, if it is accompanied with proper enforcing, monitoring, redressing and mass-awareness creating mechanisms. The role of civil society in supporting the process cannot be over-emphasized here.

The knowledge of existing legislation is the first step in enforcing or improving the policy and legal environment. This document attempts to put together the legislations in Karnataka which form a major part of the existing policy environment in the state. However this has to be seen in the context of other policies and practices including the functioning of the Taskforce on Health which was set up the state Government, role of judiciary, rules framed under various Acts and regulations of local bodies like corporations, municipalities, panchayats, etc. and Government Orders (G.O.).

This purpose of this document is to serve a handbook for NGOs, health activists, academicians, Government functionaries, media persons and anybody who wishes to know the existing Acts as provided by the Karnataka state. It has been updated up to December 2002. A few important Acts passed in 2003 have also been included. The website of the Department of Parliamentary Affairs and Legislation, Government of Karnataka (http://dpal.kar.nic.in/) came in handy for preparing the handbook.

This handbook is only a preliminary document and needs to be expanded further to include laws and policies applicable at different levels. A critique of the contents of these laws and policies are also needed for an informed debate and policy refinement. That would be the next step in this journey!

24 Sep 2003

Note: The following section lists the various Acts of Karnataka state, which have a link with health. The Acts of Karnataka state have been divided into seven sections:

1) Health related Acts
2) Agriculture/ Veterinary/ Animal related Acts
3) Urban related Acts
4) Rural related Acts
5) Tobacco/ Alcohol related Acts (including industrial use)
6) General Acts

Health related Acts

Sl.	Act	Amendment(s) / Remarks
1.	Anatomy Act, 1957 (23 of 1957)	Amended by Act 15 of 1999
2.	Ayurvedic, Naturopathy, Siddha, Unani and Yoga (Registration and Medical Practitioners) Miscellaneous Provisions Act, 1961 (9 of 1962)	Amended by Act 9 of 1966, 32 of 1966, 3 of 1968, 8 of 1969, 13 of 1972, 7 of 1977, 46 of 1981, 38 of 1991 and 11 of 1992
3.	Health Cess Act, 1962 (28 of 1962)	Amended by Acts 19 of 1968, 33 of 1976
4.	Medical Registration Act, 1961 (34 of 1961)	
5.	Nurses, Midwives and Health Visitors Act, 1961 (4 of 1962)	Amended by Act 27 of 1981
6.	Private Nursing Homes (Regulation) Act, 1976 (75 of 1976)	Amended by Act 9 of 1977
7.	Rajeev Gandhi Health Sciences University Act, 1994 (44 of 1994)	Amended by Act 11 of 1998
8.	District Vaccination Act 1892 (Bombay Act I of 1892)	Act which is in force in Belgaum area
9.	Drugs (Control) Act, 1952, (Bombay Act XXIX of 1952)	Act which is in force in Belgaum area
10.	Female Infanticide Prevention (Amendment) Act, 1897 (Bombay Act III of 1897)	Act which is in force in Belgaum area
11.	Indian Lunacy (Bombay Amendment) Act, 1938 (Bombay Act XV of 1938)	Act which is in force in Belgaum area
12.	Nursing Homes Registration Act, 1949 (Bombay Act XV of 1949)	Act which is in force in Belgaum area
13.	Vaccination Act, 1877 (Bombay Act I of 1877)	Act which is in force in Belgaum area
14.	Indian Medical Degrees (Coorg Amendment) Act, 1949 (Coorg Act IV of 1949)	Act which is in force in Coorg area
15.	Public Health Act, 1943 (Coorg Act I of 1943)	Act which is in force in Coorg area
16.	Vaccination Act, 1950 (Coorg Act IV of 1950)	Act which is in force in Coorg area
17.	Infections Diseases Act, 1950 (Hyderabad Act XII of 1950)	Act which is in force in Gulbarga area
18.	Vaccination Act, 1951 (Hyderabad Act XXIV of 1951)	Act which is in force in Gulbarga area
19.	Dangerous Drugs (Madras Amendment) Act, 1950 (Madras Act XVI of 1950)	Act which is in force in Mangalore – Kollegal area
20.	Drugs (Control) Act, 1949 (Madras Act XXX of 1949)	Act which is in force in Mangalore – Kollegal area
21.	Medical Degrees (Madras Amendment) Act, 1940 (Madras Act XX of 1940)	Act which is in force in Mangalore – Kollegal area
22.	Opium and Dangerous Drugs (Madras Amendment) Act, 1947 (Madras Act XXXIV of 1947)	Act which is in force in Mangalore – Kollegal area
23.	Opium (Madras Amendment) Act, 1951 (Madras Act XXXII of 1951)	Act which is in force in Mangalore – Kollegal area
24.	Public Health Act, 1939 (Madras Act III of 1939)- Amended by Karnataka Act 13 of 1965, 83 of 1976.	Act which is in force in Mangalore – Kollegal area
25.	Tuberculosis Sanetoria (Regulation of Buildings) Act, 1947 (Madras Act XVI of 1947)	Act which is in force in Mangalore – Kollegal area
26.	Drugs Control Act 1950 (Mysore Act V of 1950)	Act which is in force in Mysore area

27.	Lepers Act, 1925 (Mysore Act IV of 1925)	- Act which is in force in Mysore area - Amended by Karnataka Act 13 of 1965
28.	Public Health Act, 1944 (Mysore Act 10 of 1944)	- Act which is in force in Mysore area - Amended by Karnataka Act 13 of 1965
29.	Vaccination Act, 1906, (Mysore Act I of 1906)	- Act which is in force in Mysore area

Agriculture/ Veterinary/ Animal related

Sl.	Act	Amendment(s) / Remarks
1.	Agricultural Pests and Diseases Act, 1968 (1 of 1969)	
2.	Animal Diseases (Control) Act, 1961 (18 of 1961)	
3.	Live-Stock Improvement Act, 1961 (30 of 1961)	
4.	Sheep and Sheep Products Development Act, 1973, (12 of 1974)	- Amended by Acts 22 of 1978 and 20 of 1980 - Proposed for Repeal
5.	Prevention of Cruelty to Animals (Bombay Amendment) Act, 1953 (Bombay Act XXII of 1953)	Act which is in force in Belgaum area
6.	Prevention of Cruelty to Animals, the Bombay District Police and the City of Bombay Police (Amendment) Act, 1946 (Bombay Act XXVIII of 1946)	Act which is in force in Belgaum area
7.	Improved Seeds and Seedling Act, 1951 (Hyderabad Act XXVIII of 1951)	Act which is in force in Gulbarga area
8.	Restriction of Cash Crops Cultivation Regulation (Repealing) Act, 1953 (Hyderabad Act XIV of 1953)	Act which is in force in Gulbarga area
9.	Slaughter of Animals Act, 1950 (Hyderabad Act VII of 1950)	Act which is in force in Gulbarga area

