

June 2010

Final report

No. 10 - 05

# Enhancing Public Health Delivery System in India: Impact of judicial decisions towards access to universal health care

---

*Project Report Submitted on*

**10<sup>th</sup> Round Regional Research Competition of**



**South Asia Network of Economic Research Institutes**



Project Report No. 2008IA05

[www.teriin.org](http://www.teriin.org)

The Energy and Resources Institute

---

### Suggested format for citation

T E R I. 2010  
“Enhancing Public Health Delivery System in India: Impact of  
judicial decisions towards access to universal health care”  
New Delhi: The Energy and Resources Institute. 38 pp.  
[Project Report No. 2008IA05]

---

### For more information

Project Monitoring Cell  
T E R I  
Darbari Seth Block  
IHC Complex, Lodhi Road  
New Delhi – 110 003  
India

**Tel.** 2468 2100 or 2468 2111  
**E-mail** [pmc@teri.res.in](mailto:pmc@teri.res.in)  
**Fax** 2468 2144 or 2468 2145  
**Web** [www.teriin.org](http://www.teriin.org)  
India +91 • Delhi (o) 11

---

## Table of Contents

Project Team .....	4
CHAPTER 1 Introduction .....	5
Indian Judiciary, PILs and Policy interface .....	9
Scope and Objectives of the Project .....	11
Methodology .....	11
CHAPTER 2 Access to health care and judicial initiatives .....	13
Non Discrimination.....	14
Physical Accessibility .....	16
Economic Accessibility .....	19
Information Accessibility.....	20
CHAPTER 3 Court influencing national and state health law and policy .....	22
1. National Blood Policy and the Supreme Court.....	22
2. Emergency care of victims of accident and the Supreme Court of India .....	25
3. Emergency medical care guidelines by Supreme Court .....	27
4. Provision of free treatment facilities for poor patients in private hospitals and Delhi High Court.....	29
5. Mental Health law and policy and Supreme Court.....	32
CHAPTER 4 Conclusion.....	35
Bibliography .....	37

---

## Project Team

M P Ram Mohan

M V Shiju

Nupur Chowdhury

---

## CHAPTER 1 Introduction

Health has been recognized as a fundamental human right indispensable for the exercise of other human rights<sup>1</sup>. Right to Health finds mention in the international human rights documents right from the days of Universal Declaration of Human Rights<sup>2</sup>. One can notice a gradual widening of the definition of health in these documents with the progress in time. The constitution of the World Health Organization defines health as a “state of complete physical, mental and social well being and not merely the absence of disease or infirmity.” However, the right guaranteed under the International Covenant on Economic, Social and Cultural Rights (ICESCR) is “the enjoyment of highest attainable standard of physical and mental health<sup>3</sup>.” The drafting history of ICESCR as well as the specific enumerations contained in Article 12.2 point out that right to health embraces a number of socio economic factors that promote conditions for leading a healthy life. The Alma Ata Declaration clearly brings out this nexus. Article III of the Declaration states: “Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all.”

The UN Committee on Economic, Social and Cultural Rights in General Comment No.14 adopted a wider definition of health to include social determinants such as access to safe water and food, adequate nutrition and housing, healthy environmental conditions, access to health – related education and information including on sexual and reproductive health<sup>4</sup>.

Many other international and regional conventions contain specific reference to right to health<sup>5</sup>.

The absence of a credible international mechanism to enforce these rights poses serious challenge to the very

---

<sup>1</sup> See e.g., CESR, General Comment 14, Para 1.

<sup>2</sup> Article 25, UDHR.

<sup>3</sup> Article 12.1 ICESCR

<sup>4</sup> CESR, General Comment 12, Para 11.

<sup>5</sup> See: Articles 11(1)(f), 11(2), 12 and 14(2)(b), *Convention on the Elimination of all forms of Discrimination against Women (CEDAW)*; Articles 3(3), 23(3), 23(4) and 24, *Convention on the Rights of the Child (CRC)*;

Article 5(e)(iv), *International Convention on the Elimination of all forms of Racial Discrimination (ICERD)*

Articles 11 and 13, *European Social Charter*

Article 35, *Charter of fundamental rights of the European Union*

Article XI, *American Declaration on the rights and duties of man*

Article 16, *African Charter on Human and People's rights*

Article 14, *African Charter on the Rights and welfare of the Child*

usage of the term 'right'. The jurisprudential debate about the importance of enforceability in characterizing something as right still continues. Since right to health comprehensively and prominently appears in ICESCR, this debate assumes greater significance.

As Article 2.1 makes the realization of economic, social and cultural rights subject to the availability of resources of a state party and allows for progressive realization of these rights, a hierarchy has been noticed between the rights enumerated in ICESCR and the rights enumerated in the International Covenant on Civil and Political Rights (ICCPR), wherein these conditions have not been prescribed for ensuring the guarantee of rights. This has led to the characterization of rights mentioned in ICESCR as 'aspirational rights'<sup>1</sup>. But a powerful argument has been advanced by Shany (2006) to suggest that economic and social rights are internationally justiciable and can be meaningfully enforced by international courts and tribunals<sup>2</sup>. The proposal to introduce a new complaint mechanism to implement ICESCR by authorizing the UN Committee on Economic, Social and Cultural Rights (CESCR) to exercise quasi-judicial powers of review is a step towards enforceability of these rights<sup>3</sup>. There have also been developments in treating all human rights as universal, indivisible and interdependent and interrelated<sup>4</sup>.

Indian Constitution contains several provisions that have a bearing on the right to health. The Directive Principles contained in Articles 39 (e), 39 (f), 42 and 47 touch on the subject of health<sup>5</sup>. But under the Indian Constitutional

---

<sup>1</sup> Philip Harvey, "Aspirational Law", *Buffalo Law Review*, Vol.52, p.701(2004), See also the address by Chief Justice K.G. Balakrishnan in the National Seminar on Right to Health delivered on September 14, 2008.

<sup>2</sup> Yuval Shany, "Stuck in a Moment of Time: The International Justiciability of Economic, Social and Cultural Rights", Research Paper No. 9 – 06, International Law Forum, The Hebrew University of Jerusalem (2006).

<sup>3</sup> Draft Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (1996), UN Doc. E/CN.4/1997/105.

<sup>4</sup> Vienna Declaration and Programme of Action (1993) adopted by the World Conference on Human Rights, Para 5.

<sup>5</sup> Article 39: The State shall, in particular, direct its policy towards securing—

(e): That the 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

scheme, Directive Principles of State Policy, though fundamental in the governance of the country are not enforceable through courts of law<sup>1</sup>. No direct reference on right to health can be found in any of the rights mentioned under Part III Fundamental Rights. It is important to note here that Fundamental Rights under the Indian Constitution are enforceable<sup>2</sup>. But through judicial decisions right to health has been read into the fundamental right guaranteed under Article 21, which guarantees right to life and personal liberty<sup>3</sup>. The distribution of power between the union and the states regarding health also needs mention here<sup>4</sup>. Most of the entries relating to health appear in the State List giving power to the states to legislate and administer the health services<sup>5</sup>. But it does not mean that the central

---

healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment.

Article 42: The State shall make provision for securing just and humane conditions of work and for maternity relief.

Article 47: 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.

<sup>1</sup> See Article 37: 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.

<sup>2</sup> See Articles 32 and 226.

<sup>3</sup> Article 21: No person shall be deprived of his life or personal liberty except according to procedure established by law.

