Minor Research Project

On

"A STUDY ON RIGHT TO HEALTH AS A BASIC HUMAN RIGHT WITH SPECIAL REFERENCE TO SATARA DISTRICT"

Submitted to
University Grant Commission, New Delhi

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CERTIFICATE

This is to certify that a copy of the Final Report of Minor Research Project entitled **"A Study On Right To Health As A Basic Human Right With Special Reference To Satara District"** by Nikumbh Ghanshyam Yuvraj, Assistant Professor, Ismailsaheb Mulla Law College, Satara has been kept in the library of the college and an executive summary of the report has been posted on the website of the College.

Mr. Nikumbh Ghanshyam Yuvraj

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It was a great incident to study the research topic “A Study On Right To Health As A Basic Human Right With Special Reference To Satara District” I have made honest hard work in highlighting the importance of “A Study On Right To Health As A Basic Human Right With Special Reference To Satara District” under Indian Constitution Article 21 Provide that No person shall be deprived of his life and personal liberty and the Supreme Court states that the right to health is a constitutional right as well.

The present research on the topic on “A Study on Right to Health as A Basic Human Right with Special Reference to Satara District” is the very important and is a research in to fact and actual law, to check the law in books and law in practice at Hospital. Researcher find lacunas in implementation of Right to Health as A Basic Human Right with Special Reference to Satara District. The study is accomplished with important solutions.

I would like to express my gratefulness to all those who have guided and helped me in completion of this task. I would like to thanks Principal, colleagues, office Staff for research work.

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LIST OF ABBREVIATIONS

ACC	Antenatal Care Centres
AG	Accountant General
AIDS	Acquired Immuno Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
BMS	Basic Minimum Services Programme
CED	Chronic Energy Deficiency
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHC	Community Health Centres
Cr.P.C	Code of Criminal Procedure
CRC	Convention on the Rights of the Child
DH	District Hospitals
ECG	Electrocardiogram
FRU	First Referral Unit
GoI	Government of India
GoM	Government of Maharashtra
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
ICESCR	International Covenant on Economic, Social, and Cultural Rights
IOL	Intra Ocular Lens
IPHS	Indian Public Health Standards
LHV	Lady Health Visitor
LHV	Lady Health Worker
MCH	Mother and Child Health
MNP	Minimum Needs Programme
NCOP	National Council for Older Persons
NGO	Non Governmental Organasation
NHP	National Health Policy
NMHP	National Mental Health Programme
NPHCE	National Programme for the Health Care for the Elderly
NPHCE	National Programme for the Health Care for the Elderly
NPP	National Population Policy
NRHM	National Rural Health Mission
PHC	Primary Health Centers
RCH	Reproductive Child Health
RH	Rural Hospital
RMP	Registered Medical Practitioners
RTI	Reproductive Tract Infections
SDH	Sub-District Hospitals
STI	Sexually Transmitted Infections
TB	Tuberculosis

UDHR	Universal Declaration of Human Rights
UMHFW	Union Ministry of Health and Family Welfare
UoHFW	The Union Ministry of Health and Family Welfare
WHO	World Health Organization

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CHAPTER – I

INTRODUCTION

1) BACKGROUND :

The right to healthcare is first and foremost a claim to an entitlement, a positive right, not a defensive fence. As advantaged rights are contrasted with privileges, group ideals, communal obligations, or acts of charity, and once legislated they become claims justified by the laws of the state. The emphasis thus needs to shift from 'respect' and 'protect' to focus more on 'fulfil'. For the right to be effective optimal resources that are needed to fulfil the core obligations have to be made available and utilized efficiently. Further, using a human rights approach also implies right to health 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. But this does not discount the special needs of disadvantaged and any vulnerable groups who may need special entitlements through affirmative action to rectify historical or other inequities suffered by them. Thus establishing universal healthcare through the human rights route is the best way to fulfil the obligations mandated by international law and domestic constitutional provisions. International law, specifically International Covenant on Economic Social and Cultural Rights, 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. In 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 for right to health.

2) CONCEPT OF RIGHT TO HEALTH:

i) Health Means

Physical and mental and emotional health status

ii) Medical care

Used here to refer to what many call “health care,” to distinguish it from health (i.e., health status) itself. Medical care includes preventive services, such as vaccinations, preventive checkups and health education, as well as treatment and rehabilitation services.

iii) The Right to Health

Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and several other human rights agreements include “the right to the highest attainable standard of physical and mental health[1].”

iv) According to World Health Organization

Health is a state of complete physical, mental and social well being and not merely the absence of disease[2] From the definition itself, it is clearly indicated that condition of life of the individual should incorporate physical, mental and social well being and must be devoid of disease & infirmity.

v) Indian Constitution as on Right to Health

[1] See P. Braveman, “Health disparities and health equity: Concepts and measurement,” Annual Review of Public Health 27 (2006), 167–194.p

[2] Preamble to the Constitution of the WHO as adopted by the International Health Conference (Official records of the WHO, no 2, P. 100

The Preamble of the Indian Constitution which gives a broad direction refers to social, economic and political justice and also equality of status and of opportunity. Under the term Social Justice, one can bring in the question of right to health care facilities and the principle of justice involved in the equality of right to health as well. In the same way, equality of status and of opportunity may be taken to refer to the equality of practice of the medical profession, access to the medical educational institutions etc. for improve the citizens' socio-economic and personal health status as well.

vi) The Right to Health contains entitlements.

These entitlements include:

- The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health,
- The right to prevention, treatment and control of diseases,
- Access to essential medicines,
- Maternal, child and reproductive health,
- Equal and timely access to basic health services,
- The provision of health-related education and information,
- Participation of the population in health-related decision making; at the national and community levels.

Thus, health status and physical fitness in the case of some Person are considered as the requirement for citizenship. It may also imply that, the health status or physical conditions of the job seekers are considered as restricting the right of employers to employ or even the right of the citizens to seek employment. Since these rights are

justifiable, the state have authority to impose its preferences on the citizens with the interest of maintaining right to health and Healthcare conditions in the country for better future of the state.

Under the Article 21 of the Indian Constitution, guarantees the Right to Life and Personal Liberty. The concept of democratic and socialism aims to improve the condition of health care of the people. The right to health has been treated by the Supreme Court as part of the right to 'life' in article 21[3]. But, the right to health is not a right to be 'healthy'. It means a right both to certain 'freedoms' and 'entitlements'. The freedoms include the right to control ones' health and body, including sexual and reproductive freedom and the right to be free from interference, such as by non-consensual medical treatment and experimentation. Entitlements include a right to a system of health protection with equality of opportunity to enjoy the highest attainable level of health – a right to the enjoyment and availability of facilities, good services and conditions such as physical accessibility, economic accessibility and information accessibility. It must be qualitative and should include the right to healthy working conditions and preventive medicine.

In the case for a most powerful support of economic and social rights was made by the Supreme Court in the **Francis Coralie Mullan's Case (1981)**, when the court held that the expression right to life in Article 21, must include 'the right to live with human dignity and all that goes along with it, the bare necessities of life such as adequate nutrition, clothing and shelter over the head'. While acknowledging the potential economic constraints, the court ruled that the right to 'life' must include the

[3] AIR 1978 SC 597

right to minimum resources so as to carry on functions and activities that may be considered at least the bare minimum expression of human life.

3) NATURE AND CHARACTERISTICS OF RIGHT TO HEALTH:

Poverty is one of reason In the India for degradation of right to health. 3/4 of the population of The India lives below Poverty line. So that In India 70% to 90% of their incomes spends on food and related consumption. In such a context social security support for right to health, right to education, right to housing, gender inequality, disability etc. becomes grave. The right to health and Health services are very inadequate In India. Rural areas are so deterrent and primitives services Such as family planning and vaccination. The health care Services in India, like in the USA, is based on a supply-induced demand and keeps growing within its territorial parts, especially in the relation of new development. The cost of looking for such care is also increasing. It difficult to access to health care is receiving poor, and not only the poor but also the middle classes get rigorously affected[4]. Thus India has a large area, unregulated, poor quality, costly and dominant private health sector, and an inadequately resourced, selectively focused and seen better days public health sector in spite of its poverty, with the former having health-giving monopoly and the latter carrying the burden of preventive services.

According to above context the lack of right to health is the main reason why health status of the Indian population is inadequate. For example, the inequality between

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[4] The 52nd Round NSS data reveals that for inpatient care 46 per cent of poorer classes and 34 per cent of the richer classes either sold assets or took loans to pay for treatment. And those using private hospitals were 16 per cent more likely to get into indebtedness than those using public hospitals. (NSS-1996 : Report No. 441, 52nd Round, NSSO, New Delhi, 2000)

the top 18 per cent (socio-economically high) households and the bottom 36 per cent (socio-economically low) households, favouring the former. In infant and child mortality rates it is of the amount of 2 ½ times[5], predominance of malaria 3 times, predominance of tuberculosis 4 times, access to antenatal care nearly 4 times, completed immunisation 2 times, childbirth by doctors 4 times, malnourishment amongst women in reproductive age-group 3 times[6]. This is clearly due to inadequate right to health and healthcare services, because even in conditions of poverty if access to primary healthcare is common then it can become a level of healthcare outcome. In the case of nutritional outcomes it is mostly connected with the function of income of the family. The reality is that today we experience starvation deaths in many places in India even with having overflowing Government godon of reserved food-stocks which are under state control. With such inequities prevailing it is evident that the healthcare and food distribution systems are biased in favour of those with purchasing power and hence such a system is grossly discriminatory.