Urban

Sl.	Act	Amendment(s) / Remarks
1.	Bangalore Water Supply and Sewerage Act, 1964 (36 of 1964)	Amended by Acts 6 of 1966, 10 of 1966 and 18 of 1984
2.	Prohibition of Beggary Act, 1975 (27 of 1975)	Amended by Acts 7 of 1982 and 12 of 1988
3.	Karnataka Slum Areas (Improvement and Clearance) Act, 1973 and Karnataka Public Premises (Eviction of Unauthorized Occupants) Act, 1974 (33 of 1974)	Amended by Acts 19 of 1981, 34 of 1984, 26 of 1986, 7 of 1988 and 21 of 2002
4.	Urban Water Supply and Drainage Board Act, 1973 (25 of 1974)	Amended by Acts 7 of 1976, 20 of 1977, 45 of 1981 and 19 of 1993
5.	Urban Development Authorities Act, 1987 (34 of 1987)	Amended by Acts 17 of 1991, 14 of 1992 and 12 of 1996
6.	The Karnataka Slum Areas (Improvement and Clearance) and Certain Other Law (Amendment) Act, 2002 (21 of 2002)	

Rural

Sl.	Act	Amendment(s) / Remarks
1.	Panchayat Raj Act 1993 (14 of 1993)	Amended by 10 of 1995, 9 of 1996, 17 of 1996, 1 of 1997, 10 of 1997, 29 of 1997, 29 of 1998, 10 of 1999, 21 of 1999, 8 of 2000, 11 of 2000 and 30 of 2001
2.	Village Defence Parties Act, 1964 (34 of 1964)	Amended by Act 22 of 2000
3.	Village Offices Abolition Act, 1961 (14 of 1961)	Amended by Acts 8 of 1968, 13 of 1978, 27 of 1984, 47 of 1986 and 22 of 2000

Tobacco/ Alcohol Related

Sl.	Act	Amendment(s) / Remarks
1.	Excise Act, 1965 (21 of 1966)	Amended by Acts 1 of 1970, 1 of 1971, 61 of 1976, 32 of 1982 28 of 1987, 36 of 1987, 1 of 1994, 2 of 1995. 7 of 1997, 21 of 98, 12 of 1999, 21 of 2000 and 15 of 2001
2.	Prohibition Act, 1961 (1 of 1962)	Amended by Act 10 of 1967
3.	Prohibition of Smoking in Show Houses and Public Halls Act, 1963 (30 of 1963)	
4.	Toddy Worker's Welfare Fund Act, 1981 (31 of 1994)	
5.	The Karnataka Prohibition of Smoking and Protection of Health of Non-Smokers Act, 2001 (2 of 2003)	
6.	(District) Tobacco Act, 1933 (Bombay Act II of 1933)	Act which is in force in Belgaum area
7.	Opium Smoking Act, 1936 (Bombay Act XX of 1936)	Act which is in force in Belgaum area
8.	Smoke-nuisances Act, 1912 (Bombay Act VII of 1912)	Act which is in force in Belgaum area
9.	Tobacco Duty (Town of Bombay) Act, 1857 and the Bombay (District) Tobacco Act, 1933 (Suspension) Act, 1945 (Bombay Act XI of 1945)	Acts which are in force in Belgaum area
10.	Power Alcohol Act, 1350 F (Hyderabad Act XI of 1350 F)	Act which is in force in Belgaum area
11.	Cigarette- Tobacco Safeguarding Act, 1939 (Mysore Act VI of 1939)	Act which is in force in Mysore area
12.	Power Alcohol Act, 1939, (Mysore Act VIII of 1939)	Act which is in force in Mysore area

General

Sl.	Act	Amendment(s) / Remarks
1.	Civil Services (Prevention of Strikes), Act, 1966 (30 of 1966)	Amended by Act 6 of 1967
2.	Civil Services (Regulation of Promotion, Pay & Pension) Act, 1973 (11 of 1974)	Amended by Acts 40 of 1976 and 25 of 1982
3.	Co-operative Societies Act, 1959 (11 of 1959)-	Amended by Acts 40 of 1964, 27 of 1966, 16 of 1967, Presidents Act 1 of 1972, Karnataka Acts 14 of 1973, 2 of 1975, 39 of 1975, 19 of 1976, 70 of 1976, 71 of 1976, 14 of 1978, 16 of 1979, 3 of 1980, 4 of 1980, 5 of 1984, 34 of 1985, 34 of 1991, 25 of 1998, 2 of 2000, 13 of 2000, 6 of 2001 and 24 of 2001

4.	Debt Relief Act, 1976 (25 of 1976)	Amended by Act 63 of 1976
5.	Departmental Inquiries (Enforcement of attendance of Witnesses and Production of Documents) Act, 1981 (29 of 1981)	Amended by Acts 43 of 1981 and 28 of 1986
6.	Devadasis (Prohibition of Dedication) Act, 1982 (1 of 1984)	
7.	Evacuee Interest (separation) Supplementary Act, 1961 (3 of 1961)	
8.	Existing Laws (Construction of References to Values) Act, 1957 (12 of 1957)	
9.	Essential Services Maintenance Act, 1994 (21 of 1994) (for a period of 10 years from the date of commencement i.e., 16-4-1994)	
10.	Famine Relief Fund Act, 1963 (32 of 1963)	
11.	Lokayukta Act, 1984 (4 of 1985)	Amended by Act 15 of 1986, 31 of 1986, 1 of 1988 and 30 of 1991
12.	Prohibition of Admission of Students to the Un-recognised and Un-affiliated Educational Institutions Act, 1992 (7 of 1993)	
13.	Resettlement of Project Displaced Persons Act, 1987 (24 of 1994)	
14.	Repealing and Amending Act, 2000 (22 of 2000)	
15.	Right to information Act, 2000 (28 of 2000)	
16.	Societies Registration Act, 1960, (17 of 1960)	Amended by Acts 1965, 20 of 1975, 65 of 1976, 7 of 1978, 48 of 1986, 11 of 1990, 9 of 1999, 7 of 2000 and 6 of 2002
17.	State Aid to Industries Act, 1959 (9 of 1960)	Amended by Acts 3 of 1964 and 20 of 1978
18.	State Commission for Women Act, 1995 (17 of 1995)	
19.	State Universities Act, 2000 (29 of 2001)	
20.	Transparency in Public Procurement Act 1999 (29 of 2000) and 21 of 2001	
21.	The Karnataka Fiscal Responsibility Act, 2002 (16 of 2002)	
22.	Charitable Endowments Act, 1890. (Central Act 6 of 1890)	This is a Central Act which has been amended by the Karnataka Act 19 of 1973
23.	Famine Relief Fund Act, 1936 (Bombay Act XIX of 1936)	Act which is in force in Belgaum area
24.	Fodder and Grain Control Act, 1939 (Bombay Act XXVI of 1939)	Act which is in force in Belgaum area
25.	Growth of Foodcrops Act, 1944 (Bombay Act VIII of 1944)	Act which is in force in Belgaum area
26.	Hindu Women's Rights to Property (Extension to Agricultural Lands) Act, 1947 (Bombay Act XIX of 1947)	Act which is in force in Belgaum area
27.	Molasses (Control) Act, 1956 (Bombay Act XXXXVIII of 1956)	Act which is in force in Belgaum area
28.	Refugees Act, 1948 (Bombay Act XXII of 1948)	Act which is in force in Belgaum area
29.	State Guarantees Act, 1954 (Bombay Act XXII of 1954)	Act which is in force in Belgaum area
30.	Village Industries Act, 1953 (Bombay Act XLI of 1954)	Act which is in force in Belgaum area
31.	(Emergency Powers) Whipping Act, 1947 (Bombay Act XXVII of 1947)	Act which is in force in Belgaum area