<sup>4</sup> Seventh Schedule of the Constitution enumerates subjects under three lists, viz., Union, State and Concurrent Lists. The Union government has exclusive power to legislate on subjects contained in the Union List. States normally have the exclusive power subject to specific exceptions mentioned in the Constitution to legislate on subjects mentioned in State List. Both the Union and the States have competence to enact legislations contained in the Concurrent list with primacy given to Union law in case of a repugnancy.

<sup>5</sup> Entry 6 Public health and sanitation; hospitals and dispensaries.

Entry 9 Relief of the disabled and unemployable.

However, there some other entries which appear in the concurrent list

## 8 Enhancing Public Health Delivery System in India: Impact of judicial decisions towards access to universal health care

Government does not have any role in the health sector in India. Central Government provides funds for the states under different health schemes formulated by it. After the 73<sup>rd</sup> and 74<sup>th</sup> Constitutional Amendments, the local bodies have also been brought within the ambit of health service delivery<sup>1</sup>. Thus, health sector in India is the responsibility

---

which have a bearing on the subject health. See Entry 16: Lunacy and mental deficiency, including places for the reception or treatment of lunatics and mental deficient.

Entry 19 Drugs and poisons,

Entry 26 Legal, medical and other professions.

<sup>1</sup> Article 243 G provides: Subject to the provisions of this Constitution, the Legislature of a State may, by law, endow the Panchayats with such powers and authority as may be necessary to enable them to function as institutions of self-government and such law may contain provisions for the devolution of powers and responsibilities upon Panchayats at the appropriate level, subject to such conditions as may be specified therein with respect to—

(a) the preparation of plans for economic development and social justice;

(b) the implementation of schemes for economic development and social justice as may be entrusted to them including those in relation to the matters listed in the Eleventh Schedule.

The following entries in the Eleventh Schedule has a direct bearing on Health:

11. Drinking water.

23. Health and sanitation, including hospitals, primary health centers and dispensaries.

24. Family welfare.

25. Women and child development.

26. Social welfare, including welfare of the handicapped and mentally retarded.

Similarly, Article 243W speaks about devolution of powers to Urban Local Bodies:

243 W: Subject to the provisions of this Constitution, the Legislature of a State may, by law, endow—

(a) the Municipalities with such powers and authority as may be necessary to enable them to

function as institutions of self-government and such law may contain provisions for the devolution of

powers and responsibilities upon Municipalities, subject to such conditions as may be specified therein,

with respect to—

(i) the preparation of plans for economic development and social justice;

(ii) the performance of functions and the implementation of schemes as may be entrusted to them including those in relation to the matters listed in the Twelfth Schedule;



of the Central and State Governments and the local bodies.

### Indian Judiciary, PILs and Policy interface

The Indian Judiciary is an independent body separate from the Executive and the Legislature and has got very important powers under the Constitution. The judicial hierarchy in India is as follows: At the apex level is the Supreme Court of India which has got original, appellate, writ and advisory jurisdictions. At the state level there are High Courts, which also has appellate and writ jurisdictions. The lower judiciary in India consists of the District Courts and other courts. The Supreme Court and the High Courts with powers to issue writs for the enforcement of fundamental rights have the power to review the administrative as well as legislative functions of the state.

Certain characteristic features of the Indian Judiciary are mentioned here, which have bearing on this study. The first feature is the extent of judicial review exercised by the Indian judiciary and the power enjoyed by it in the Indian Constitutional set up. A high water mark in the Indian legal history is the *Keshavananda Bharti v. State of Kerala*<sup>1</sup> decision wherein the Supreme Court asserted its power to examine the validity of a constitutional amendment by enunciating the basic structure doctrine. This was a power that was never exercised by any municipal adjudicating body anywhere in the world. Another milestone was the *SC Advocates on Record v. Union of India*<sup>2</sup>, wherein the Supreme Court of India asserted the primacy of opinion of the Chief Justice of India in the appointment of judges to the higher judiciary. The effect of that judgment is that nobody can be appointed to the higher judiciary without the concurrence of the Chief Justice of India.

The inroads made by the Indian judiciary in the Rights jurisprudence is another remarkable feature. In *Maneka*

---

(b) the Committees with such powers and authority as may be necessary to enable them to carry out the responsibilities conferred upon them including those in relation to the matters listed in the Twelfth Schedule. The relevant entries in the Twelfth Schedule are:

5. Water supply for domestic, industrial and commercial purposes.
6. Public health, sanitation conservancy and solid waste management.
9. Safeguarding the interests of weaker sections of society, including the handicapped and mentally retarded.

<sup>1</sup> AIR 1973 SC 1461

<sup>2</sup> AIR 1994 SC 268

*Gandhi v. Union of India*<sup>1</sup>, Bhagwati J. held:

“The attempt of the Court should be to expand the reach and ambit of the fundamental rights rather than attenuate their meaning and content by a process of judicial construction<sup>2</sup>.”

This expansive interpretation of the rights, especially that of Article 21 has led many of the economic and social rights finding place within the ambit of the Fundamental rights. The immediate consequence of this type of interpretation was that these rights became enforceable in a court of law. Right to health is a classic example of this expansive interpretation. The Supreme Court in a number of cases has held right to health to be a part of right to life guaranteed under Article 21 of the Constitution<sup>3</sup>.

Another notable feature of the Indian judicial system is the emergence of Public Interest Litigation. Public Interest Litigation in legal terms means the relaxation of the traditional rules of *locus standi*. It meant that a public-spirited individual or an association could bring a cause of action before the higher judiciary on behalf of a disadvantaged group that is not capable of representing itself. The impact of PILs were that the Supreme Court and the High Courts became a forum for adjudicating disputes which would have never come before it but for this relaxation. The cause of bonded labourers, child workers, pavement dwellers, prisoners, AIDS patients, mentally retarded, sex workers etc. were brought before the Courts and remedies granted.

Yet another feature, which has an impact on the present study, is the overreach by the Judiciary. The traditional distinction between judicial functions and administrative functions often got blurred and the judges started assuming the role of an administrator. Judiciary started even entering the policy space, which was traditionally the forte of the executive. The Courts started giving detailed directions as to how certain matters have to be implemented. From a policy angle this was an interference with the executive function as the state is entitled to adopt any measure from a wide range of possible measures to meet its obligations. The traditional principle of non-interference in policy matters as long as the policy is a reasonable one taken in good faith was breached in

---

<sup>1</sup> AIR 1978 SC 597

<sup>2</sup> Id., at p. 624.

<sup>3</sup> See *Parmanand Katara v. Union of India*, AIR 1989 SC 2039 and *Paschim Banga Khet Mazdoor Samiti v. State of West Bengal*, AIR 1996 SC 2426.

this line of cases.

## Scope and Objectives of the Project

In this backdrop, the present study is an attempt to evaluate the role of the Indian Judiciary in enforcing right to health in its many dimensions. The study focuses on certain select decisions of the Supreme Court and High Courts wherein the courts while interpreting the right to health have entered the policy space. The specific objectives of the study are:

1. To study the decisions of the Supreme Court and two High Courts (one from the North and another from the South) during the period of 1980 to 2006 in the field of right to health.
2. To study how these decisions are reflected in the state initiatives on basic access to health care.
3. To study the experiences and difficulties in the implementation of the decisions of the court.