Under The Constitution of India Health doesn’t categorize ‘right to health’ as a fundamental right. The Constitution directs the State to take measures to improve the condition of health care of the people. Article 38 of Indian Constitution imposes a liability on the State that it will secure a social order for the promotion of welfare of the people, but without public health we cannot achieve it[7].

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[5] It is estimated that 2 million children under 5 years of age die each year because of the high child mortality rate. If the entire country experienced the child mortality rate of Kerala the number of such deaths each year would fall by a whopping 1.6 million (Shukla, 2001-Right to Health Care, Health Action, In May 2001)

[6] NFHS-1998, 2000- National Family Health Survey–2: India, IIPS, Mumbai.

[7] By Dr. Phad M N in the article “Right To Health As Basic Human Right” in RESEARCH FRONT journal year 2014

4) SIGNIFICANCE OF THE STUDY :

Human being, who is classified as an animal by the science, but due to his unusual characteristics and tremendous power of reasoning later on proved himself to be different from mere animal and get treated as a social animal. Day by day human being gets powerful with advanced scientific technology and knowledge. Human being made qualitative as well as quantitative efforts to achieve better quality of life with utilizing natural resources, at the time of doing this human being never realized the unprecedented and ever increasing hazards, which he is facing today. The excessive exploitation of natural resources and there imprudent use rather misuse have unfortunately led to serious ecological crises which now brought the human health in danger. Therefore activities of man and state are not only posing serious threat to the ecosystem but also the existence of entire human race, including future generations. Therefore in this context it is desirable to undertake a detailed study and find out the possible measures which will recognise right to health as a basic human right.

The Indian Constitution has granted certain fundamental rights to its citizen under part III of it these rights play an important role with reference to the health and health care. It guarantees 'Right to Life and personal liberty to all persons'[8] though it does not provides expressly for the healthcare however the liberal interpretation adopted by the Indian Supreme Court to the word life brought the healthcare it the ambit of word life and declared it as a basic human right to every citizen of India.

[8] Article 21 of the constitution of India "No person shall be deprived of his life and personal liberty except procedure established by law"

In the constitution where the words "right to health" are included. The constitutions of Bhutan, Bangladesh, India, Myanmar and Sri Lanka do not recognize the right to health as a fundamental right but, nevertheless, compel the state to provide health services or in some cases, more indirectly to improve public health. It should be noted that although the right to health has not been included as a positive right in some constitutions of the Region, other national legislation guaranteeing this right might be in place, or access to health could be treated *de facto* as a right[9].

In India there is some statistical information for right to health, In India annually 22 lakh infants and children die from preventable illnesses; 1 lakh mothers die during child birth, 5 lakh people die of Tuberculosis. Diarrhoea and Malaria continue to be killers while 5 million people are suffering from HIV/AIDS.[10] In context of poverty, access to public health systems is critical in India. Since 1990s, the public health system has been collapsing and the private health sector has flourished at the cost of the public health sector. Health policy in India has shifted its focus from being a comprehensive universal healthcare system as defined by the Bhore Committee (1946) to a selective and targeted programme based healthcare policy with the public domain being confined to family planning, immunization, selected disease surveillance and medical education and research.

Considering the locational aspect that 63% of our population lives in rural areas and lack hospitals, hospitals without doctors, shortage of medicines, etc., this research work may attract the attention of policy makers to have an effective distribution of right

[9] The Right to Health in the Constitutions of Member States of the World Health Organization South-East Asia Region 2011 Report

[10] Gangolli, Leena V. and *et.al.* (2005), *"Review of Healthcare in India"*, Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai, January.

to health measures through proper designing and effective implementation of right to health policies and programmes of the government, so, as to reach the benefits of right to health and healthcare to the maximum numbers in maximum areas. In urban areas, many needy and deserving people are not getting health care services of public hospitals. Again these hospitals prove costly, when a patient, referred to private labs for test and evaluation, is made to pay user fee and made to buy medicines from private vendors for the want of adequate quota of essential medicines with the government hospital.

5) STATEMENT OF THE PROBLEM :

As we aware that there are three organs of the state which are established by the constitution and every organ is allotted with the particular task to perform. Therefore judiciary is also having its own task towards the human being. Judiciary is the guardian of the fundamental rights. Even in social engineering theory as propounded by the Roscoe pound he provided two solutions to maintain the balance between the conflicting rights i.e. Judiciary and legislation. Judiciary had recognized health as a fundamental right in several cases such as, One crucial question relating to medical care and health was arose in *Mr. X. V. Hospital Z*[11] the question before the court was can a doctor disclose to the would be wife (with whom the marriage is contracted) of a person that he is HIV positive or does it violate the right to privacy of the person concerned. The court answered both the question is negative court stated that the lady proposing to marry such a person is also entitled to all the human right which are available to any human being, therefore it include the right to be told that a person with whom she was proposed to be

[11] AIR 1999 SC 495

married, was the victim of a deadly disease which was sexually communicable. Supreme Court here gave primacy to the right to health over right to privacy.

In *Parmanand Katara V. Union of India*[12] The supreme court has considered a very serious problem exiting in a medico-legal cases such as accident the doctors usually refuse to give immediate medical aid to the victim till legal formalities are completed. In some cases injured die for want for medical aid pending the completion of legal formalities. Court stated that preservation of health is of paramount importance once life is lost it cannot be restored. Hence, It is the duty of doctors to preserve the life whether the concerned person is a criminal or an innocent person.

In *Paschim Banga khet mazoor samity V. State of West Bengal*[13]. Court ruled that in the welfare state policy, the primary duty of the government is to provide adequate medical facilities for the people. The Govt. discharges this application by running hospitals and health centres to provide medical care to those who needs it.

There is no right to health in the Indian constitution, but the Supreme Court of India has interpreted the constitution's article on the protection of life and personal liberty so as to include access to health care into the article's scope[14].

In *Consumer Education and Resource Centre Vs Union of India*[15], the Supreme Court has held that the right to health and Medical care is a fundamental right under Article 21 of the constitution as it is essential for making the life of the workman

[12] AIR 1989 SC 2039
[13] AIR 1996 SC 2426
[14] Swarup J and Singhvi LM. *Constitution of India.* New Delhi: Modern Law Publications, 2006: p. 1100.
[15] Consumer Education and Resource Centre vs. Union of India. AIR (1995) 3 SSC, 42.

meaningful and purposeful with dignity of person. "Right to life" in Article 21 includes protection of the health and strength of the worker.

The expression 'life' in Article 21 does not connote mere animal existence. It has a much wider meaning which includes right to livelihood, better standard of life, hygienic conditions on workplace and leisure. The court held that 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 period of employment and leisure and health even after retirement as basic essentials to life with health and happiness.

In *Mahendra Pratap Singh vs. State of Orissa*[16], a case pertaining to the failure of the government in opening a primary health care centre in a village, the court had held "In a country like ours, it may not be possible to have sophisticated hospitals but definitely villagers within their limitations can aspire to have a Primary Health Centre. The government is required to assist people get treatment and lead a healthy life. Healthy society is a collective gain and no Government should make any effort to smother it.

Primary concern should be the primary health centre and technical fetters cannot be introduced as subterfuges to cause hindrances in the establishment of health centre." It was also stated that, "great achievements and accomplishments in life are possible if one is permitted to lead an acceptably healthy life". Thereby, there is an implication that the enforcing of the right to life is a duty of the state and that this duty covers the

[16] *Mahendra Pratap Singh vs. State of Orissa*. AIR 1997 Ori 37.

providing of right to primary health care. This would then imply that the right to life includes the right to primary health care.

From the above judicial interpretations it can be said that the judiciary in India had played an active role for the understanding of right to health as a basic human right. From the above discussion of cases it is evident that the judiciary has clearly read into Article 21, Right to Life, the right to health. It in fact has gone deeper into the meaning of right to health and has substantiated the meaning of the right to life.

The question that must be discussed more thoroughly is whether an amendment to the Constitution, which will state the fundamental right to health, is desirable? Enumerated rights have an edge over wider interpretations of existing rights, as States can be held accountable for violations of right to health and healthcare.

However, with the extensive case law that is available is it not possible to use what is available to ensure that right to healthcare; facilities and condition ensuring health are fundamental rights for every citizen. If the case law reflects the ability of the courts to read the meaning of 'health' in very wide sense (everything from the responsibility of the municipal corporation to provide sanitation facilities down to access to emergency medical treatment has been interpreted in the right to health) then why not use the instrument of case law to confer rights as right to health. It is this question that must be examine in the light of the recent amendment guaranteeing primary Health education for all. The process is led to the amendment must be looked at critically as well as how the implementation of it is currently taking place.