32.	Abolition of Whipping Act, 1956 (Hyderabad Act XXXVI of 1956)	Act which is in force in Gulbarga area
33.	Children Protection Act, 1343 F (Hyderabad Act IX of 1343 F)	Act which is in force in Gulbarga area
34.	Famine (Stricken Pettadars Property Protection Act, 1931 F (Hyderabad Act III c.1381 F)	Act which is in force in Gulbarga area
35.	Labour Housing Act, 1952 (Hyderabad Act XXXVI of 1952)	Act which is in force in Gulbarga area
36.	Mining Settlements Act, 1956 (Hyderabad Act XLIV of 1956)	Act which is in force in Gulbarga area
37.	Poisons Act 1322 F (Hyderabad Act IV of 1322 F)	Act which is in force in Gulbarga area
38.	Protection of Flood Stricken Debtors Property Act, 1318F (Hyderabad Act I of 1318 F)	Act which is in force in Gulbarga area
39.	Protection of Houses from the Floods of Mossi River Act, 1318 F (Hyderabad Act II of 1318 F)	Act which is in force in Gulbarga area
40.	Sati Regulation, 1830 (Madras Regulation I of 1830)	Act which is in force in Mangalore – Kollegal area
41.	Essential Articles Control and Requisitioning (Temporary Powers) Act, 1949 (Madras Act XXIX of 1949)	Act which is in force in Mangalore - Kollegal area
42.	Essential Articles Control and Requisitioning (Temporary Powers Re-enacting) Act, 1956 (Madras Act VI of 1956)	Act which is in force in Mangalore - Kollegal area
43.	Famine Relief Fund Act, 1936 (Madras Act XVI of 1936)	Act which is in force in Mangalore - Kollegal area
44.	Prevention of Couching Act, 1945 (Madras Act XXI of 1945)	Act which is in force in Mangalore - Kollegal area
45.	Rivers Conservancy Act, 1884 (Madras Act VI of 1884)	Act which is in force in Mangalore - Kollegal area
46.	Abolition of Whipping Act, 1949 (Mysore Act XII of 1949)	Act which is in force in Mysore area
47.	Betting Tax Act, 1932 (Mysore Act IX of 1932)	- Act which is in force in Mysore area - Amended by Karnataka Acts 11 of 1958, 7 of 1974, 22 of 1980, 20 of 1981, 21 of 1989, 18 of 1994, 6 of 1995, of 1997, 3 of 1998, 5 of 2000
48.	Essential Service (Maintenance) Act, 1942 (Mysore Act XXIII of 1942)	Act which is in force in Mysore area
49.	Limitation (War Conditions) Act, 1947 (Mysore Act I of 1947)	Act which is in force in Mysore area
50.	Lotteries and Prize Competitions Control and Tax Act, 1951 (Mysore Act XXVII of 1951)	- Act which is in force in Mysore area - Amended by Karnataka Acts 26 of 1957, 13 of 1965)
51.	Pension Act, 1871 (Mysore Act XXII of 1871)	Act which is in force in Mysore area
52.	Poisons Act, 1910 (Mysore Act 10 of 1910)	Act which is in force in Mysore area

→ Nat. Health Policy
Drug Policy
Population
→ Prevention of food adulteration Act (centre)
→ ~~Indian~~ Medical ~~Botanical~~ Act
→ Tobacco control Act,
→ Homeopathy central council Act
→ Monopolies and Restricting Trad practices Act (MRTP)

AIDS AND PUBLIC HEALTH

A. INTRODUCTION

The AIDS epidemic is growing globally and at present there are more than 40 Million people in the world suffering from the killer virus. Much requires to be done for arresting the spread of the epidemic in India. Though the directive principles enshrined in the constitution of India state that it is the primary duty of the State to improve public health, the public health system is in shambles.

'Directive Principles of State Policy' under the Constitution enumerate guiding principles for States to be followed while formulating their policies. These provide that it is the primary duty of State to improve public health[1], and it should promote a social order in which justice, social, economic and political shall form part of all institutions of national life.[2]
The above provisions, in context of AIDS, imply that a person suffering from AIDS/HIV cannot be condemned by denying him ways of or affording him opportunity to lead a normal life. It is the duty of State to provide for his treatment or treatment at affordable price, employment to ensure he does not die an economic death, rehabilitation et al. State must also direct its public health policy to prevent spread of AIDS/HIV.
The 'Directive Principles of State Policy' are mere guidelines and unenforceable in the Court of law. However the State can be compelled to execute its duties so far as it concerns public health because as set out in the earlier chapters various Supreme Court judgments have interpreted the expression 'life' under Article 21 to include right to health and all reasonable health facilities. Therefore disregard of public health is a violation of fundamental rights of people to life.

As is obvious, litigation concerning AIDS in India is of recent origin and so still in an embryonic form. After the first few cases of HIV were detected in 1986 the government of India constituted the National Aids Committee in 1986 under the Ministry of Health and Family welfare and representatives from different sectors and similarly the State Aids Control Societies were formed in various states. At present the Aids control programme of the government of India is under the National Aids Control Organization (NACO). The response of the Govt. in India has always been a knee jerk reaction in dealing with such issues and that has lead to loss of liberty of individuals and also discrimination in the society. The Goa Public Health Act, 1987 is the best example of the reaction of the governments and the discrimination that followed where AIDS patients were sought to be stigmatized under the law and segregated. Much more needs to be done by the Governments in spreading awareness to reducing the costs of essential drugs and proper implementation of programmes to curb the spread of the virus.

The Courts in India in recent past have taken a very reasonable approach towards the issue of HIV/AIDS and have passed orders which have helped in reducing discrimination. Right from stopping people being kept under captivation to stopping discrimination on the basis of the disease and safeguarding the employment of the affected people and to the policy on drugs required for the positive people the Courts have played a very important role. The present Chapter contains some of the important judicial responses dealing with the epidemic of Aids.