## Methodology

A major component of this study is the review of decisions by the Supreme Court of India and the High Courts of Delhi and Andhra Pradesh. The cases selected for review concerned right to health. The time period chosen for the selection of cases were from 1980 to 2006. This time period was chosen for the following reasons: 1) The Indian courts started interpreting fundamental rights in an expansive way only in the eighties after the famous *Maneka Gandhi* case. 2) The year 2006 was selected, as the objective of the study was also to find out the implementation of these decisions and the impact that those decisions had on the policy initiatives. It was felt that a reasonable period of two to three years should be taken as the period for implementing and reflecting them in the government policy initiatives. The High Courts of Delhi and Andhra Pradesh were selected based on the following factors: 1) India being a vast and diverse country, it was decided to study the decisions of a High Court from the South and that of a High Court from the North at the first stage. Analysis of the decisions of all the High Courts would have been a Herculean task. 2) The High Court of Delhi was selected, as the Union Territory of Delhi is predominantly an urban area and because of the presence of a large number of urban poor in the city. 3) The High Court of Andhra Pradesh was selected as the State of Andhra Pradesh performs poorly compared to other South Indian states in all health indices. It was assumed that the cases brought before these High Courts would bring out most of the challenges in the realization of right to health and the judicial prescriptions for overcoming them. In the second stage, cases relating to access to health care were identified during this time period. A further

## 12 Enhancing Public Health Delivery System in India: Impact of judicial decisions towards access to universal health care

reduction was made to those cases wherein the courts have entered the policy sphere. The cases are discussed by identifying the issues involved first, followed by the ruling of the court. At third stage attempt was made to see the status of implementation of these cases and whether they have triggered action on the part of the governments both at the central and State Government level to bring in policy changes or initiatives. Special care was taken not to have any bias in the selection process. For this all the cases decided by the courts in the field of health care were identified. This was done by using databases like Manupatra and Indian Kanoon. After going through all these cases, those decisions which clearly entered the policy sphere were listed for further analysis.

The study is divided into four parts. The first part provided an introduction to the study. The second part deals with judicial decisions concerning access to health. The third part contains an analysis of some select cases, their implementation and the impact of those decisions on the policy initiatives of the Governments. Fourth part of the study provides a conclusion.

---

## CHAPTER 2 Access to health care and judicial initiatives

An attempt is made in this chapter to analyze some of the decisions of the Supreme Court of India and the High Courts of Andhra Pradesh and Delhi concerning access to health care. The terms right to health, access to health care are loose formulations that can be interpreted in many different ways. The UN Committee on Economic, Social and Cultural Rights in its General Comment No. 14 (2000) provides a very useful interpretation. General Comment No. 14 is on Article 12 of the ICESCR which speaks about the 'right to the highest attainable standards 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<sup>1</sup>." The participation of the population in all health-related decision-making at the community, national and international levels has also been mentioned as an important aspect of right to health. According to the Committee, 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:

- Availability
- Accessibility
- Acceptability
- Quality.

Accessibility in the context of right to health means health facilities; goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. The term health facilities, goods and services is used in a very wide way to include the underlying determinants of health such as access to safe and potable water, adequate sanitation, 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. Accessibility has four overlapping dimensions, viz., Non Discrimination, Physical Accessibility, Economic Accessibility and Information Accessibility. It is this framework which is used

---

<sup>1</sup> CESCR, CESR, General Comment 14, Para 11.

to categorise the decisions of the Indian courts. The following section analyses some of the important judgments relating to accessibility in these dimensions. As mentioned earlier, only those decisions wherein the courts have entered the administrative and policy sphere have been analyzed here.

## Non Discrimination

Non discrimination in the context of access to health care means that health facilities, goods and services in their broadest sense should be accessible to everyone especially the most vulnerable or marginalized sections of the population. Indian courts had in many occasions dealt with this aspect of right to health.

*Sheela Barse v. Union of India*<sup>1</sup>, is an important decision on the health facilities extended to the mentally ill. It was a public interest litigation filed in the Supreme Court concerning the condition of children and adults confined to jails in Calcutta as lunatics. It was pointed out that not all of them were mentally ill. The health facilities in the jail were abysmal. The court as a first step in this case appointed a commission to find out the conditions in the jail. The commission found that no psychiatrist is on the permanent staff of any jails in West Bengal. Jails have only consultancy arrangements, either the psychiatrist visiting the jail or the inmates sent to the District hospital or Medical College. This facility extended only in those districts which had a psychiatric wing in the district hospital. There were no other trained personnel for the treatment of mentally ill persons. After considering the report, the court issued certain directions. The court declared that admission of non-criminal mentally ill persons to jails is illegal and unconstitutional. The court gave specific directions to the state of West Bengal to immediately upgrade mental hospitals in the state, to set up psychiatric services in all district hospitals, to fill up the post of psychiatrists in all the hospitals and to integrate mental health care with primary health care. In addition to these the High Court at Calcutta was requested to appoint a committee comprising a mental health professional/psychiatrist, a social worker and a law person to evaluate the state of the existing mentally ill persons in the jails. *Rakesh Chandra Narayan v. State of Bihar*<sup>2</sup> is another important decision of the Supreme Court of India concerning the mentally ill patients. The Supreme Court considered as a PIL, a letter written by two residents of Ranchi regarding the conditions of the mental hospital in Ranchi. The pathetic

---

<sup>1</sup> (1993) 4 SCC 204.

<sup>2</sup> AIR 1989 SC 348.

condition in which the inmates were housed is described in greater detail in the judgement. The Court gave the following interim directions during the course of the case.

1. “In respect of each patient in the Ranchi Mansik Arogayashala the daily allocation for diet will be increased from the existing inadequate rates; and articles of that value shall be supplied to each patient.
2. Arrangements should be made forthwith to supply adequate quantity of pure drinking water to the hospital, if necessary, by engaging water tankers to transport potable water from outside.
3. Immediate arrangements should be made for the restoration of proper sanitary conditions in the laboratories and bathrooms of the hospital.
4. All patients in the hospital who are not at present having mattresses and blankets should be immediately supplied the same within 15 days from today. Such of the patients who have not been given cots should also be provided cots within six weeks from today so that no patient shall be thereafter without a cot.
5. The ceiling limit at present in vogue in respect of cost of medicines allowable for each patient will stand removed, with immediate effect and the patients will be supplied medicines according to the prescription made by the doctors irrespective of the costs.
6. The State Government shall forthwith take steps to appoint a qualified Psychiatrist and a Medical Superintendent for the hospital and they should be posted and take charge in the Institution within six weeks from today”.

These orders were reproduced to show the micro management done by the court concerning one hospital in a state in India. In the final judgement in this case, the court appointed a Committee to oversee the implementation of these directions.

These two cases from a plethora of judgements show the concern that the Indian judiciary has got when it comes to the health facilities for the disadvantaged groups. The nature of the petition, the process of appointing commissions to find out the ground reality, issuance of interim directions, appointment of Committees to oversee the implementation, providing for compulsory reporting of the progress made etc. are some of the unique mechanisms devised by the Courts in these types of petitions. But it is interesting to note here that the Court did not take into account the costs involved in the implementation of this decision.

## Physical Accessibility

Physical accessibility means 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<sup>1</sup>.