Any amendment guaranteeing the right to health should have a focus on primary health care and Healthcare services, which is preventive and curative. It should also

have specific focus on the health of women more specifically reproductive health, children Health, and the disabled- both physically and mentally. Keeping this in mind there must be more detailed examination of an amendment to the Constitution, guaranteeing the right to health[17].

6) REVIEW OF LITERATURE :

Several researches had been done in this area from the medicinal science point of view. However the researcher would like to analyse the subject from the legal and social point of view. The condition of the government hospitals is worsening day by day. *"Review of Healthcare in India"*, Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai, January in most it discuss about services for problems such as the right to health with government hospitals there is inadequate staff, the supply of medicines is insufficient and the infrastructure is also inadequate. The facilities for safe deliveries or abortions are also very inadequate. Given the fact that women do not even get adequate treatment for minor illnesses such as anaemia,

Law and Social Transformation, P Ishwara Bhat (Eastern Book Company) it discuss about services for problems such as the health effects of domestic violence remain almost completely unavailable. Paula Braveman, in "Social conditions, health equity, and human rights" Health and Human rights, volume 12, No. 2 it discuss about on the village level, there is no resident health care provider to treat illnesses or implement preventive measures. All hospitals are located in cities, and here too public hospitals are increasingly starved of funds and facilities.

[17] By Indrajit Khandekar, B. H. Tirpude, P. N. Murkey in "Right to Health Care" In Forensic Med, April-June 2012, Vol. 34, No. 2

V.N.Shukla's: Constitution of India: Eastern Book Company: Lucknow: 11th Ed: 2008 it discuss about there is lack of availability of government health care services on one hand and the very expensive cost of private health services on the other. Elderly People, National Human Rights Commission India, 2011 it discuss about This often leaves common people in rural areas with no other option but to resort to treatment from quack doctors who often practice irrationally. Thus most of the population is being deprived of the basic Right to Health Care, which is essential for healthy living.

M. P. Jain, Indian constitutional Law, Sixth edition, Lexis Nexis, (2013) it discuss about Rights under the Indian Constitution under article 21, in part III and, Part IV of Art 39(e), Art 41, Art 42, Art 43(a), Art 47, Art 51(a), Art 243(G) of the constitution. Directive principles and Fundamental right explain about right to health.

7) AIMS AND OBJECTIVES OF THE STUDY:

The basic aim which the researcher would like to achieve through the present research is to strengthen the public health care system and its monitoring through the impartial and independent authorities, the reason is due to the advancement in medical sciences and technology, several issues in health and medicine have emerged which requires legislative intervention and control. Therefore the legislature should play a vital role in regulating products or behavior detrimental to health related issues. For an instance, the pre-natal diagnostic techniques' were developed to detect genetics and other abnormalities at a fatal stage. However, because of the preference for a male child in our society, these tests were misused for gender detection followed by abortion if the test revealed a female foetus.

This research is based on the following important objectives.

1.To study and analyze the legal provision with relation to right to health.

2.To evaluate and study on factors effecting on degrading health care system in Satara District.

3.To analyze the data collected to assess the compliance, the reasons for the non compliance if any.

4.To suggest the remedies & measures in this regard with in Satara District.

5.To arrive at the concluding remarks.

Hence in the light of above significance and objective of these research the title of the research is "A Study on Right to Health as a basic Human Right with Special Reference to Satara District."

8) HYPOTHESIS :

In the light of significance and objectives above mentioned, researcher has framed the following hypothesis for the present research

1. ***Recent development in to bio-medical sciences had paved the way for health deterioration.***
2. ***Today's Fast growing society is deliberately ignoring the health precautions.***
3. ***Effective implementation of judicial decisions and legislative enactments is required.***

9) RESEARCH DESIGN AND METHODOLOGY:

Researcher would like to adopt the analytical method for the present research. The researcher will rely upon Doctrinal method for detailed research about the topic. The doctrinal method includes an analysis of the judicial decisions of Indian Supreme Court and various High Courts situated in India, Several policies framed by the

Government from time to time, Constitutional provisions and legislative enactments. This research is predominantly based on the primary data.

Researcher would like to utilise sources of information by- Questioner, Interview, and Observation techniques will be used for collection of data. Few in depth case studies will be conducted to collect detailed information about implementation of legal norms and difficulties if any in their compliance. For above objectives both primary and secondary data will be collected through primary and secondary sources of data collection. Primary data will be collected, by administering an interview schedule directly with the respondents. Secondary sources of data collection will be reports published by state and central government, municipal reports, books, journals and periodicals.

10) TOOLS OF DATA COLLECTION :

PRIMARY DATA: In order to understand the general pattern of right to health and their growth problem in society, basic data available with the Civil Hospital at Satara, census records, Economic Survey of Maharashtra 2012-2013 and personal field observation have collected and analyzed. Researcher collected articles, reports, study reports and Survey Reports, on the basis of current data, which on the Doctrinal/Non Doctrinal method for detailed research about the topic with different people, experts, Activist, Legal Experts, Professor, Researcher found that the Information is first-hand information & can be used for the present Doctrinal Legal Research.

SECONDARY DATA: This research is Doctrinal/Non Doctrinal legal Research, based on document or written material available. This research is based on the existing data available through Books, Journals, National and International Convention and declaration, Articles published, Review papers, Periodical materials, News,

Magazines and papers, Internet books, Internet Articles, Self findings – Materials etc on rights to health. It includes Constitution of India, Acts, Rules, Regulations, Supreme Court and High Court Judgment. It includes also original material like governments reports, study reports. It also summarized and assessed Doctrinal/Non Doctrinal work done by the other jurists, legal experts and professors and law makers in India.

Primary data were collected from the officials of Civil Hospital at Satara and primary health centers in Satara District that is Karad and phaltan. Semi-structured interviews were conducted from Doctors and Patient for collection of the primary data. Fieldwork was carried out between Years 2013 to 2016. Secondary data were collected from the official records of the Government of Maharashtra websites. Secondary data were also collected between Years 2013 to 2016.

11) LIMITATION ON STUDY :

It covers a vast area so that it is difficult to study all the parts in a Doctrinal/Non Doctrinal study in Satara, so it is necessary to delimit the study. Hence the researcher had decided to carry out Empirical study as Socio-Legal Research in Satara city to give precise overview of right to health in Satara. Even with all constraints and limitations, the findings and conclusions resulting there upon and suggestions and recommendations given at the end of the study would go a long way in improving and enhancing right to health care facilities in the Satara District. These suggestions will guide the health care policies of not only the Government of Maharashtra but also the State Governments of the other states in the country.

12) CHAPTER SCHEME :

CHAPTER-I- INTRODUCTION:- Background of Right to Health with The Concept of Right to Health in which Researcher Focus on Health means, Medical Care means,

The Right to Health means, World Health Organization on Right to Health, Indian Constitution as on Right to Health and The Right to Health Contains. Researchers also focus on Nature and Characteristics of Right to Health with respect of Significance of the Study and Statement of the Problem on Right to Health. Review of Literature on Right to Health with aims and Objectives of the Study with Hypothesis and Research Design and Methodology which Classifying Tools of Data Collection on Right to Health. Researcher put Limitation on Study of Right to Health.

CHAPTER-II-RIGHT TO HEALTH IN INDIA: INTERNATIONAL AND NATIONAL PERSPECTIVES WITH INTRODUCTION AND APPROACHES TO RIGHT TO HEALTH WITH INTERNATIONAL PERSPECTIVES:

Reference with International Convention and Declarations on Right to Health. Researcher has Focus on Right to Health with Indian Constitutional Law on Reference to the Panchayat, Municipality on Health with Schedule 7. Right to Health Policies in India with National Mental Health Programme-1982, National Health Policy-1983, The National Nutrition Policy-1993, The National Health Policy-2002, National Rural Health Mission-2005 and Conclusion.

CHAPTER III - HEALTH AS A BASIC HUMAN RIGHT: ISSUES RELATING TO HUMAN RIGHT OF ELDERLY PEOPLE WITH SPECIAL REFERENCE TO SATARA DISTRICT OF STATE OF MAHARASHTRA:-

Chapter III Start with Introduction about Elderly People with Special Reference to Satara District. The Concept and Population Of Elderly People Under Maintenance And Welfare Of Parents And Senior Citizens Act, 2007 Which Define Who Is Senior

Citizen, Parent, Child Or Relative Under The Act. Researcher Has Draw Attention On Right To Health Of Elderly People In India With Legislative Framework. Under The Maintenance and Welfare of Parents and Senior Citizen Act, 2007 Working of Maharashtra State: Under Ministry of Health And Family Welfare its Objectives of The National Programme for The Health Care In view of The Elderly People. Researcher has Draw Attention on The Human Right to Health and Poor Elderly People in Satara District Right to Health Programme applied. Researcher has Draw Focus on Old Age Home at Satara City and Statutory Framework in Various Aspects for Elderly People and Conclusion.