The major litigation concerning HIV has been related to three aspects:

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[1] Art. 47
[2] Art. 38

a. Employment related issues:
b. Confidentiality
c. Access to medicines

B. **CASE LAW**

Though a wide range of litigation in courts on the issue of HIV/AIDS has been covered in this chapter, it's mainly to show the apathy of the government and also highlight the discriminatory policies adopted by the state in dealing with persons suffering with HIV/AIDS.

Lucy D' Souza v. State of Goa[3] was one of the first litigations on the issue of Hiv/AIDS in India. The Bombay High Court was of the opinion that isolation of persons with AIDS was not in violation of the constitution of India. The court further held that the particular provision of the Goa Public Health Act was for preventing the spread of the disease and in a conflict between the public interest and right of an individual the latter should prevail.

S. 53(1)(vii) of the Goa Public Health Act, 1987, empowered the government to isolate a person suffering with AIDS. The Act did not state that how long the isolation was to be done and where but stated that the isolation could be done for such person, and at such institution or ward as may be prescribed. Thus wide powers were given to the government to take away the liberty of the individual on the grounds that a person was suffering from AIDS.

Section 53 of the controversial Act, is highly draconian and needs to be reproduced in full to understand the implications:

> "53(1): If it appears to the Health Officer that any person is suffering from an infectious disease, and that such person -
>
> (i) is without proper lodging or accommodation, or
>
> (ii) is without medical supervision directed to the prevention of the spread of the disease, or
>
> (iii) is lodging in a place occupied by more than one family; or
>
> (iv) is in a place where his presence is a danger to the people in the neighbourhood; and
>
> (v) should be removed to a hospital or other place at which patients suffering from such disease are received for treatment, the Health Officer may remove such person or cause him to be removed to such hospital or place.
>
> (vi) no person including a foreigner shall refuse collection of blood for investigation of acquired imuno deficiency syndrome or any other communicable/infectious diseases if the Health Officer has reasonable ground to suspect that such person is suffering from acquired imuno deficiency syndrome or other infectous disease as defined under the Act;

[3] AIR 90 BOM 355

(vii) In the case of a person who is found to be positive for acquired imuno deficiency syndrome by serological test, the Government may isolate such person for such period and on such conditions as may be considered necessary and in such Institution or ward thereof as may be prescribed.

(viii) all such persons admitted in prescribed wards/hospitals shall be provided with materials, equipment, etc. which shall not be used for any other purpose;

(ix) the parenteral medication of the patents suffering from acquired imuno deficiency syndrome shall be given through disposable sets/syringes;

(x) the linen, matteresses, etc. used for the deceased patients who were suffering from acquired imuno deficiency syndrome shall be immediately destroyed by burning;

(xi) all the staff working for the management of the patient suffering from acquired imuno deficiency syndrome shall be effectively protected with long rubber gloves, sterilized linen and mask;

(xii) persons handling the dead bodies of patients who suffering from acquired imuno deficiency syndrome shall be instructed to ensure that they do not come into contact with any secretions such as saliva; etc.

(xiii) the dead body of patient who was suffering from acuired imuno deficiency syndrome shall be enclosed be in a polythene bag and tied with knots at both the ends and sealed before further action for its cremation/ burial or despatch abroad as the case may be;

(xiv) no transplant operation of any kind shall be performed unless the donor as well as the receptor is confirmed to be free from acquired imuno deficiency syndrome through serological investigation;

(xv) all the Blood Banks shall send the blood specimen for ELIZA test to the Surveillance Centre of the Goa Medical College and only after obtaining the negative result, it shall be used for the patients;

Provided that in the case of emergency, where blood transfusion is deemed necessary without waiting for the report of ELIZA test, written consent of the patient or gaurdian or relative shall be obtained before such blood transfusion."

Apart from the violation of the rights guaranteed under the Constitution of India the petition raised four basic issues regarding the said provision :

(a) provision for isolation is based on wrong scientific material and foundation;
(b) Object sought to be achieved by isolation is nullified by the provision;
(c) discretion to isolate is unguided and uncontrolled; and
(d) the provision for isolation is procedurally unjust in the absence of the right of hearing

while dealing with the aspects (a) and (b) the court was of the opinion that, isolation was an invasion on the personal liberty of a person and it may also lead to ostracization. At the same time the court held that a balance has to be drawn between the right of the individual and society at large. In a situation of conflict between right of a private

individual and the society at large the right of the society should prevail over the right of the individual.

It was also considered that the isolation might lead to people not coming forward and going underground if they are suffering from HIV/AIDS. Thus they will not be able to take proper treatment. Upholding the constitutional validity of the provision the court held that,

> '11. It has always to be remembered that matters like this essentially fall in the realm of policy. This policy decision is taken by those who are in charge of advancing public health and who are equipped with the requisite know-how. We find ourselves too ill-equipped to doubt the correctness of the Legislative wisdom. Even if there is any doubt about its correctness, its benefit must go in favour of the policy maker. We are quite conscious that Courts are not powerless to examine the correctness of a policy decision. But such power has to be very cautiously exercised, field of exercise being very limied. Settled legal principle is that there is a presumption that the Legislature understands and appreciates the needs of its people good faith and knowledge of the existing conditions has also to be presumed in its favour. There is no weighty evidence -- either, intrinsic or extrinsic -- on the basis of which the above presumption or the presumption of constitutionality of a statute is rebutted.'
>
> '14..... we find it difficult to accept the submission that there is no scientific basis whatsoever for considering isolation as one of the proper measures for prevention of AIDS or that the object sought to be achieved by isolation is nullified by the impugned provisions of Section 53(1)(vii).'

Regarding the contention that the discretion of isolation was unguided and uncontrolled, the court held that the government was within its powers to make provisions for controlling the spread of AIDS. It also stated that a proper rules have been formulated by the government in this regard.

In the matter of notice and hearing prior to the action of isolation the court held that there are many provisions and actions in which this principle of natural justice cannot be complied with. The court was also of the opinion that the condition of prior hearing and notice will frustrate the provision of isolation. Such a hearing can be given after the isolation also.

Thus in the first ever case regarding HIV/AIDS the court upheld the Constitutional validity of a highly suspect Act and this view of course reflected the lack of awareness about the issue in 1990.

Blood Banks

In the case of [4]*Common Cause v. Union of India* the Supreme Court laid down guidelines regarding operation of blood banks. The issue raised before the court was that the deficiencies and shortcomings in collection, storage and supply of blood through blood centres operating in the country could prove fatal.

Blood is one of the medium through which HIV/AIDS is transmitted. Blood has become a commodity. Some people become professional donors as it is a source of earning for them.