In *Parmanad Katara v. Union of India*<sup>2</sup>, the petitioner, a Human Rights activist filed a PIL in the Supreme Court after reading a news item concerning the plight of an accident victim. In the said news item it was alleged that a speeding car knocked down a scooterist. Seeing the profusely bleeding scooterist, a person who was on the road picked up the injured and took him to the nearest hospital. The doctors refused to attend on the injured and told the man that he should take the patient to a named different hospital located some 20 kilometres away as they were not authorized to handle medico-legal cases. The Good Samaritan carried the victim, lost no time to approach the other hospital but before he could reach, the victim succumbed to his injuries. The court in this case ruled that Article 21 of the Constitution did cast an obligation on the state to preserve life. The court held that a doctor at the Government hospital positioned to meet this obligation was therefore, duty bound to extend medical assistance for preserving life. The court gave effect to the directions contained in the minutes of the 10<sup>th</sup> Meeting of the Standing Committee on Forensic Medicine (a Committee set up by the Ministry of Home Affairs of the Government of India) held on 27.4.1985. These directions are:

1. "Whenever any medico-legal case comes to 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

---

<sup>1</sup> CESR, General Comment 14, Para 13.

<sup>2</sup> (1989) 4 SCC 286.



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 expert facilities required for the treatment are not available in that Institution."

The court further ordered that this decision had to be publicized widely in the media and also through Doordarshan and All India Radio so that every doctor wherever he is within the territory of India was aware of this position.

*A. S. Mittal v. State of U.P.*<sup>1</sup> addresses another dimension of this issue. This case concerned with the mishap in an eye camp due to contamination. Because of this many people lost their eye sight. In this case the Supreme Court took note of the guidelines prepared and submitted to the Court by the Indian Medical Council. The Court ordered the incorporation of the following points in the revised guidelines issued by the Government.

*Maneka Gandhi v. Union Territory of Delhi*<sup>2</sup> is an example of the consideration of right to health in a wider meaning by the Court. Disturbed by the unhygienic conditions in the Idgah slaughter house, the petitioner approached the Delhi High court for issuing directions to ensure hygiene at the slaughter house. The direction issued by the court is worth quoting.

1. "The Municipal Corporation of Delhi must ensure supply

---

<sup>1</sup> (1989) 3 SCC 223

<sup>2</sup> (1994) DLT 190.

of wholesome and pure drinking water of the residents of Delhi, and adjoining areas.

2. The Administrator, of the Municipal Corporation of Delhi must set up a committee of experts to ensure supply of wholesome and pure water. The committee must send its monthly report to the high-powered Committee, set up by this court.
3. The Idgah slaughter house must be closed, but if for any reason it continues for some time, in that event, for maintaining at least the minimum standard of hygiene and sanitation, number of animals slaughtered must be reduced to 2500 per day i.e. 2000 sheep/goats and 500 buffaloes.
4. The Administrator, M.C.D. is directed to ensure meticulous compliance of these directions and submit a monthly report to the Committee.
5. Children below the age of 18 years shall not be allowed to work in the slaughter house.
6. The M.C.D. is directed to take necessary steps to stop illegal slaughtering.
7. Licenses be issued to the butchers by the M.C.D. within three months from today, and the M.C.D. may also prescribed necessary conditions for ensuring the object of hygienic conditions and to proved wholesome meat to the meat eating population of Delhi.
8. The M.C.D. is directed to appoint adequate number of veterinary doctors for the purpose of proper ante-mortem examination of animals.
9. Slaughtering hours must be fixed and strictly maintained, so that sufficient time is left for cleaning the abattoir and the other sections of the slaughterhouse.
10. The M.C.D. shall ensure ante-mortem medical examination of the animals.
11. The M.C.D. must ensure compliance of the provisions and rules framed there under regarding minimum prescribed age of animals before they are slaughtered.
12. The M.C.D. must ensure supply of adequate drinking water for the livestock and for washing and cleaning the abattoir, and other sections of the slaughterhouse.
13. Direction given to MCD to allow the maximum number of animals to be carried in open trucks.
14. The M.C.D. must ensure proper light, electricity, fans coolers, in various sections of the slaughter house.”

The court assumed jurisdiction in this case on the basis of the violation of right to health as contained in Article 21. This case is a pointer towards the extent to which the courts can go in micro managing the affairs. The subsequent filing of petitions by the traders and the petitioner point out the difficulties in

implementing a court order of such administrative details.

## Economic Accessibility

Economic accessibility or affordability means 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.

*Social Jurist vs. Government of NCT of Delhi*<sup>1</sup> directly concerned the economic accessibility issue in right to health. In this PIL, a group of lawyers had sought the direction of the court to strictly adhere to the land allotment norms for the hospitals. The petitioners alleged that around twenty hospitals in Delhi are situated in land allotted by the civic authorities at concessional rates. One of the conditions attached to the allotment was that those hospitals had to admit a certain percentage of poor patients free of cost. The petitioners alleged that none of the hospitals complied with this condition. The Court appointed a committee and on the basis of its report issued detailed direction for the strict implementation of the conditions.

In *M Vijayan vs. Chairman and Managing Director, Singareni Collieries Co*<sup>2</sup>, the Andhra Pradesh High Court dealt with the plight of the AIDS patients. After examining all the details the court came out with the following directions:

1. Sufficient AIDS/HIV+ve test kits/ equipment to all hospitals and institutions should be provided. The Government Blood Banks as well as licensed blood banks should be compelled to buy pool proof HIV+ve /AIDS test equipment.
2. All the Government hospitals should use only disposable needles in injections. Registered medical practitioners should be compelled to use only disposable 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

---

<sup>1</sup> WP(C)No. 2866/2002

<sup>2</sup> 2001(5)ALT154

**20** Enhancing Public Health Delivery System in India: Impact of judicial decisions towards access to universal health care

should be made to supply anti-AIDS drugs free of cost like in anti-TB and anti-leprosy programmes and family welfare programmes.

6. Doctors should be encouraged to undergo special training programmes for diagnosis and treatment of AIDS patients.
7. There should be proper schemes for rehabilitation of patients who are diagnosed as HIV+/AIDS as there is 'social ostracising' attached to HIV+/AIDS infected person.
8. There should be compensatory mechanism to deal with the AIDS in case of negligence on the part of the blood banks/hospitals by way of free facilities and free access to State funded health institutions,
9. There should be special treatment facilities in hospitals for those who suffer from HIV+/AIDS.
10. 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 man the blood banks.
11. Government may consider introducing sex education in schools at least from adolescence stage.
12. Identity of patients who come for treatment of HIV+/AIDS should not be disclosed so that other patients will also come forward for taking treatment.
13. There should be change in the method of AIDS propaganda and no slogans, which promote indiscriminate sex, should be used in the propaganda.
14. The infected HIV+ patient should be educated properly about the AIDS so that he may not inadvertently or innocently be responsible in spreading the disease.
15. 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.
16. Like the Central Government, which has exempted from payment of Central excise duty in respect of medicines imported for the treatment of AIDS, the State Government should also consider the desirability of grant of sales tax exemption in relation thereto.

### Information Accessibility

Information accessibility means 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<sup>1</sup>.

---

<sup>1</sup> CESR, General Comment 14, Para 12.

In *Vincent Panikulangara v. Union of India*<sup>1</sup> the Supreme Court was requested to direct banning of import, manufacture, sale and distribution of drugs which have been banned in Western countries or recommended to be banned by the Drugs Consultative Committee under the Drugs and Cosmetics Act, 1940. Though the Court refused to grant the remedy sought by the petitioner, it ordered that every indigenous drug manufacturer must have an obligation by law to disclose the formula of preparation and other statutory information in the national language and at least one or two other languages, keeping in view the place of manufacture of the drug and the area of its circulation. The Court further held that any statutory warning to be administered should also follow the same course.