CHAPTER IV- A STUDY ON RIGHT TO HEALTH AS A BASIC HUMAN RIGHT WITH SPECIAL REFERENCE TO SATARA DISTRICT: - Introduction and Profile of The Satara District with Literacy and Education Profile of Satara District State Provided Health Care and Right to Health Profile of The Satara Town. Researcher has Physically Examined Civil Hospital Satara. Researcher has Verifying Documentary, Physical Infrastructure Profile of Satara and Health Infrastructure of Maharashtra and Health Infrastructure in Satara and Achievement of Objectives to Arrive at The Concluding Remarks.

CHAPTER V- CONCLUSION

CHAPTER VI- SUGGESSIONS

13) SUMMING UP :

Right to Health is a constitutional right; denial of Right to health may interfere with the social justice and equality. It is the sign of Health development of a nation. The greater inequality in the attainment of Right to health services can adversely affect the human Rights development index of the nation. As the concept of Right to Health development has become more important than other development; health, education, social and gender equality are significant subjects of study. The objective is to recommend some improvements in Right to health policies to obtain social and Basic Human Rights for all.

The study also identifies the factors that lead to non-utilisation of public health services in the Satara District, which has more public health facilities compared to any other parts of the country. This raises the question that although the services may be available, the access to Right to Health is determined by several other factors. In short, the results present a forceful plea for greater attention to the allocation and quality of Right to health care services for poor and needy, accessible to Every Human Being As Part of Human Rights.

CHAPTER II

RIGHT TO HEALTH IN INDIA: INTERNATIONAL AND NATIONAL PERSPECTIVES

1) INTRODUCTION:

As the whole world now coming closer due to globalization, consequently majority of the state are the members of United Nations as well as the other relevant treaties adopted at the International level. Therefore from the right to heath point of view number of International treaties has been adopted by the several countries. World health Organization as it established in the year 1948 to work as a agency of United States for health and it ensures that "all people attain the highest possible level of health"[18] Similarly, right to enjoyment of the highest attainable standard of health is enshrined in numerous international human rights treaties, such as Universal Declaration of Human Rights adopted in 1948, it provides that "The right to standard of living adequate for the health and well-being, including medical care and necessary social services, and the right to security in the event of sickness & disability"[19].

The International Covenant on Economic, Social and Cultural Rights provides the cornerstone protection of the right to health[20].This includes an obligation on the part of all States parties to ensure that health facilities, goods and services are accessible to everyone, especially the most vulnerable or marginalized sections of the population, without discrimination. The Convention on the Rights of the Child also refers to right to

[18] www.healthcare.org/globe_health/essential_medicines.shtm
[19] Article 25(1) of The Universal Declaration on Human Right 1948
[20] Article 12(1) of The International Covenant on Economic, Social and Cultural Rights 1966

the highest attainable standard of health of children[21]. In the context of non-discrimination in health and access to health care, references can be found in the Convention on the Elimination of Discrimination against Women Art.12(1) and the Convention on the Elimination of all forms of racial Discrimination Art 5 (e)(iv). Furthermore, the World Health Organization Constitution adopted in 1946 states: "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 1948 Universal Declaration of Human Rights also mentioned health as part of the right to an adequate standard of living (art. 25). The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights. Since then, other international human rights treaties have recognized or referred to the right to health or to elements of it, such as the right to medical care. The right to health is relevant to all States: every State has ratified at least one international human rights treaty recognizing the right to health. Moreover, States have committed themselves to protecting this right through international declarations, domestic legislation and policies, and at international conferences.

This Researcher aims to enlighten on the right to health in international human rights law as it currently stands, amidst the plethora of initiatives and proposals as to what the right to health *may* or *should be*. Consequently, it does not purport to provide an exhaustive list of relevant issues or to identify specific standards in relation to them.

[21] Article 24(2) of The Convention on the Rights of the Child 1989

2) APPROACHES TO RIGHT TO HEALTH:

As part of a 'Right to Health' in international human rights instruments and under Article 25 of the *Universal Declaration of Human Rights, 1948* (UDHR) say the 'right to health' in the following words[22]:

"1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection."

While this declaration articulated the core elements of public health concerns, it did not create any binding obligations on the members of the United Nations. In subsequent years, the right to health came to be incorporated in the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) which was presented before the UN General Assembly in 1966 and adopted in 1976. While Article 12(1) of the ICESCR referred to the 'right to health' in terms, Article 12(2) mandated specific measures on part of the state parties to the covenant. Its language reads as follows:

> *"1.The State Parties to the present Covenant recognise 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:*

[22] United Nations (1946), Universal Declaration of Human Rights, New York.

(a) The provision for the reduction of the still-birth 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.'[23]

Right to life is considered one of the fundamental rights, and health is one of the vital indicators reflecting quality of human life. In this context, it becomes one of the primary responsibilities of the state to provide health care services to all its citizens. India, despite being a signatory to the Alma Ata Declaration of 1978, which promised 'Health for All' by 2000, is far from realising this objective. In India has required an excellent health care structure that has the potential to reach a large section of the population.

Declaration of Alma-Ata on Primary Health Care, 1978 Governments at Alma-Ata reiterated Health for all by 2000 and committed to ensuring comprehensive, primary health care. This Declaration is not binding on governments but it reiterated the commitment of the governments/states towards achieving the right to health. The Declaration highlighted that:

- ❖ Health is a fundamental right and its realisation requires the action of many other social and economic sectors. The current gross inequality in health status is politically, socially and economically unacceptable.

[23] Address by Hon'ble Justice K.G. Balakrishnan, Chief Justice of India At Bhopal in National seminar on the *'Human right to health'* Organized by the Madhya Pradesh State Human Rights Commission - September 14, 2008

- People have a right and duty to participate individually and collectively in the planning and implementation of their health care.
- Primary Health Care includes in the least, health education, promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, immunisation against the major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries and provision of essential drugs.

3) **RIGHT TO HEALTH: INTERNATIONAL PERSPECTIVES: SPECIFIC REFERENCE INTERNATIONAL CONVENTION AND DECLARATIONS**-

1) **Convention on the Elimination of all forms of Discrimination Against Women- (CEDAW)** The Right to Health is interdependent on the Right to Food. In Article 24(2) (c) of the Convention on the Rights of the Child (CRC)[24] and Article 12(2) of Convention on the Elimination of Discrimination against Women (CEDAW)[25], the right to food is considered part of the right to health of both women and children. Therefore, when considering the Right to Health, the above-mentioned Articles should also be taken into account. This is true of all other rights connected to the determinants of health – environment, exclusion, prohibition on the basis of sex, caste, class, education, etc. CEDAW's Article 12

[24] Children's Convention (adopted 1989; entered into force 1990): Convention setting forth a full spectrum of civil, cultural, economic, social, and political rights for children, http://www.umn.edu/humanrts.

[25] Women's Convention (adopted 1979; entered into force 1981): The first legally binding international document prohibiting discrimination against women and obligating governments to take affirmative steps to advance the equality of women, http://www.umn.edu/humanrts

establishes the obligation to adopt adequate measures to guarantee women access to health and medical care, with no discrimination whatsoever, including access to family planning services. It also establishes the commitment to guarantee adequate maternal and child health care[26]. Article 12 (1) states that governments shall take all appropriate measures to eliminate discrimination against women in the field of health care to ensure, access to health-care services, including those related to family planning. Article 12 (2) ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. States Parties[27] are encouraged to address the issue of women's health throughout the woman's lifespan. The articles of the convention are applicable to women, including girls and adolescents

2) **The World Health Organisation (WHO)** issues the *International Health Regulations* from time to time as a guiding framework for domestic policies. There regulations have further strengthened the link between human rights and health. For instance, **Article 3(1)** of the same states: *"The new International Health Regulations shall be implemented with full respect for the dignity, human rights and fundamental freedoms of persons."*[28]

   (WHO)'s Commission on the Social Determinants of Health released its final report in 2008, marking a watershed event in the history of public health and

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[26] Ibid.

[27] Those countries that have ratified a Covenant or a Convention and are thereby bound to conform to its Provisions, http://www1.umn.edu/humanrts.

[28] World Health Assembly, *Revision of the International Health Regulations*, WHA58.3 (May 23, 2005).

human development[29]. The WHO Commission's report was ground-breaking in its unequivocal endorsement by the health sector of the importance of addressing inequalities in social conditions in order to address inequalities in health. Backed up by massive collections of evidence and examples of promising interventions in economically, politically, and culturally diverse settings, the WHO Commission report called for action, while also acknowledging the need for further investment in research to guide future action on the social determinants of health[30].

3) **The Child Rights Convention (CRC), 1989** Articles 23 and 24 of the CRC recognise the right to health for all children and identify several steps for its realisation. Article 23[31] ensures the rights of a mentally or physically disabled child to dignity; to enjoy a 'full and decent life'; to special care and encourages the promotion of self-reliance so that the child may actively participate in the community.