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[4] AIR 1996 SC 929

Blood banks play an important role at different stages of medical treatment. Supply of wrong or contaminated or bad blood can cost the life of the one being treated, therefore, the Court felt that it was essential to regulate donation of blood and its quality. Under Drugs and Cosmetics Act, 1940 blood is treated as a 'Drug' for the purpose of regulating its collection, storage and supply.[5] The instant PIL was against the deficiencies and shortcomings in collection, storage and supply of blood through blood centres operating in the country. The Supreme Court issued the following directions concerning operation of blood banks.

1. Union Government shall take steps to establish forthwith National Council of Blood Transfusion as a society registered under the Societies Registration Act.
2. In consultation with the National Council, the State Government/Union Territory Administration shall establish State Council in each State/Union Territory, which shall be registered as a society under the Societies Registration Act.
3. National Council shall undertake training programmes for training of technical personnel in various fields connected with the operation of blood banks.
4. National Council shall take steps for starting special postgraduate courses in blood collection, processing, storage and transfusion and allies field in various medical colleges and institutions in the country.
5. Union Government, State Governments and Union Territorories should ensure that within a period of not more than one year all blood banks cooperating in the country are duly licensed and if a blood bank is found ill-equipped for being licensed, and remains unlicensed after the expiry of the period of one year, its operations should be rendered impossible through suitable legal action.
6. Union Government, State Governments and UTs shall take steps to discourage the prevalent system of professional donors so that the system of professional donors is completely eliminated within a period of not more than two years.
7. The existing machinery for the enforcement of the provisions of the Drugs and Cosmetics Act and Rules should be strengthen and suitable action be taken in that regard on the basis of the Scheme submitted by the Drugs Controller (I) to the Union Government for up-gradation of the Drugs Control Organization at the Centre and the States.
8. Necessary steps should be taken to ensure that Drugs Inspectors duly trained in blood banking operations are posted in adequate numbers so as to ensure periodical checking of the operations of the blood banks through out the country.

Union Government should consider the advisability of enacting a separate legislation for regulating the collection, processing, storage, distribution and transportation of blood and the operation of the blood banks in the country. This direction, of course has as yet not been carried out.

Employment

In [6]***MX of Bombay Indian Inhabitant v. M/s. ZY*** the issues raised concerned not only the right to employment of an HIV affected person but also the safety of other employees and responsibility of employer to provide medical treatment to its employees who are suffering from HIV/AIDS. The high Court held that an HIV affected person cannot be denied employment or be discontinued unless it is medically shown that he is suffering from such a disease that can be transmitted through daily chores. Taking into consideration the

[5]Blood banks are regulated under Drugs and Cosmetics Rules. 1945. Part X-B 'Requirements for the collection, storage, processing & distribution of whole human body, human blood components by blood banks & manufacture of blood products'

[6] AIR 1997 BOM 406

widespread and present threat of this disease in the world in general and this country in particular, the State cannot be permitted to condemn HIV persons to economic death. The Court felt that it was not in public interest and is impermissible under the Constitution. The interest of the HIV affected persons, employers and society will have to be balanced in such a case, if it means putting certain economic burden on the State or public corporation or society, they must bear the same in the larger public interest.

Petitioner was a casual labourer with the Respondent, a State corporation who had been short listed for being absorbed into latter's permanent workforce. In the pre-employment medical test, he was found HIV+ive and consequently, denied regularization.[7]

Respondent's case was that if a candidate was inflicted with a disease that was most likely to assume serious proportions in due course, the public body could not be saddled with responsibility and liability of extending medical facility and treatment to such a candidate by recruiting him. In prescribing pre-employment medical test, employer intends to recruit such persons who'll be able to serve the full term of employment, i.e., till the age of superannuation.

High Court rejected the contention of Respondent and held that the object of medical test prior to employment or during the course of employment, is to ensure that such a person is capable of or continues to be capable of performing his normal job requirements and that he does not pose a threat or health hazard to other persons or property at workplace. Persons who are rendered incapable of performing their normal function or pose a risk to other persons at workplace, for instance, due to a contagious disease that can be transmitted through normal activities at workplace, can be reasonably and justifiably denied employment or discontinued from employment. Such a classification has clear nexus with the object to be achieved, viz., to ensure the capacity of such persons to perform normal job functions as also to safeguard the interest of other persons at workplace.

AIDS is transmitted through sexual intercourse; blood transfusion or from mother to her newly born child. HIV is not transmitted through insects, food, water, sneezing, coughing, toilets, human excreta, sweat, shared eating and drinking utensils or other items such as protective clothing or telephones. Thus HIV person cannot be denied employment or be discontinued unless it is medically shown that he suffering from such a disease that can be transmitted through daily chores.

High Court further stated that State and public corporation cannot take ruthless and inhuman stand that they will not employ a person unless they are satisfied that that person will serve during the entire span of service from employment to superannuation. The most important thing in respect of persons infected with HIV is community support, economic support and non-discrimination. This is also necessary for prevention and control of this incurable condition. Taking into consideration the widespread and present threat of this disease in the world in general and this country in particular, the State cannot be permitted to condemn HIV persons to economic death. It isn't in public interest and is impermissible under the Constitution. The interest of the HIV persons, employers and society will have to be balanced in such a case, if it means putting certain economic burden on the State or public corporation or society, they must bear the same in the larger public interest.

[7] A person already in employment cannot be terminated merely because he suffers from AIDS/HIV unless shown that it has incapacitated him to continue working and he poses a threat to the health of other employees. 'Termination of the services of a workman on ground of continued ill-health.' Section 2(oo) of Industrial Dispute Act, 1947

In this case, the Court also permitted an HIV afflicated person to file a case without disclosing his identity due to the stigma attached.

Liability of the hospitals

In [8]*M. Vijaya v. The Chairman and Managing Director, Singareni Collieries Company Ltd.* the Andhra Pradesh High Court held that it was the duty of the hospital to check whether the blood was infected or not and not having proper equipments to detect the virus was not an excuse. The High Court went beyond the point of medical negligence and laid down important guidelines for the effective implementation of the programmes to curb the spread of virus and to deal with the people who have been tested positive of HIV.

Petitioner underwent blood transfusion during an operation at the hospital run by the Respondent-company. Petitioner's brother was the blood donor and the said hospital had conducted various tests including test for AIDS, which showed the results as negative. After operation Petitioner's health deteriorated. Numerous tests were conducted on the Petitioner and she was found suffering from AIDS. To determine the source, Petitioner's brother's blood was again tested for HIV after a gap of 10 months and the report was positive. In the instant petition Petitioner alleged that Respondent's hospital was negligent in conducting test on her brother because of which HIV could not be detected. Respondent-company, on the other hand urged that during the window period or asymptomatic period, HIV/AIDS can go undetected, and it could unknowingly be transmitted to others. Therefore, they cannot be held negligent.

duty of the hospitals test blood

High Court observed, based on the information provided by the Respondent-company that approximately 1000 employees were suffering from AIDS/HIV and this number was bound to increase when their family members were included. Under such circumstances, High Court held the Respondent-company negligent as they failed to disclose whether the doctors working in their hospital are themselves aware of the problem; if the pathologists working are technically competent to carry on the tests; and if both Elisa and/or Weston Blot tests were conducted on the blood donor.