An analysis of these select judgements brings out the following important points.

- Even though right to health is not specifically mentioned as a Fundamental right in the Indian Constitution, the judiciary has read this right into article 21 of the Constitution dealing with right to life and personal liberty. It means that certain components of the right to health are enforceable in the Indian context.
- Coming specifically to accessibility, the Indian courts have dealt with this issue in all its dimensions viz., Non discrimination, Physical accessibility, Economic accessibility and Information accessibility.
- In interpreting right to health, the courts have blurred the distinction between judicial functions and administrative functions. In a traditional framework, an adjudicating body is not expected to go into the measures adopted by the executive branch. Its function is confined to see whether the measure adopted is a reasonable one and whether it is taken in good spirit. In the select cases analyzed above, the Courts have gone into the micro management issues of a mental hospital, slaughterhouse etc.
- In its attempt to do justice to the affected parties, the court has adopted many an innovative methods like appointing commissions etc.

In the next chapter an attempt has been made to see how these policy prescriptions by the Judiciary are translated into practice by the Executive.

---

<sup>1</sup> AIR 1987 SC 900.

---

## CHAPTER 3 Court influencing national and state health law and policy

This chapter analysis few selected judicial pronouncements of the Supreme Court and the High Courts to see how these decisions are honoured at the implementation level by the respective Governments both at the Centre and at the State. Importance of health as a subject of policy and law lay in its decentralized approach of Governance. Constitution of India recognizes this and has placed health in the state list giving predominance to the state governments in policy and legal formulation. But as noted earlier, it does not mean that the central government does not have any role to play. The central government has framed a number of health schemes which are implemented by the state governments. So an attempt has been made here in evaluating the policy responses of both the central government and the state governments in certain fields of healthcare, where the judiciary has been actively involved. The present study does not dwell into the effectiveness of such judicial decisions. What is attempted here is pointing out the linkages between the judicial decisions and policy formulation.

The inter-linkages between the decision and policy/plan documents are explained on following thematic categories..

### 1. National Blood Policy and the Supreme Court

In the case of "*Common Cause Vs Union of India*", a writ petition (Writ Petition (civil) 91 of 1992) which was filed in the Supreme Court of India, the petitioner has high-lighted the serious deficiencies and short-comings in the matter of collection, storage and supply of blood through the various blood centres operating in the country. The petition requested that an appropriate writ order or direction be issued directing the Union of India and the States and the Union Territories, to ensure that proper positive and concrete steps in a time bound programme are immediately initiated for obviating the malpractices, malfunctioning and inadequacies of the blood banks all over the country.

The Court after hearing the dismal state of management and administration of blood banks and also taking up the cause of blood transfusion in the Country has given a landmark ruling in 1996. The Court has given following specific directions<sup>1</sup> to

---

<sup>1</sup> There are total of 18 specific directions. The directions discussed in the paper is limited to 12

Central and State Governments,

1. The Union of India shall take steps to establish a representative body known as the National council of Blood Transfusion as a registered society to be funded by the government of India.
2. The state government shall establish state councils in consultation with the national council.
3. Programs and the acts of the national and the state council shall cover the following;
  - a. Launching of effective motivating campaigns for stimulating voluntary blood donations.
  - b. Launching programs for blood donations.
  - c. Training of personnel in relation to all operations of blood collection, storage and utilization.
4. National council should undertake training programs to establish institution for research.
5. National council shall take steps for starting special postgraduate courses in medical colleges in Blood transfusion, collection and storage.
6. Donations to the National council or the state council to be made tax free.
7. The government should ensure that the blood banks should be duly licensed.
8. Professional donor systems should be eliminated in 2 years.

The study of this Supreme Court case brings out the following as the post judgment implementations schemes.

1. There has been a major modification and change in the blood transfusion service post 1996 judgment
2. In 2002 Government of India has formulated a National Blood Policy and development of a National Blood Programme
3. The Drugs and Cosmetics Rules, 1945 have been suitably amended in 1992 to bring it in conformity with the judgment. Further, there have been a series of amendments towards strengthening of the rules till 1992
4. The supreme Court directive of May, 1996 has helped in phasing out unlicensed blood banks by May, 1997 and professional blood donors by December, 1997
5. Mandatory testing of blood for HIV along with Syphilis, Malaria Hepatitis B and C has helped in checking transmission of HIV virus through blood transfusion.

It is important to see how NBP has been framed. The introductory chapter on National Blood Policy (NBP)<sup>1</sup>

---

<sup>1</sup> National Blood Policy (2002), National AIDS Control Organisation,

**24** Enhancing Public Health Delivery System in India: Impact of judicial decisions towards access to universal health care

acknowledges the importance attached to the 1996 directives of the Supreme Court of India in the following words,

“Thus, a need for modification and change in the blood transfusion service has necessitated formulation of a National Blood Policy and development of a National Blood Programme which will also ensure implementation of the directives of Supreme Court of India – 1996”

Further, the mission statement of NBP says,

*“the policy aims to ensure easily accessible and adequate supply of safe and quality blood and blood components collected / procured from a voluntary non-remunerated regular blood donor in well equipped premises, which is free from transfusion transmitted infections, and is stored and transported under optimum conditions  
.....”*

To achieve the mission of NBP, the policy further spells out eight objectives. Each of the eight objectives has a detailed strategy plan of implementation. The reading of the strategies highlights how well these strategies are in line with the direction of the Court. For example, objective 1 of the NBP says, “ to reiterate firmly the Govt. commitment to provide safe and adequate quantity of blood, blood components and blood products”. The strategies that are been mentioned to carry forward this agenda is a National Blood Transfusion Programme to be developed to ensure establishment of non-profit integrated National and State Blood Transfusion Services in the country. To achieve this, among other things is the establishment of National Blood Transfusion Council (NBTC) as the policy formulating apex body in relation to all matters pertaining to operation of blood centres. Like wise, most of policy prescriptions of NBP can be traced its origin in the direction of the court.

Few more examples that can be easily related to the judgment have been briefly described below. NBP calls of trading in blood i.e. Sale & purchase of blood be prohibited, the practice of replacement donors shall be gradually phased out in a time bound programme to achieve 100% voluntary non-remunerated blood donation programme. In terms of standards, it is prescribed that there should be minimum standards for testing, processing and storage and a Quality System Scheme shall be introduced in all blood centers.



The policy prescribes the efforts towards recruitment and retention of voluntary, non-remunerated blood donors through education and awareness programmes. While enrolment of safe donors will be stepped up, rigid adherence to donor screening guidelines shall be enforced.

Education and training has been given prominence in NBP. It says training in effective clinical use of blood shall be organized and Medical Council of India be requested to initiate Transfusion Medicine as a subject at undergraduate and all post graduate medical courses. Further, it calls for Transfusion Medicine to be treated as a speciality and a separate Department of Transfusion Medicine shall be established in Medical Colleges.

In terms of license towards new and renewal of blood bank licenses including plan of a blood bank are concerned, a committee, comprising of members from State/ UT Blood Transfusion Councils including Transfusion Medicine expert, Central & State/UT FDAs shall be constituted which will scrutinise all applications as per the guidelines provided by Drugs Controller General (India). Policy clearly lay down, that fresh licenses to stand-alone blood banks in private sector should not be granted. Renewal of such blood banks shall be subjected to thorough scrutiny and shall not be renewed in case of non-compliance of any condition of license. Also, NBP suggests, all State/UT Blood Transfusion Councils shall develop a State Action Plan for the State/UT Blood Transfusion Service where in Regional Blood Transfusion Centres shall be identified.