4) **Vienna Declaration and Programme of Action (1993)** had emphasized the fundamental inter-relatedness between civil and political rights on one hand and economic, social and cultural rights on the other hand. The said Declaration specifically provides:

"All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While

[29] Commission on Social Determinants of Health.
[30] By Paula Braveman, in "Social conditions, health equity, and human rights" Health and Human rights, volume 12, No. 2
[31] http://www.ohchr.org

the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms."[32]

5) **Other Instruments that guarantee Right to Health are**:

- The International Convention on the Elimination of All Forms of Racial Discrimination;
- The Convention relating to the Status of Refugees;
- The International Convention on the Protection of the Rights of All Migrant Workers and members of Their Families;
- The Declaration on the Protection of Women and Children in Emergency and Armed Conflict;
- The Standard Minimum Rules for the Treatment of Prisoners;
- The Declaration on the Rights of Mentally Retarded Persons;
- The Declaration on the Rights of Disabled Persons;
- The Declaration on the Rights of AIDS Patients.[33]

6) ***Constitution of South Africa (1996):*** **Chapter II, Section 27**: Health care, food, water and social security:

"(1) Everyone has the right to have access to

a. health-care services, including reproductive health care;

b. sufficient food and water;

[32] Cited from: *1993 Vienna Declaration and Programme of Action*, U.N. GAOR, World Conference on Human Rights, 78th Session, UN Doc. A/CONF 157/23 (1993)
[33] International Human Rights Internship Program (IHRIP) and Forum Asia, Circle of Rights, Module 14, http://www.umn.edu

(2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

(3) No one may be refused emergency medical treatment."

4) RIGHT TO HEALTH IN INDIAN SCENARIO

A) In the **Bhore Committee (1946)**[34] that was also greatly inspired by the aspirations of the national movement. Some of the key recommendations of the Bhore Committee were:

I) Integration of preventive and curative health services at all administrative levels,

II) Development of primary health centers in two stages,

III) Major change in medical education,

IV) Formation of district health board for each district,

V) Laid emphasis on preventive health services,

VI) Inter-sectored approach to health service development.

B) Indian Constitutional Law

Part III and IV of our Constitution which deals with Directive principles of State policy has several provisions that touch on the subject of health and one can refer to the text of Articles 39(e), 39(f), 42 and 47 is as follows:

Article 39(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

[34] The Bhore Committee was constituted by the government in 1940 to prepare a comprehensive proposal for the development of national programme of health services. They submitted the same in 1946. Several National Programmes were developed based on their recommendations.

necessity to enter avocations unsuited to their age or strength." The State must try to ensure that its policies are based on people's (men and women equally) right to an adequate means of livelihood; ensure equitable distribution of wealth and prevent the concentration of wealth and means of production; equal remuneration regardless of sex; ensure that the existing system do not abuse the health and strength of men and women, and children and that they are not pushed by economic necessity to work in occupations that is detrimental to their age. And also provide opportunities and facilities to children to develop in a healthy manner, in the absence of exploitation[35]

Article 39 (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[36].

Articles 41: under the Directive Principles states as follows: "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, sick-ness and disablement and in other cases of un-deserved want."

Article 42: "The State shall make provision for securing just and humane conditions of work and for maternity relief." Under Art- 42 of the Directive Principles, there is a reference to the provision for just and human conditions of work and maternity relief. This implies that it is not simply the sickness or disablement which requires the state to intervene but it is also under the normal situations of work and the normal experiences of the citizens under certain circumstances that the state should provide the

[35] The constitution of India-Article 39
[36] Constitution of India, as of 2006 (source: Ministry of Law and Justice, http://indiacode.nic.in/coiweb/welcome.html).

needed assistance. Thus, the state has to intervene to secure for these citizens, proper conditions in the place of work. Such conditions of work should be available to all citizens irrespective of their gender, region, language, community, race etc.

Articles 43, 43(A): provide just and humane conditions of work and maternity relief, secure wages by ensuring a decent standard of life and full enjoyment of leisure and social and cultural opportunities, including participation in the management of organizations

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 purpose of intoxicating drinks and of drugs which are injurious to health." Under Art-47 in the chapter on Directive Principles, it is said that the state shall record the raising of the level of nutrition and standard of living of its people and the improvement of public health as one of its primary duties. It is, in this context that the state is required to take steps to bring about 'Prohibition' of the consumption except for medical purposes of intoxicating drinks and of drugs, excessive doses of which are injurious to health. This indeed is a clear-cut articulation of the fraternal role of the state in protecting the health of the citizens according to the Indian Constitution. This implies a positive interference of the state with the consumer sovereignty.

Right to health, a prominent decision was delivered in *Parmanand Katara* v. *Union of India*[37]. In that case, the court was confronted with a situation where hospitals

[37] AIR 1989 SC 2039

were refusing to admit accident victims and were directing them to specific hospitals designated to admit ‘medico-legal cases’.

The court ruled that while the medical authorities were free to draw up administrative rules to tackle cases based on practical considerations, no medical authority could refuse immediate medical attention to a patient in need. The court relied on various medical sources to conclude that such a refusal amounted to a violation of universally accepted notions of medical ethics. It observed that such measures violated the ‘protection of life and liberty’ guaranteed under Article 21 and hence created a right to emergency medical treatment[38].

Under Fundamental Duties **Article- 51A** of the section on Fundamental Duties states that every citizen of India has the duty to protect and improve the natural environment including forests, lakes, rivers and wild life and to have compassion for living creatures. In this sense, there is a joint responsibility from the state as well as the citizens towards the maintenance of human and animal health and also the long term issues relating to the improvement in the health conditions of the human beings and the animals.

Panchayat, Municipality and Health:

Not only the state but also panchayat, Municipalities are liable to improve and protect public health. “The legislature of a state may endow the panchayats with

[38] Commentary cited from: Arun Thiruvengadam, “The global dialogue among Courts: Social rights jurisprudence of the Supreme Court of India from a comparative perspective” in C. Raj Kumar & K. Chockalingam (eds.), Human Rights, Justice and Constitutional Empowerment (New Delhi: Oxford University Press, 2007) at p. 283

necessary power and authority in relation to matters listed in the eleventh schedule."[39] The entries in this schedule having direct relevance to health are as follows;

- Drinking
- Health and sanitation including hospitals, primary health centers & dispensaries
- Family welfare
- Women and child development
- Social welfare including welfare of the handicapped and mentally retarded
- Water supply for domestic industrial and commercial purpose
- Public health, sanitation conservancy and solid waste management
- Regulation of slaughter – houses and tanneries.

SCHEDULE 7 OF INDIAN CONSTITUTION UNDER ARTICLE 246, THE UNION LIST-I-28: Hospitals connected therewith, seamens and marine hospitals are legitimately put under the Union List implying the responsibilities of the Union Government towards this function. Also the maintenance and development of the quality of goods to be exported out of India or transported from one state to another even within India are mentioned as the concern of the Union Government.

SCHEDULE 7 OF INDIAN CONSTITUTION UNDER ARTICLE 246, THE UNION LIST-II-THE STATE LIST-6 to 10, 14 to 16: Under the State List, there are direct references to the provisions of health care facilities. For example, Clause No.6 under the State List refers to public health and sanitation, hospitals and dispensaries. Clause No.7 refers to the pilgrimages within India in which case, the provision of health care facilities comes under the state responsibilities. Clause No.8

[39] Article 243G

refers to the intoxicating liquors, the production, manufacture, possession, transport, purchase and sale etc. of which will have to be overseen by the State Government in the federal framework. Clause No. 10 refers to the burials and burial grounds, cremation and cremation grounds, proper maintenance of which is very crucial for human animal health. This also is put under the State List.

SCHEDULE 7 OF INDIAN CONSTITUTION UNDER ARTICLE 246, THE UNION LIST-III-CONCURRENT LIST-3, 17 to 19, 26 to 27: The following items are included under a Concurrent List – List III of the Indian Constitution. These items refer to the various aspects of physical, mental and social health care policy, the policy with regard to drugs and medicines etc.

5) RIGHT TO HEALTH POLICIES IN INDIA

India is one of the largest democratic countries in the world, and is one of the fastest growing economies Country as Well, which is Right to Health projected to be more than double, in the next five years. Among all the sectors of the Indian economy, health care sector and Services is the second fastest growing sector next to Information Technology.

India has become a burning medical destination for patients in the Middle East State, African Continental and even the Western Countries. In a nation like India, where there is no formal social security system in place, healthcare and right to health become that much more crucial. Word is fast spreading that Indian hospitals can provide world-class care at ready for action rates. Right to Health is vibrant and dynamic sector which imperative for the new human resource intensive world. Quality of Right to health is vital for the growth of any nation. The key objectives of an effective healthcare system

and Services would be to enhance average life expectancy and to improve quality of life and productivity for Welfare State.

The Central and State Governments in India have promulgated several legislations to safeguard the health of its population. The Union Ministry of Health and Family Welfare (UoHFW) is responsible for implementation of national programmes, sponsored schemes and technical assistance relating to the Indian healthcare industry. The following acts done by the Ministry: **Department of Health, Department of Family and Welfare, Department of AYUSH, Autonomous Institutions conducting Research and Development.**

A) National Mental Health Programme-1982

A National Mental Health Programme (NMHP) was launched in 1982, keeping in view the heavy burden of mental illness in the country and the inadequacy of the health system to meet the specific mental health needs. This programme aimed to shift the basis of practice from the traditional (psychiatric) services to community care.