The importance of this judgment is that in the light of the magnitude of the problem among Respondent-company's employees, nature of disease and the social dimension to it, High Court shifted the burden on Respondent-company to show that its hospital was well trained and equipped, both technically as well as with requisite expertise to prevent spread of the same. Importance was also given to the attitude of the employer in cases of AIDS/HIV. The Court expressed its disapproval at the apathy of Respondent-company's hospital in neither carrying out requisite blood tests on the Petitioner when she approached them after the operation nor referring her to any other super specialty hospitals for test and treatment. HC also noted that despite the knowledge that Petitioner was suffering from AIDS, Respondent-company gave her no financial or other help.

High Court went beyond the issue of medical negligence to issue appropriate directions for the effective implementation of various AIDS control programmes taken up by the Government and the NGOs.[9]

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[8] 2002 ACJ 32

[9] The judgment also has negative connotation when it states that 'in an apparent conflict between the right to privacy of a person suspected of HIV not to submit himself forcibly for medical examination and the power and duty of the State to identify HIV infected persons for the purpose of stopping further transmission of the virus. In the interests of the general public, it is necessary for the State to identify HIV positive cases and any action taken in that regard cannot be termed as unconstitutional as under Article 47 of the Constitution, the State was

AIDS control measures:

To begin with the High Court noted the AIDS control programmes of the Government. Central Government established National AIDS Control Organization (NACO) to ensure high level of awareness of HIV/AIDS and its prevention, to promote the use of condoms for safe sex in high risk population, i.e., Migrant labours, truckers, prison inmates etc.

In the State of AP Directorate of AIDS Control Programme was established in 1992 in close coordination and collaboration with other Government Departments, Public, Private and Non-Governmental Organizations. The Directorate was responsible for development and implementation of AIDS control plan as approved by NACO. As per the guidelines of NACO an AIDS Control Society was constituted for the Andhra Pradesh in 1998 to take long-term and short-term objectives. The term objectives are:

a) Prevent spread of HIV infection; **b)** Reduce the morbidity and morality associated with HIV infection, **c)** Establishment of effective programme management at all levels; **d)** Provision of technical and operational support; and **e)** To mobilize community support to restrict transmission by conventional methods.

Short-term objectives are **a)** Strengthen Sexually Transmitted Disease (STD) clinics; **b)** Modern Blood Banks to facilitate HIV testing; **c)** Strengthening of HIV/AIDS surveillance and prevention activities; **d)** Human Resource Development to manage HIV infected and AIDS patients; **e)** To create awareness about HIV transmission and its control; **f)** Promote safety of blood and blood products; **g)** Organize social support to HIV/AIDS patients.

In AP there are 142 licensed blood banks of which 44 from Government sector, 5 Central Government, 2 autonomous, 11 Quasi Government, voluntary, 33 Hospital attached and 38 are private commercial blood banks. NACO has upgraded the Zonal Blood banks and the District level blood banks by supplying equipments like blood blank refrigerators, Centrifuges, water baths, etc. HIV and Hepatitis-C Elisa and Raid test kits are being supplied by NACO. All the Medical Officers, staff nurses and Laboratory technicians working in Government Blood Banks are allegedly trained in HIV testing Techniques and Blood Banking technology. Further, State Blood Transfusion Council (SBTC) was formed in 1998 to create awareness on voluntary blood donation. The Government and charitable blood bank involving NGOs are arranging Blood donation camps. Workshops are being held involving members of Indian Medical Association and Nursing Home Association, MO of all blood banks, on blood safety programme and rational use of blood. Technicians are also instructed on preventive maintenance of Elisa system. STBC also resolved that no private blood bank should be given fresh licenses and only corporate hospitals and philanthropic organization/NGOs like Rotary can be considered after careful scrutiny. The Director, Drug Control Department has also been directed to raid blood banks and the medical shops for unauthorized supply of blood bags. Every blood bank is instructed to do all the mandatory tests, HIV, HCV, HbsAg by Elisa method in addition to the VDRL and malaria. From 1st June 2000 as per NACO guidelines, voluntary Counseling and Testing Centres have been established in all district headquarter hospitals and in Microbiology Departments of the medical colleges. Surveillance centres known as Blood Testing Centres have also been established at various medical colleges to monitor the trends of the disease.

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under an obligation to take all steps for the improvement of public health. A law designed to achieve this object, will not be in breach of Article 21 of the Constitution of India." (p.513, para.52)

The above position of HC is an obiter dicta and has no precedent value. It should be noted that courts as a principle do not substitute their views for that of experts in a concerned field. There are statistic and observation of National and International bodies that forced exposure hasn't succeeded in preventing AIDS/HIV. The above observation is an outcome of ill-founded notions and that is why public education and awareness is important.

It is stated that Family Health Awareness Campaigns are being held at the sub-centre level for 15 days covering the entire rural and urban slum population in the State to give counseling to all HIV effected and their relatives about future course of action in prolonging their lives, suggesting appropriate methods for use of condoms, proper nutritious diet and treating their psychological depression.

Ultimately, the High Court issued the following directions:

1. Sufficient AIDS/HIV test kits to all hospitals and institutions shall be provided. The Government Blood banks as well as licensed blood banks should be compelled to buy fool proof HIV/AIDS test equipment;
2. All the government hospitals should use only disposable needles in injections. Registered medical practitioners should be compelled to use only disposal syringes.
3. Bio-medical waste collected from hospitals and nursing homes should be properly destroyed or disposed of.
4. There should be more awareness programmes undertaken by the government especially in rural areas, in slum areas so that people can take preventive measures;
5. Having regard to the cost of anti-AIDS drugs, efforts should be made to supply anti-AIDS drugs free of cost like in anti-TB and anti-leprosy programmes and family welfare programees;
6. Doctors should be encouraged to undergo special training for diagnosis and treatment of AIDS patients;
7. There should be proper scheme for rehabilitation of patients who are diagnosed of HIV/AIDS as such persons are ostracized by their community;
8. There should be compensatory mechanism to deal with AIDS in case of negligence on part of the blood banks/hospitals by way of free facilities and free access to State funded health institution.
9. Doctrine of constitutional tort should be recognised even for prevention and control of AIDS and State should be made liable for any negligence on part of the health service system subject to the principles laid down in Indian Medical Association v. V P Shantha (1995)6 SCC 651;
10. There should be special treatment facilities in hospitals for those who suffer from HIV/AIDS;
11. There should be strict vigilance on licensed blood banks with reference to pre-blood transfusion testing for HIV and there should be effective educational and training programmes for those who manage the blood banks.
12. Government may consider to introduce sex education in schools at least from adolescence stage;
13. Identity of patients who come for treatment of HIV/AIDS should not be disclosed so that other patients will also come forward for treatment;
14. There should be change in the method of AIDS propaganda and no slogans, which promote indiscriminate sex, should be used in the propaganda;
15. The HIV infected person should be educated about AIDS so that he may not inadvertently or innocently be responsible in spreading the disease;
16. The latest method of testing blood for HIV/AIDS should be introduced in all the hospitals by giving subsidies so that tests can be conducted at reduced costs;
17. HC observed that the manner in which bio-medical waste are disposed off has relevance to the prevention of HIV/AIDS because such wastes includes used needles and syringes, and there is a possibility of the used syringes and needles being reused. All the hospitals and nursing homes should be directed to dispose of their bio-medical waste in terms of Bio-medical Waste (Management and Handling) Rules 1998 and they shall strictly