Thus a review and study of National Blood Policy (NBP) in the context of Supreme Court judgment provides a good picture on how well the directions of Court have been taken towards formulation of NBP. Taking a cue from the National Blood Policy, various States have brought respective State Blood Policy and an action plan.

## 2. Emergency care of victims of accident and the Supreme Court of India

In *Parmand Katra v. Union of India* (1989)<sup>1</sup> case Supreme Court held that every injured citizen brought for medical treatment should instantaneously be given medical aid to preserve life and thereafter the procedural criminal law should be allowed to operate in order to avoid negligent death. There is no legal impediment for a medical

---

<sup>1</sup> AIR 1989 SC 2039

professional when he is called upon or requested to attend to an injured person needing his medical assistance immediately.

The Supreme Court further held that it is for the Government of India to take necessary and immediate steps to amend various provisions of law which come in the way of government doctors as well as other doctors in private hospitals or public hospitals to attend to the injured/serious persons immediately without waiting for the police report as completion of police formality. It is further submitted that a doctor should not feel himself handicapped in extending immediate help in such cases fearing that he would be harassed by the police or dragged to court in such a case.

In response to the decision, there have been several initiatives at the Central Government and State Government level.

Road Safety Cell of the Department of Road Transport & Highways, Ministry of Shipping, Road Transport & Highways Government of India issued a letter<sup>1</sup> addressing all the states urging to take steps to put in place mechanisms towards the need to build confidence in public for helping road accident victims. Citing the Supreme Court decision in Parmand Katra case, the letter clearly describes the information contained in the judgment regarding emergency medical care which is a paramount duty of any doctor/hospital with out any fear of procedural laws. A brief paper on the subject 'Need to build confidence in public for helping road accident victims' was also annexed by the Ministry with a request to the State Government to widely publicize the judgment.

Also importantly, following the Supreme Court order in 1989, the Motor Vehicles Act was amended in 1994, to make it mandatory on both the driver/owner of the vehicle to take the accident victim to the nearest doctor, and the doctor to treat the victim without waiting for any formalities. The duty of the driver of the vehicle involved in an accident has been specified below,

1. The driver or the owner of a vehicle involved in any accident that has caused injury or damage to any person is required to secure medical aid for the injured person, by taking him to the nearest doctor
2. He shall report the matter to the nearest police station within 24 hours, and

---

<sup>1</sup> "Need to build confidence in public for helping road accident victims" Letter issued by Ministry of Shipping, Road Transport & Highways Government of India Dated the 9th September 2004.

3. Also inform the insurance company about the occurrence of the accident, namely, insurance policy number and period of its validity; date, times and place of accident; particulars of the persons injured and / or killed in the accident' and name of the driver and particulars of his driving licence.

These have been mandated under the amended Motor Vehicles Act. Section 134 of the Motor Vehicles (MV) Act, 1988 states that the driver and / or the owner of the motor vehicle responsible for a road accident is required to take all reasonable steps to secure medical attention for the injured person by conveying him to the nearest medical practitioner or hospital, unless it is not practicable to do so on account of mob fury or any other reason beyond his control.

Under Section 187 of MV Act 1988, whoever fails to comply with the provisions of the clauses of Section 134, shall be punishable with imprisonment for a term which may extend to 3 months, or with fine which may extend to Rs. 500, or with both. If it is the second time for the person concerned, then the penalty is harsher. The imprisonment may extend to 6 months, or with fine, which may extend to Rs.1000, or with both.

### 3. Emergency medical care guidelines by Supreme Court

In *Paschim Banga Khet Mazdoor Samiti v. State of West Bengal* case<sup>1</sup>, Paschim Banga Khet Mazdoor Samiti along with Hakim Sheikh have filed the writ petition in Supreme Court feeling aggrieved by the indifferent and callous attitude on the part of the medical authorities at the various State run hospitals in Calcutta in providing treatment for the serious injuries sustained.

It is very interesting to note that during the pendency of the writ petition the State Government decided to make a complete and thorough investigation of the incident and take suitable departmental action against the persons responsible for the same and to take suitable remedial measures in order to prevent recurrence of similar incidents. The said committee submitted the report and recommended various measures to deal with such emergencies in future.

In this case, the Court having considered all the submissions and the recommendations made by the Committee and the subsequent action taken by the State Government articulated

---

<sup>1</sup> Paschim Banga Khet Mazdoor Samity vs State of West Bengal writ petition (Civil) No 796 of 1992, on May 6, 1996

**28** Enhancing Public Health Delivery System in India: Impact of judicial decisions towards access to universal health care

through seven guidelines the responsibility of the State in healthcare matters and those are,

1. Adequate facilities are available at the Primary Health Centres where the patient can be given immediate primary treatment so as to stabilize his condition;
2. Hospitals at the district level and Sub-Division level are upgraded so that serious cases can be treated there;
3. Facilities for giving Specialist treatment are increased and are available at the hospitals at District level and Sub-Division level having regard to the growing needs;
4. In order to ensure availability of bed in an emergency at State level hospitals there is a centralise 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 is made for transport of a patient from the Primary Health Centre to the District Hospital or Sub-Division hospital and from the District hospital or Sub-Division hospital to the State hospital.
6. The ambulance is adequately provided with necessary equipment and medical personnel;
7. The Health Centres and the hospitals and the medical personnel attached to these Centres and hospitals are geared to deal with larger number of patients needing emergency treatment on account of higher risk of accidents on certain occasions and in certain seasons.

In concluding the decision, the Supreme Court held that lack of financial resources couldn't be a reason to deny treatment. It is every patient's right to get emergency treatment. The Court directed that a copy of this judgment be sent for taking necessary action to the Secretary, Medical and Health Department, of the States.

The following can be termed as court influenced measures at the State Level.

The State Government appointed Committee during the pendency of the petition. One of the terms of reference is to recommend.....,

.....

- (d) Recommendations on actions that should be taken by the State Government to rule out the recurrence of such incident in future and to ensure immediate medical attention and treatment to patients in real need".

While in the pendency of the case, the recommendations of the Committee have been accepted by the State Government and memorandum dated August 22, 1995 has been issued wherein detailed directions have been given for dealing with

patients approaching health centres/OPD/Emergency  
Departments of hospitals:

The directions that are most suited to mention here would be,

Proper medical aid within the scope of the equipments and facilities available at Health Centres and Hospitals should be provided to such patients and proper records of such aid provided should be preserved in office. The guiding principle should be to see that no emergency patient is denied medical care. All possibilities should be explored to accommodate emergency patients in serious condition.

The drawbacks in the system of maintenance of admission registers of patients in the hospital it has been directed that the Superintendents and Medical Officer of the hospitals should take the following actions to regularise the system with a view to avoiding confusion in respect of Admission / Emergency Attendance Registers.

With regard to identifying the individual medical officers attending to the individual patient approaching Out Patients' Department/Emergency Department of a hospital on the basis of consulting the hospital records, detailed directions has been given on how the procedure should be followed in future.

#### 4. Provision of free treatment facilities for poor patients in private hospitals and Delhi High Court

The Delhi Development Authority and Land & Development Office of Govt of India had allotted land to the registered societies and trusts on concessional rates (predetermined and zonal variant rates) for establishment of hospitals and also stipulated the conditions that they would provide certain percentage of beds in the hospitals free for the poor /indigent category patients. Similarly in the OPD, it was stipulated that free treatment has to be provided to the patients belonging to the indigent category.