B) National Health Policy-1983

The **National Health Policy (NHP) comes** in the year of 1983. Its talked about comprehensive primary health care services linked to extension and health education; large scale transfer of knowledge, skills and requisite technologies to 'health volunteers'; intersectional cooperation and better utilisation and strengthening of traditional systems of medicine.[40]

C) The National Nutrition Policy-1993

[40] See NHP 2002, www.nic.in

The National Nutrition Policy (1993) advocates a comprehensive inter-sectoral strategy for alleviating all the multi-faceted problems related to nutritional deficiencies, so as to achieve an optimal state of nutrition for all sections of society, but with emphasis on women and children. The strategies adopted include – screening of all pregnant women and lactating mothers for **Chronic Energy Deficiency (CED)**; identifying women with weight below 40 kg and providing adequate ante-natal, intra-partum and neo-natal care under the RCH programme, and ensuring they receive food supplementation through the **Integrated Child Development Services (ICDS)** Scheme. The ICDS, launched in 1975, provides supplementary feeding to bridge the nutritional gaps that exist in respect of children below 6 years and expectant and nursing mothers. However, the ICDS programme has not been able to reach the nutritional need of children below three years.

D) Reproductive and Child Health (RCH)

The Mother and Child Health (MCH), nutrition and immunization programmes were brought under the umbrella of the Family Welfare Programme and was finally transformed into the Reproductive Child Health (RCH) programme[41]. The national RCH programme was launched in 1997 to provide integrated health and family welfare services for women and children. The programme aimed at improving the quality, distribution and accessibility of services and to meet the health care needs of women in the reproductive ages and children more effectively. The components included:

- prevention and management of unwanted pregnancy;
- services to promote safe motherhood and child survival;

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[41] By Qadeer, Imrana (1999) 'Policy on Women's Health' for National Consultation towards Comprehensive Women's Health Policy and Programmes Feb 18-19.

- nutritional services for vulnerable groups;
- prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs);
- reproductive health services for adolescents;
- health, sexuality and gender information, education and counselling;
- establishment of effective referral systems;

E) The National Health Policy-2002

The National Health Policy 2002 is a continuation of the earlier indicated trends. The new policy deliberates on the need to improve access to health services among all social groups and in all areas, and proposes to do so by establishing new facilities in deficient areas and improving those existing. Recognizing that women and other underprivileged groups are most affected by poor access to health care, it aims at improving such groups' access to basic services. Most importantly, the central government is to give top funding priority to programmes promoting women's health. The policy sets forth several time bound objectives including reduction of MMR, IMR, mortality due to TB and malaria by 2010, and zero growth of HIV/AIDS by 2007.

F) National Rural Health Mission-2005

NRHM 2005: launched in 18 states that were identified as having poor health indicators emphasizes on comprehensive primary health care for the rural poor. The main goal of the mission is to provide for effective health care facilities and universal access to rural population. The principle thrust areas as identified in the document are:

- Strengthening the three levels of rural health care- sub-centre, PHC and the CHC. It also states that all 'assured services' including routine and emergency

care in Surgery, Medicine, Obstetrics and Gynaecology and Paediatrics in addition to all the National Health programmes; and all support services to fulfil these should be available and strengthened at the CHC level[42].

- New health financing mechanisms for additional resource allocation and upgradation of facilities.
- Appointing ASHA (Accredited Social Health Activist) at the village level as the link worker for the rest of the rural public health system.
- Private public partnerships and regulation of private sector. The programme document identifies all these as attempts to establish the horizontal linkages of various health programmes and provide comprehensive primary health care rather than promoting the vertical programmes, which has till now failed to provide health for all.
- Primary health care is provided to city and district hospitals and rural primary health centres (PHCs). These hospitals provide treatment free of cost to every person. Primary health care is focused on immunization, prevention of malnutrition, care during pregnancy, child birth, postnatal care, and treatment of common illnesses. Patients who receive specialised care or have complicated illnesses are referred to secondary care centres and class care hospitals which located in district and state headquarters or those that are teaching hospitals.

6) CONCLUSION

In today scenario, we share several fundamental Right, all of which center on the equal dignity and value of all human beings in universe. In case of human rights and

[42] Dasgupta, Rajib (2006) 'Quality Assurance in the National Rural Health Mission (NRHM): Provisions and Debates' in Background Papers for MFC Annual Meet.

health equity efforts can be strong by growing awareness and understanding of the person in importance of social conditions for Right to health. And right to health is promoting social conditions are an essential prerequisite for right to health.

In particular, the global CONVENTION AND DECLARATIONS like *Universal Declaration of Human Rights-1948, International Covenant on Economic, Social and Cultural Rights*-(ICESCR), Alma-Ata on Primary Health Care-1978, Convention on the Elimination of all forms of Discrimination Against Women-(CEDAW), The World Health Organisation-(WHO) Convention on the Rights of the Child-(CRC), The Child Rights Convention-1989, Bhore Committee-(1946), Indian Constitutional Law which on values reflected by human rights agreements and norms represents a potentially influential promotion tool in struggles for greater Health equity. Human rights frameworks and principles can be used to support the conceptual basis for health equity and Care, notably by providing a rationale for the specification of vulnerable groups whose rights require special protection and promotion for social welfare, and thus informing analytic approaches to understanding right to health and its determinants.

Come within reach of from the field of Right to health can strengthen efforts to protect and promote the right to health with the highest attainable level of health and care, by extension activity of the government at large, the right to health is the social conditions essential for health public at large, by indicating how to operational these concepts for the purpose of quantity, which is essential for accountability by Government Authority.

In the end, battles for human rights and right to health will not be won or lost fully based on the conceptual clarity and coherence of the arguments, the living

soundness of measurement methods we required, or the great quantity of supporting data. These are, however, important resources for building society harmony and arming advocates among and on behalf of the undelivered and marginal Society.

The Right to health is not mentioned in the constitution yet the Supreme Court has interpreted it as a fundamental right under Right to life enshrined in Article 21. It is a significant view of the Supreme Court that first it interpreted Right to Health under part IV. i.e. Directive Principles of state policy & noted that it is the duty of the state to look after health of the people at large. In its wider interpretation of Article 21 it was held by the Supreme Court that, the rights to Health is a part and parcel of right to life & therefore are of fundamental right provided under Indian Constitution. In the real sense Honorable court has played a pivotal role in imposing positive obligations as authorities to maintain & improve public Health[43].

Now a day effective steps need take to implement the constitutional obligation upon the state to secure the right to healthcare and strength of people. It was rightly said that nutrition, health & education are the three inputs accepted as significant for the development of human resources. For achieving the Constitutional obligation and also objectives of Right to Health care for all there is a need on the part of the government to mobilize organization and the general public towards their participation for monitoring and implementation of right to health care facilities to needy person of the society at large.

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[43] By Deepu. P, "Right To Health As A Constitutional Mandate In India", ISSN 2321-4171

CHAPTER III

HEALTH AS A BASIC HUMAN RIGHT: ISSUES RELATING TO HUMAN RIGHT OF ELDERLY PEOPLE WITH SPECIAL REFERENCE TO SATARA DISTRICT OF STATE OF MAHARASHTRA

1) INTRODUCTION

In this chapter researcher would like to analyse the health issues pertaining to the poor elderly people. As there is a large number of disparities in providing health care services to the elderly people in the context of poverty which is the hard socio-economic reality in India which leads to illness and bad health and affect the poor people in the evening of their life. Human life is valuable and it must be preserve at all cost, therefore preservation of human life is of principal importance. Food, clothing and shelter are said to be the primary needs of every human being. These needs arise out of the very existence of a human being. Fulfilment of these needs alone would secure the existence of a human being. A human being has the inherent right to get his needs fulfilled. Thus, they can be regarded as a part of human right. Health of a person is a physical wellbeing or freedom from disease. Modern concept of health is a state of total physical, mental and social well being. At the same time health is a crucial indicator of human development. The concept of health is a most central concept in medicine and in the health science in general, traditionally in a welfare state, the responsibility for providing affordable and at times free health care lies with the state. There has been a reawakening that health is a fundamental right and a world-wide social goal; that it is essential to the satisfaction of basic human needs and to an improved quality of life, and, that it is to be

attained by all people. Hence in 21st century access to quality health care is a basic human right

Since 1991, the first day of October has been observed as International Day of Older Persons and 1999 was observed as the International Year of Older Persons. The Indian government announced the National Policy for Older Persons in 1999, which elaborated on the UN Convention on Ageing, Vienna, 1982. The same year, the UN General Assembly endorsed an International Plan of Action on Ageing, setting forth a number of recommendations to deal with the situation of older persons.