comply with the norms specified therein. Such hospitals shall be directed to obtain the necessary authorization for disposal of the waste from PCB;

18. Like the Central Government that has exempted medicines imported for treatment of AIDS from payment of Central excise duty, the State Government should also consider the desirability of grant of sales tax exemption in relation thereto;
19. It is axiomatic that no mandamus would issue to the Legislature to enact legislation in the matter but, having regard to the submissions made at the Bar as also taking notice of the fact that the States of Maharashtra and Karnataka have already introduced Bills in this behalf in its respective Legislature, the Government of AP may also consider the desirability of introducing a similar Bill before the State Legislature.
20. The State shall issue necessary circulars to such public sector undertakings and other private sector companies to see that the person suffering from HIV/AIDS are identified and/or given proper treatment.

Pension Benefits

[10]*Ex. Const. Badan Singh v. Union of India and Anr*, was a case decided by the Delhi High Court in which the petitioner was a BSF Jawan who had completed six years service with the force and was detected suffering with HIV. The medical board came to the conclusion that he was unfit for further service and his service was terminated. The court held that Badan Singh should be given pension.

The medical board was convened and it was of the opinion that the petition was 70 per cent disabled. The petitioner's contention was that he should be given alternative employment or pensionary benefits.

The court held that '*it could hardly be presumed that he intended to contract the fatal and stigmatic health order. No person would be happy to reap the benefits of a pension. Given a choice any person would prefer to work. It's the duty of the government to provide for health care and a pension is not a paisa more than his obligation.*'

Confidentiality And Right to Marry

[11]***Mr. X v. Hospital Z*** brought the issue of privacy before the courts. The petition dealt with two issues; firstly, right to privacy of a patient, specially an AIDS/HIV patient and secondly, the right of an individual to be safeguarded from any threat to her health.
Petitioner was tested positive for HIV by the Respondent hospital, who acted upon the discovery and informed Petitioner's fiancée about this condition because of which the marriage was called off and his community ostracized him. Thus, this petition was filed claiming that there was a breach of privacy and confidentiality by the hospital and the doctor.
The Supreme Court observed that the relationship between doctor and patient is that of trust. No information acquired during course of treatment should be divulged without the prior permission of the patient. In case of HIV/AIDS patients, confidentiality is paramount because of repercussions of disclosure. Nevertheless, HIV infected person has a right to lead a normal life but not at the cost of others. In the instant case the right of health of Petitioner's fiancée was pitched against his right to privacy. Supreme Court held that when two rights collide the one that promotes morality and public interest shall be upheld.

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[10] 97 (2002) DLT 986
[11] AIR 2003 SC 664

Further, to condemn a person to death by transmitting AIDS not only violates his/her right to life but is also punishable under provisions of Indian Penal Code. Sections 269 and 270 of the Penal Code are as follows:

> '*269. Negligent act likely to spread infection of disease dangerous to life*- Whosoever unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease, dangerous to life, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both.
> *270. Malignant act likely to spread infection of disease dangerous to life*- Whosoever malignantly does any act which is, and which he knows or has reasons to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.'

The above statutory provisions impose a duty upon the Appellant not to marry as marriage would have the effect of spreading the infection, which obviously is dangerous to life of the woman whom he marries.[12]
Respondent's act was to protect the life of another person therefore, they cannot be held liable for consequences of their act. Supreme Court expressed that in fact Respondent's silence would have made them *particeps criminis* i.e. partners in crime.

The Supreme Court however made a further totally uncalled for observation namely that HIV/ AIDS patients did not have a right to marry at all. This was going beyond what the issues before the Court were. This would mean that even if a person wanted to get married to a person with HIV/AIDS after full disclosure she could not do so. This observation was subsequently removed by the Supreme Court in a review application.

On the issues of confidentiality in the case of [13]*Dr. Tokugha Yepthomi v. Appolo Hospital and Anr*, the Apex court held that, the timely disclosure of the HIV positive status of the patient to his fiancée, saved her from being contracted with HIV and hence the disclosure did not invade the right to privacy.

Discrimation during recruitment
The Andhra Pradesh high court in [14]*Mr.X, Indian Inhabitant v. Chairman, State level Police Recruitment Board and others* observed that the clause in the revised AP Police Manual that person suffering with HIV cannot be taken into any government service was unconstitutional.

In this case the petitioner an armed reserve police with the Andhra Pradesh Police, applied for the post of stipendary cadet trainee of police (Civil). The petitioner qualified in the physical tests, completed the 5 km run within the stipulated 25 minutes and was thereafter permitted to appear in the written examination. Pursuant to the written examination held on 29-02-2004, the petitioner was provisionally selected as a sub-inspector of police. The petitioner was asked to be present on 24-6-2004, for verification and medical examination. Petitioner came to know later that he was not sent for training and was not appointed, as he had tested HIV positive.

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[12] Sections 269 & 270 ignores a situations where consummation of marriage is with the knowledge of the other partner's condition and consent.
[13] AIR 1999 SC 495
[14] 2006 (2) ALT 82

In the high court the petitioner contended that, a person, though found HIV positive, would be fit to perform normal functions for long durations throughout the asymptomatic period, and it is only in the last stage (known as AIDS) that a person may be unfit to perform the functions or duties in his/her employment. A person's job not only provides him or her with daily sustenance but also helps to define his or her life and that most people, who are HIV positive, are fully capable of carrying out their job responsibilities and find comfort in continuing their employment, that persons with HIV positive would not put other employees at risk and as long as an HIV infected person is able to perform his job he should be treated as any other employee.