The Justice Qureshi Committee, a high power committee constituted in the year 2000 recommended that there should be 10% free beds in the IPD and 25% of the patients in the OPD should be provided free treatment. It was also recommended that the conditions should be uniform and applicable to all the allottees with or without having conditions and the free treatment should be totally free. Delhi Govt found these recommendations reasonable and accepted the same and intimated the concerned land allotting agencies, to solve this whole gamut of problems.

Social Jurist has filed a writ petition [Social Jurist vs. Govt. of NCT & Ors. CW No.2866/2002] in the High Court of Delhi against the failure on the part of the Delhi Government to ensure that all hospitals and nursing homes to whom lands have been allotted on concessional rates/free complied with the conditions of allotment with regard to free treatment to the poor and indigent patients.

Delhi High Court, after hearing the matter in detail and also studying the Justice Quershi Committee report, issued specific and general directions to Delhi Government complying with the lease and other guidelines of the land allocation scheme.

1. The Court viewed that all the hospitals to whom the Government had allotted land free of cost or at concessional rates should be directed to furnish details of the patients, who were treated free of charge as per the formula devised by the Quershi Committee which was accepted by the Delhi Government
2. The Court said this percentage of patients would not be liable to pay any expenses in the hospital. In other words, they will be provided free admission, bed, medication, treatment, surgery facility, nursing facility and consumables and non-consumables.
3. The hospitals charging any money from such patients shall be liable to be proceeded against in accordance with law. Besides that, this would be treated as violation of the orders of the court
4. In case these hospitals have made unwarranted profits by breach of the terms of allotment of lands to them, the amounts should be recovered and a pool should be set up for the health care of the people.

#### Response of the Delhi Government

In response to the interim orders and the final judgment of the Delhi High Court, Government of NCT issued detailed "Guidelines<sup>1</sup> for provision of free treatment facilities to patients of EWS category in private hospitals in pursuance of directions issued by the Hon'ble High Court of Delhi in WP (C) no 2866/2002 in the matter of Social Jurist Vs GNCT Delhi".

---

<sup>1</sup><http://www.delhi.gov.in/wps/wcm/connect/3cdo5004d9238eeaa5eaf09e0ee946a/guidelines.pdf?MOD=AJPERES>  
[http://www.publicnotice.in/show\\_notice\\_details.php?id=633](http://www.publicnotice.in/show_notice_details.php?id=633)

Few of the important points in the guidelines are reproduced below :

(A) For Private Hospitals

1. The conditions of free patient treatment shall be 25% of patients for OPD and 10% of beds in the IPD for free treatment. This percentage of patients will not be liable to pay any expenses in the hospital for admission, bed, medication, treatment, surgery facility, nursing facility, consumables and non consumables etc.
2. The hospital charging any money shall be liable for action under the law and it would be treated as violation of the orders of the court. The Director/M.S./member of the trust or the society running the hospital shall be personally liable in the event of breach /default.

(B) For Government Hospitals

1. Every Govt. hospital shall create a special referral centre within two weeks of pronouncement of the said judgment, which shall be part of the casualty as well as the OPD. The Government hospitals shall intimate the establishment of the referral centre within one week of its establishment to DHS.
2. The referral centre shall have to be managed by a senior officer round the clock and shall have a dedicated phone no, the fax and also the e-mail facility
3. The patients having no income or income below Rs 5000/- per month shall be eligible for getting free treatment at the private hospitals. (now it has been modified to Rs.4000/- per family per month by the special committee vide order dated 2.11.2007)
4. For such eligible poor patients reporting to the casualty who needed immediate care and if it is found that the particular facilities are not available or the beds are not available and the patient need urgent care , such patients may be referred to the private hospitals where the requisite facilities are available.
5. Before referral, the patient shall have to be provided necessary treatment, and only after stabilization of his/her condition, he/she may be referred with proper life support, if required.

A review of the guidelines suggests that an attempt has been made to comprehensively implement the directions of the Court as well as the Government appointed Committee report.

## 5. Mental Health law and policy and Supreme Court

In this section two notable cases are dealt with. One on the question of children and adults confined in West Bengal Jails as lunatics and another on the status of the implementation of Mental Health Act.

In the first case, a public interest litigation was filed concerning the condition of the children and adults confined to jail, in Calcutta, as lunatics<sup>1</sup>. The fact was that all the inmates were not found to be mentally ill, some were normal, some temporarily under stress or undergoing a phase of mental disturbance and a few were mentally retarded, but they had all been jailed as 'non criminal lunatics'. The absence of health facilities in the jails left these people in absolute misery

In the case the Court directed the Government of West Bengal to,

- a. Take immediate steps to upgrade mental hospitals
- b. set up of psychiatric services in all teaching and district hospitals
- c. integrate mental health care with the primary health care systems
- d. To stop the admission of mentally ill persons to jails in West Bengal on any ground whatsoever forthwith.

In addition to these directions, the Court held that the admission of non-criminal mentally ill persons to jails was illegal and unconstitutional.

The court further said, though the case relates to Government of West Bengal, all other States should implement these direction in earnest.

In second case, in the public interest litigation filed by *Saarthak Registered Society & Anr. Vs Union of India & Ors* after the death of 25 chained mentally challenged inmates in asylum fire in Tamil Nadu<sup>2</sup>, the Supreme Court has directed all State Governments, Union Territories, Chief Secretaries/ Administrator/ Commissioners and Health Secretary, Union of India the following (only few directions are mentioned below),

---

<sup>1</sup> Sheela Barse (II) and Others vs. Union of India and others (1986) 3 SCC 632 and,

Sheela Barse vs. Union of India (1993) 4 SCC 24

<sup>2</sup> Orders of the Supreme Court in Civil Writ Petition No 334/2001 & 562/2001- Erwady Saarthak Public Interest Litigation (PIL)



1. Closure of all unlicensed mental asylums in the country and asked the authorities to undertake a countrywide survey to ensure that the inmates were not chained.
2. Directed the Centre to frame a policy and initiate steps for the establishment of at least one Central Government-run mental health hospital in each State. Similarly, the State Governments were directed to formulate a policy for establishing one State Government-run mental hospital. A ward or a psychiatric unit in a Government hospital would not be construed as a mental hospital for this purpose, the judges said.
3. The Centre was also asked to examine the feasibility of framing uniform rules regarding standard of services in both public and private mental health institutes. States and UTs were directed to undertake a comprehensive need assessment survey on the availability of mental health resource personnel, including psychiatrists in the State, and the type of mental health delivery system and rehabilitation available.
4. The court further directed that the survey report be submitted to the Union Health Secretary who, in turn, should file an affidavit on compliance to the court's directions.

#### The response of the Government

The literature review could not establish how the States have responded to both the cases. The reading of several State policy and action plan on health refers to the *Sheela Bara* case and the directions given by the court as one of the reason for the formulation of such policy and plan<sup>1</sup>.