The United Nations Principles for Older Persons, further developed by the National Policy, say among other things that the aged should have access to adequate food, water, shelter, clothing and healthcare, have the opportunity to work, and access to other income generating activities, have access to appropriate educational and training programmes and be able to live in environments that are safe and adaptable to personal preferences[44].

2) THE CONCEPT AND POPULATION OF ELDERLY PEOPLE

Maintenance and Welfare of Parents and Senior Citizens Act, 2007

Define who is Senior citizen, Parent, Child or Relative under the Act.

"Senior citizen" is any citizen of India of 60 years and above whether living in India or not.

"Parent" is the father or mother even if not of 60 years yet. "Children" are adult son, daughter, grandson and grand-daughter

[44] By Anand Kumar Navneet Anand, in "Poverty Target Programs for The Elderly In India" February 2006

“Relatives” are those who are either in possession of the property of the senior citizen or would inherit it[45].

Population of senior citizens in Andhra Pradesh, Goa, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Orissa, Punjab, Tamil Nadu, Uttarakhand and Puducherry is more than the national average (7.5%). In rural areas, the percentage share of elderly population in total population is highest in the State of Kerala while Andaman & Nicobar Islands has the lowest share. In urban areas, the percentage share of elderly population in total population is highest in the state of Kerala while Arunachal Pradesh has the lowest share[46].

Table No-3.1- HEALTH- Elderly People- India, at a Glance

Life Expectancy 60+ (Years)			
Total	**16.9**	**19.0**	**17.9**
Death Rate (60-64years) (Per Thousand)			
Rural	22.3	17.2	**19.7**
Urban	16.6	13.4	**15.0**
Total	**20.7**	**16.1**	**18.4**
Physically Disabled Among 60+(Per Hundred Thousand)			
Rural	5713	5476	**5593**
Urban	4361	4007	**4181**
Total	**5314**	**5045**	**5177**

Sources: Population Census 2011, SRS Report 2013.

[45] In Senior Citizens Guide, Policy Research and Development Department, Revised Edition 2016
[46] In Senior Citizens Guide, Policy Research and Development Department, Revised Edition 2016

Population of senior citizens in India is 17.9%. Death rate in urban area is 15.0% as compared with rural area is 19.7%. Physically Disabled among 60+ (Per Hundred Thousand) in urban area is 4181 as compared with rural area is 5593(Table No-3.1).

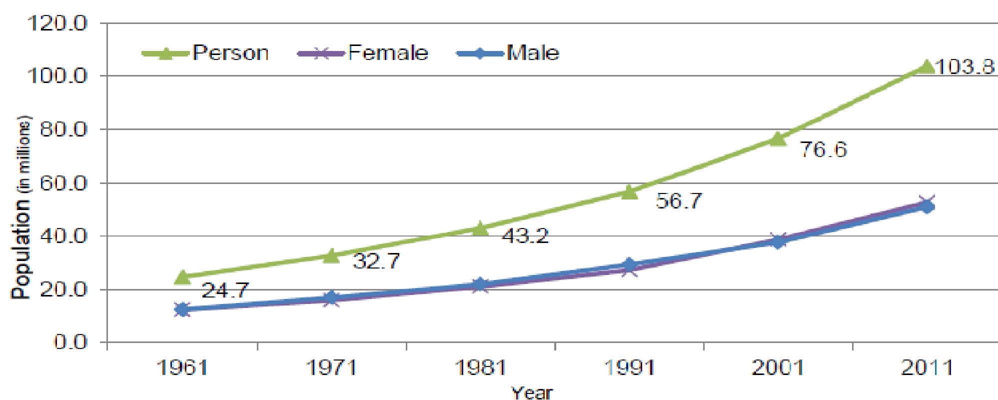
Table No-3.2- Total Population of India **(Fig. in crore)**

	Persons	Males	Females	Rural	Urban
All India	1210.9	623.3	587.6	833.8	377.1
Senior Citizens (60+)	103.9	51.1	52.8	73.3	30.6
Maharashtra	9.3	8.8	9.7	10.3	7.9
As % of total	8.6	9.0	8.2	8.8	8.1

Source: Population Census 2011

According to Population Census 2011, there are nearly 103.9 million elderly persons in India; 52.8 million females and 51.1 million males. As regards rural and urban areas, more than 73.3 million persons i.e. 73.3 per cent of elderly population reside in rural areas while 30.6 million of elderly population is in urban areas (Table No-3.2).

Figure No-3.1 Elderly population (aged 60 years & above)

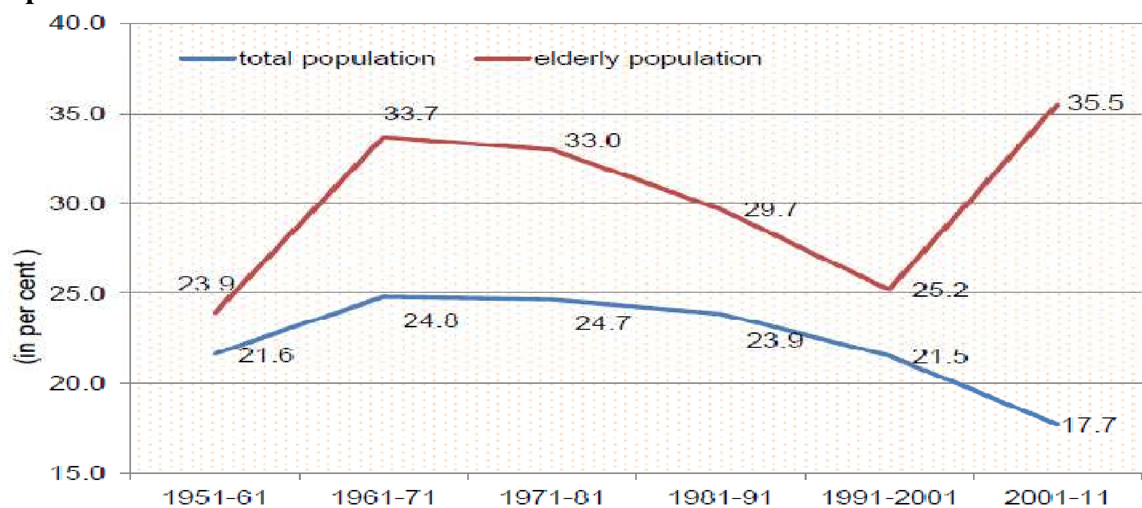


Source: Central Statistics Office Ministry of Statistics and Programme Implementation Government of India-2016

The growth in elderly population is due to the longevity of life achieved because of economic well-being, better medicines and medical facilities and reduction in fertility rates. In India, the decadal growth in general population has shown a decreasing trend

since 1961 and so is the growth in elderly population till 2001. In the last one decade, however, that is between 2001 and 2011; the growth in elderly population has shot up to 36 per cent while the same was 25 per cent in the earlier decade. The general population has grown by merely 18 per cent vis-a-vis 22 per cent in earlier decade. It is observed that in India, the growth in elderly population has always been more than the growth in general population. Very high growth rate in elderly population vis-a-vis of general population was observed earlier also in the two decades between 1961 and 1981 (Figure No-3.1).

Figure No-3.2 Decadal Growth In Elderly Population Vis-A-Vis That Of Total Population



Source: Central Statistics Office Ministry of Statistics and Programme Implementation Government of India-2016

Percentage share of elderly persons in the population of India is ever increasing since 1961. While in 1961, 5.6 per cent population was in the age bracket of 60 years or more, the proportion has increased to 8.6 per cent in 2011. The trend is same in rural as well as in the urban areas. In rural areas while the proportion of elderly persons has increased from 5.8 per cent to 8.8 per cent, in urban areas it has increased from 4.7 per cent to 8.1 per cent during 1961 to 2011. It is observed that the difference of percentage

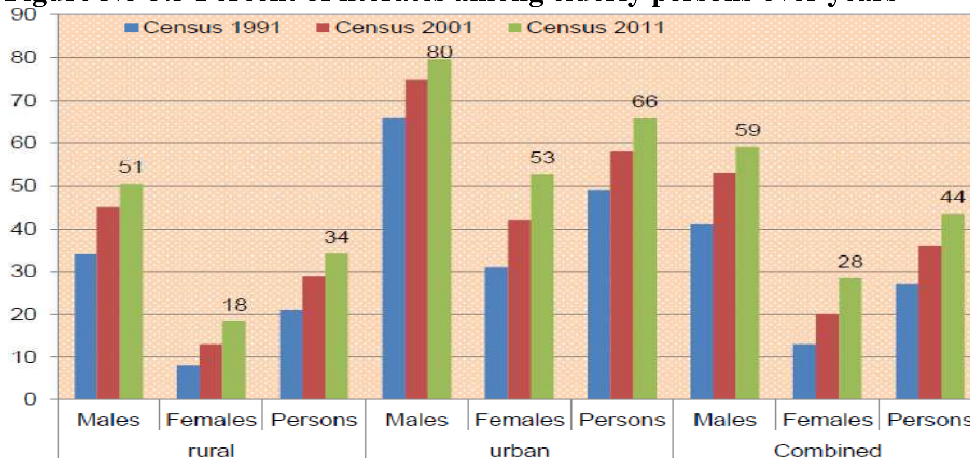
share of elderly population in whole population in rural and urban areas is narrowing (Figure No-3.2).