The court in its judgement held that,

> *'21. The petitioner is one among a large section of ourpopulace living with HIV. Society has responded to their plight with intense prejudice. They have been subjected to systemic disadvantage and discrimination. They have been stigmatised and marginalized. As the present case demonstrates, they have been denied employment because of their HIV positive status without regard to their ability to perform the duties of the position from which they have been excluded. Society's response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV/AIDS are among the most vulnerable groups in our society. Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against persons found to be HIV positive still persist. In view of the prevailing prejudice, any discrimination against them can be interpreted as a fresh instance of stigmatization and an assault on their dignity. The impact of discrimination on persons infected with HIV is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living.'*

The court further held that,

> *'34. While persons who have tested HIV positive, can be said to constitute a class distinct from others who are not so infected and to satisfy the first of the twin conditions foravalid classification, i.e., the classification being founded on an intelligible differentia which distinguishes those that are grouped together from others, it is the second condition as to whether this differentia has a rational nexus or relation to the object sought to be achieved, which requires detailed examination. As stated supra, the object is to ensure that persons appointed in the police force are of sound health and are bodily and mentally fit to discharge the duties required of officersof the police establishment. Medical evidence placed on record reveals that, in terms of physical and mental fitness, not all persons who have tested HIV positive constitute a single class, for there are different categories among them, some of whom are in the early stages of the asymptomatic period and others in the final stages and suffer from AIDS. While those in the final stages who suffer from AIDS may justifiably be denied appointment in the police establishment on the ground that they lack the required physical and mental fitness, the same cannot be said of those in the early stages of the asymptomatic period which, as stated supra, may range anywhere between 3 to 18 years, since during the prolonged asymptomatic carrier stage of HIV infection one remains fully active, physically and mentally. (MX of Bombay Indian Inhabitant (supra 1). While the medical evidence on record, of which the petitioner*

himself is a classic example, would reveal that these persons with HIV positive, at the early stages of the asymptomatic period, possess the physical and mental fitness required for employment in the police establishment, no evidence to the contrary has been placed by the respondents before this court. Grouping all persons with HIV positive together for denying employment on the erroneous presumption that they all lack the high standards of physical and mental fitness prescribed for appointment to posts in the police force does not satisfy the second of the twin conditions, for a valid classification, that the differentia must have a rational nexus to the object sought to be achieved. Since a valid classification would require segregation of a group of persons with common properties and characteristics, postulates a rational basis and does not mean herding together of certain persons and classes arbitrarily, treating all HIV positive persons as one single homogenous class, irrespective of the stage of the disease, for being denied appointment in the police force is in violation of Articles 14 and 16 of the Constitution of India.'

Thus the court rightly struck down the relevant provision of the AP Police Manual and held that it was discriminatory in nature and also denied gainful employment to persons suffering with HIV.

Liability of the State

In [15]*P of Bombay V. Union Of India* the questions raised before the Calcutta High Court were regarding the negligence of the concerned public hospital in blood transfusion through which the petitioner was infected with HIV. The union government took the responsibility and gave a job and compensation of Rs. 10 Lakhs to the petitioner.

In a hospital situate at Port Blair, under the administrative control of the Indian Navy, the petitioner got admitted for the purpose of delivering her child. A healthy child was delivered to the petitioner. After the delivery, the physician attending the petitioner felt that the petitioner required blood infusion. At that time there was no near relative of the petitioner present at the hospital to donate blood for the purpose of infusing the same to the petitioner. The requirement of infusion of blood was so acute, the hospital administration at the command of the attending physician arranged blood for the purpose of infusing the same to the petitioner. This blood did not come out from the blood storage unit of the hospital. This came out from a donation made by a sailor. At that time the hospital was not properly equipped to test such blood in all possible manner. The known tests were, however, conducted to find out whether the blood is otherwise safe for infusion or not. The blood was infused and later on, it transpired that the same carried H.I.V. Virus. This incident, though is an accident, occurred inasmuch as there was non-availability of necessary facilities at the end of the hospital to find out whether the blood to be infused is infected by H.I.V. or not. Had the hospital necessary facilities to find out whether the donor's blood is infected with H.I.V. Virus, the accident could be avoided.
A Writ petition was filed before the Calcutta High Court by the victim woman. Before the Petition could be decided, the Union Government accepted the responsibility for its negligence and failure and awarded a compensation of Rs. 10 Lakhs to the woman. She was also offered a job at the place she desired and also was provided with accommodation.

[15] 2001 Kolkatta High Court

Aids Detection Kits

[16]*Merind Ltd. V. State of Maharashtra* led the high court to hold that the Aids detection kit falls under drugs as mentioned under the Drugs and Cosmetic Act.

The Commissioner of Sales Tax by his order dated January 7, 1998 held that any medicinal formulations or preparations for being qualified as "drugs and medicines" in the new Schedule, entry C-II-37, have not only to be useful for diagnosis, treatment, mitigation or prevention of disease or disorders, but it has also to be capable of internal or external application on the body. Since the diagnostic kits sold by the assessee were admittedly not applied on the human body either internally or externally, but were used in pathological laboratories for carrying out certain tests, the Commissioner held that in spite of the word "diagnosis" in the Schedule, entry C-II-37, with effect from October 1, 1995, the diagnostic kits would not fall under Schedule, entry C-II-37, but the same would be properly quantifiable under Schedule, entry C-II-106.

It was argued before the High court that the 'Kit' falls within the definition of 'drugs' as given in the Drugs and Cosmectics Act.
The High Court after considering many aspects and referring to the earlier judgements of the Sales Tax Tribunal held that, the diagnostics cannot be classified under C-I-106 which pertains to instruments but on the contrary held that the diagnostic kits are medicinal formulations used for diagnosis of the diseases in human beings, then the same would be squarely covered under entry C-II-37 and the same cannot be said to be covered under entry C-II-106.
Thus the High Court negatived all the above-mentioned questions raised before it and held that the diagnostic kits can be termed as drugs.

C. CONCLUSION

Over the years, one can clearly discern a progressive realization by the Courts concerning HIV/ AIDS and its significance.
Since in terms of judicial time frame the issue is so new we have not confined ourselves only to cases concerning health care but have also dealt with the manner in which Courts have generally dealt with the problem. In this short span of time, the Courts have been confronted with all kinds of issues including discrimination in employment, access to safe blood, confidentiality and privacy.

The above mentioned cases do not solve the problems of discrimination and isolation or accessible health care but some of the verdicts of the courts do give a ray of hope to the persons who are being discriminated on the basis of being HIV positive by the family, employer and also the society at large. Some of the judgements clearly lay down the right to be not discriminated and also the right not to be lead towards an economic death due to the disease. As we have already mentioned above the State needs to do much more on the issue, similarly the courts have to be more open and understanding in their approach while dealing with cases of persons suffering from HIV/AIDS.

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[16] (2004) 136 STC 462 BOM