On the implementation of the directions of the *Saarthak* case, in the Lok Sabha question and answer session, the Ministry stated that “In its order dated 15.10.2001, the Hon`ble Supreme Court of India directed the State Governments and the Central Mental Health Authority, constituted under section 3 of the Mental Health Act, 1987 to conduct a survey on an All India basis with a view to identify registered and unregistered asylums as also about the state of facilities available in such asylums for treating mentally challenged and submit a compliance report within three months. The Central Government completed the survey and filed its affidavit. However, some of the State Governments sought extension of time for compliance with the directions of the Hon`ble Court when the matter came up for hearing on

---

<sup>1</sup> *Mental Healthcare Policy* (April 2004), Department Of Health And Family Welfare Government Of Gujarat

**34** Enhancing Public Health Delivery System in India: Impact of judicial decisions towards access to universal health care

21.1.2002 and 29.1.2002, and have subsequently done so"<sup>1</sup>.

In the state of Tamil Nadu where the tragic incident happened, there had been a profound effect on the implementation of the Mental Health Act. The Government has decided to implement, after decades, sections of the Mental Health Act, 1987. For instance, it made it mandatory for anyone setting up a mental home to obtain a licence as required by the Act, and ordered the closure of all "mental homes" functioning in thatched sheds and the "unchaining" of all inmates<sup>2</sup>.

One may not attribute the changes in the execution of the law purely to the directions of the Court. The tragic incident in itself might have been the reason for such actions on the part of the State Government.

The discussion of the above six cases brings out interesting analysis on how the States machinery ie. judiciary, the legislature and executive branch interact on the question of access and rights issues in health policy and law. These cases are in no way comprehensive and there are lot many important cases for eg., in the dengue epidemic case, free treatment of AIDs patients, implementation of the tobacco law and several others, in which it will be interesting to see how the States react.

---

<sup>1</sup> Lok Sabha, Unstarred Question No 6250, *Non Implementation Of Mental Health Act*, Ministry Of Health And Family Welfare. [Http://164.100.24.208/Lsq/Quest.Asp?Qref=42602](http://164.100.24.208/Lsq/Quest.Asp?Qref=42602) (Accessed on 20, May 2009)

<sup>2</sup> Asha Krishnakumar (2002) *Probe report on Erwadi*, Volume 19 - Issue 23, Frontline

---

## CHAPTER 4 Conclusion

The extensive literature and case study survey that was undertaken in the course of research finds only few instances where direct linkages can be attributed on how States have carried forward the judicial initiatives into concrete State health policies and laws. However, some limitations of this study have to be highlighted before reaching the conclusions. It may be possible that some policy documents might not be directly mentioning the judicial decisions, even though they are in some way based on the directions of the courts. Further, the literature survey being largely done through case law analysis that are read with several policy and other notifications of the government, it could happen that some notifications were beyond the access of this literature review study.

The main conclusions that can be drawn from the study are as follows:

1. Even though right to health is not specifically mentioned as a Fundamental right in the Indian Constitution, the judiciary has read this right into Article 21 of the Constitution dealing with right to life and personal liberty. It means that certain components of the right to health are enforceable in the Indian context. Coming specifically to accessibility, the Indian courts have dealt with this issue in all its dimensions viz., Non discrimination, Physical accessibility, Economic accessibility and Information accessibility.
2. In interpreting right to health, the courts have blurred the distinction between judicial functions and administrative functions. In a traditional framework, an adjudicating body is not expected to go into the measures adopted by the executive branch. Its function is confined to see whether the measure adopted is a reasonable one and whether it is taken in good spirit. In the select cases analyzed above, the Courts have gone into the micro management issues
3. The role of court as a facilitator in addressing issues of health is dynamic and timely. But many a time the governments find it difficult to implement such decisions. Most of the time what is prescribed as guidelines by the judiciary are in a way directions tending towards policy making which is and should be confined to the powers of the State. Moreover, some of the judicial decisions are reactions to some unfortunate extreme events and in their enthusiasm to do justice, judiciary comes out with a

**36** Enhancing Public Health Delivery System in India: Impact of judicial decisions towards access to universal health care

number of policy prescriptions without adequately knowing the ability of the state to implement such directions. Since this is the case, the respective State Government may not be proactive in carrying forward the decision in to implementation plans

4. The study of some of the cases clearly brings out the other extreme nature of governance. In the pendency of some of the case which are studied, it is noted that the Governments (Central and States) brings in policy changes and legal amendments and also appoints commissions and notify such changes to the satisfaction of the Court.
5. 'Health' being a State subject in the Constitution, the decision of the Supreme Court and the respective High Court adds to multitude of other issues. Invariably what is being pleaded by many states is the lack of financial and manpower resources to undertake massive health schemes. To be fair most of the health schemes involves high expenditure and requires competent people. The direction of the Supreme Court or in some cases respective High Courts are very difficult to implement owing to the above factors.

---

## Bibliography

### International Conventions

1. African Charter on Human and Peoples Rights, 1981
2. African Charter on the Rights and Welfare of the Child, 1990
3. Alma Ata Declaration, 1978 adopted at the International Conference on Primary Health Care, Almaty.
4. American Declaration on the rights and duties of Man, 1948
5. Convention on the Rights of the Child, 1989
6. European Social Charter, 1961
7. International Convention on the Elimination of all forms of Racial Discrimination, 1979
8. International Covenant on Economic, Social and Cultural Rights, 1966
9. Universal Declaration of Human Rights, 1948
10. Vienna Declaration and Program of Action, 1993, adopted by the World Conference on Human Rights.

### National Policy and legal Documents

1. “Need to build confidence in public for helping road accident victims” Letter issued by Ministry of Shipping, Road Transport & Highways Government of India, 9<sup>th</sup>September 2004, No. RT-25028/2/2003-RSC
2. Drugs and Cosmetics Rules, 1945
3. Emergency health care guidelines, Government of National Capital Region
4. Guidelines for provision of free treatment facilities to patients of EWS category in private
5. hospitals in pursuance of directions issued by the Hon’ble High Court of Delhi in WP ( C) no 2866/2002 in the matter of Social Jurist Vs GNCT Delhi
6. Mental Health Act, 1987
7. Mental Healthcare Policy 2004, Government of Gujarat
8. National Aids Prevention and Control Policy, Government of India
9. National Blood Policy 2002, Government of India
10. National Blood Programme
11. National Health Policy 1983, Government of India
12. National Health Policy 2002, Government of India

### Cases

1. A S. Mittal v. State of U.P 3 SCC 223(1989)
2. Common Cause Vs Union of India . (Writ Petition (civil) 91 of 1992)
3. Dr. Mukhtiar Chand v. State of Punjab (1998) 7 SCC 579
4. Keshavananda Bharti v. State of Kerala AIR 1973 SC 1461
5. M Vijayan vs Chairman and Managing Director, Singareni collieries Co 2001(5)ALT154
6. Maneka Gandhi v. Union of India AIR 1978 SC 597
7. Maneka Gandhi v. Union Territory of Delhi 1994 DLT 190

8. Medical Council of India v. State of Rajasthan, AIR 1996 SC 2073
9. Parmanand Katara v. Union of India, AIR 1989 SC 2039
10. Paschim Banga Khet Mazdoor Samiti v. State of West Bengal, AIR 1996 SC 2426
11. Rakesh Chandra Narayan v. State of Bihar AIR 1989 SC 348
12. SC Advocates on Record v. Union of India AIR 1994 SC 268
13. Sheela Barse (II) and Others vs. Union of India and others
14. Sheela Barse v. Union of India(1993) 4 SCC 24
15. Social Jurist vs. Government of NCT of Delhi WP(C)No. 2866/2002
16. Subhashis Bakshi v. West Bengal Medical Council (2003) 9 SCC 269
17. Vincent Panikulangara v. Union of India AIR 1987 SC 900