Table No 3.3- Percent of literates among elderly persons over years

Place of Residence	Sex	Census 1991	Census 2001	Census 2011
Rural	Males	34	45	51
	Females	8	13	18
	Persons	21	29	34
Urban	Males	66	75	80
	Females	31	42	53
	Persons	49	58	66
Rural + Urban	Males	41	53	59
	Females	13	20	28
	Persons	27	36	44

Source: Office of the Registrar General, India

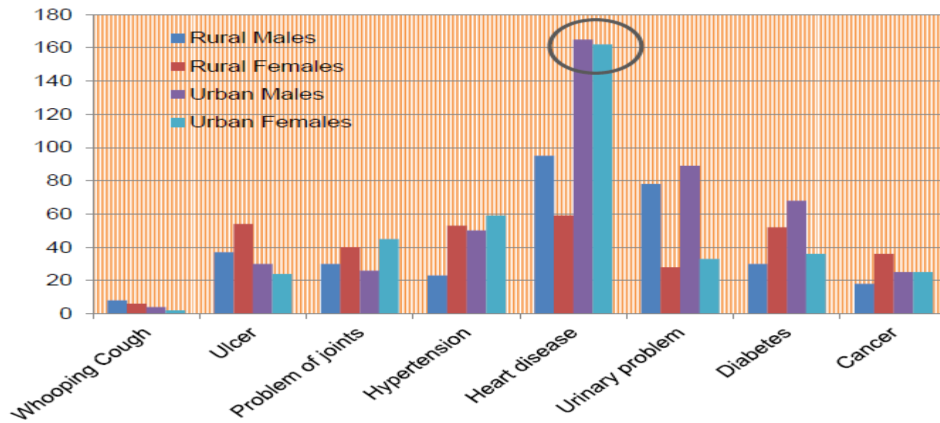
Figure No-3.3 Percent of literates among elderly persons over years



Source: Central Statistics Office Ministry of Statistics and Programme Implementation Government of India-2016

It is evident that there is a huge gap between literacy rates among elderly persons in rural and urban parts of the country. Around 30% of elderly persons in urban areas were having educational qualification matric/secondary and above but the proportion is comparatively much less (7%) in rural areas (Table No 3.3 and Figure No-3.3).

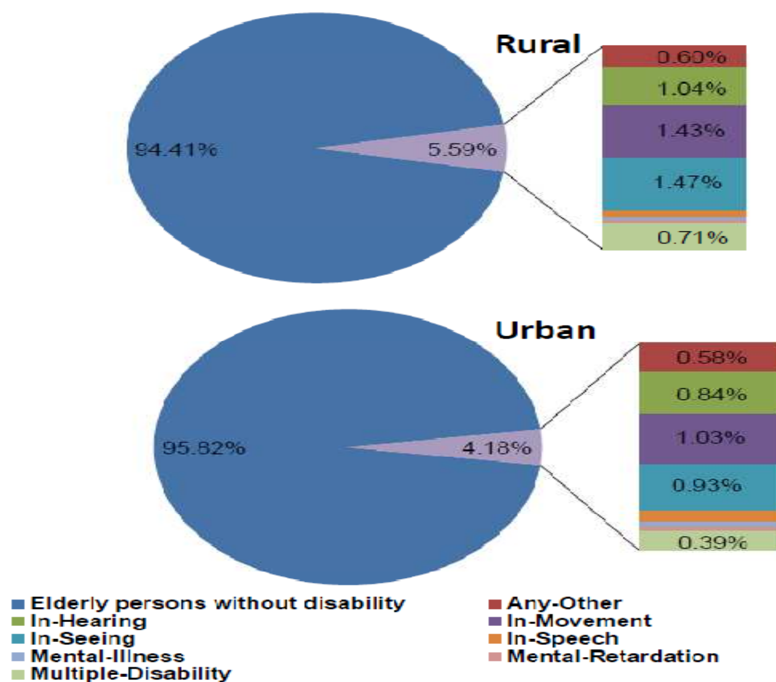
Figure No-3.4 Number of elderly persons reporting a chronic disease (per 1,000 persons)



Source: Central Statistics Office Ministry of Statistics and Programme Implementation Government of India-2016

Population Census 2011 data reveal that Locomotor disability and visual disability are the most prevalent disabilities among elderly persons. Almost half of the elderly disabled population was reported to be suffering from these two types of disabilities (Figure No-3.4).

Figure No-3.5 Number of disabled per 100,000 elderly persons for different types of disability



Source: Central Statistics Office Ministry of Statistics and Programme Implementation Government of India-2016

The population Census 2011 data tell that the percentage of currently elderly persons without Disability 95% was markedly higher than the percentage of elderly person with disability men with 4.5 in Both Rural and Urban area. Disability to elderly Person are Likely in Hearing, In Seeing, Mental- Illness, Multiple-Disability, In Movement, In Speech, Mental- Retardation As well (Figure No-3.5).

3) RIGHT TO HEALTH OF ELDERLY PEOPLE IN INDIA:

Legislative Framework

The Maintenance and Welfare of Parents and Senior Citizen Act, 2007

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 was enacted in December 2007, to ensure need based maintenance for parents and senior citizens and their welfare. The Act provides for:-

- Maintenance of Parents/ senior citizens by children/ relatives made obligatory and justifiable through Tribunals,
- Revocation of transfer of property by senior citizens in case of negligence by relatives,
- Penal provision for abandonment of senior citizens,
- Establishment of Old Age Homes for Indigent Senior Citizens,
- Adequate medical facilities and security for Senior Citizens.

The Act has to be brought into force by individual State Governments. As on 31.3.2011, the Act had been notified by 22 States and all UTs. The Act is not applicable to the State of Jammu & Kashmir, while Himachal Pradesh has its own Act for Senior Citizens. The remaining States yet to notify the Act are – Bihar, Meghalaya, Sikkim and Uttar

Pradesh. States and Union Territories which have notified the Act are required to take the following measures/steps for effective implementation of the Act:

- Frame Rules under the Act;
- Appoint Maintenance Officers;
- Constitute Maintenance and Appellate Tribunals.

The Act was enacted on 31St December 2007. It accords prime responsibility for the maintenance of parents on their children, grand children or even relatives who may possibly inherit the property of a Senior Citizen. It also calls upon the State to provide facilities for poor and destitute older persons.

Provisions of the Act

- Parents who are unable to maintain themselves through their own earnings or out of their own property may apply for maintenance from their adult children. This maintenance includes the provision of proper food, shelter, clothing and medical treatment.
- Parents include biological, adoptive and step mothers and fathers, whether senior citizens or not.
- A childless Senior Citizen who is sixty years and above, can also claim maintenance from relatives who are in possession of or are likely to inherit their property.
- This application for maintenance may be made by Senior Citizens themselves or they may authorize a person or voluntary organization to do so. The Tribunal may also take action on its own.

- Tribunals on receiving these applications may hold an enquiry or order the children/relatives to pay an interim monthly allowance for the maintenance of their Parents or Senior Citizen.
- If the Tribunal is satisfied that children or relatives have neglected or refused to take care of their parents or Senior Citizen, it shall order them to provide a monthly maintenance amount, up to a maximum of 10,000 per month.
- The State Government is required to set up one or more tribunals in every sub-division. It shall also set up Appellate Tribunals in every district to hear the appeals of Senior Citizens against the decision of the Tribunals.
- No legal practitioner is required or permitted for this process. Erring persons are punishable with imprisonment up to three months or a fine of up to rupees five thousand or with both.
- State Governments should set up at least one Old Age Home for every 150 beneficiaries in a district. These homes are to provide Senior Citizens with minimum facilities such as food, clothing and recreational activities.
- All Government hospitals or those funded by the Government must provide beds for Senior Citizens as far as possible. Also, special queues to access medical facilities should be arranged for them[47].

4) MAHARASHTRA STATE: UNDER MINISTRY OF HEALTH AND FAMILY WELFARE

The Ministry of Health and Family Welfare provides the following facilities for senior citizens of:

[47] Elderly People, National Human Rights Commission India, 2011

- Separate queues for older persons in government hospitals.
- Geriatric clinic in several government hospitals.
- The Ministry implemented the National Programme for the Health Care for the Elderly (NPHCE) from the year 2010-11.

Objectives of the National Programme for the Health Care for the Elderly

- Provide preventive, curative and rehabilitative services to the elderly persons at various level of health care delivery system of the country
- Strengthen referral system
- Develop specialized man power and
- Promote research in the field of diseases related to old age.

In Another Cases District Blindness Control Scheme the state pays Rs. 600/- per IOL (Intra Ocular Lens) operation. There are separate queues in hospitals for Elder Persons. KEM Hospital has provision of separate beds for Older Persons. Also Conducts Geriatric clinic once a week for senior citizens[48].

Table No 3.4-Per cent distribution of aged men with illness or otherwise by their perception about current state of health in State of Maharashtra and India

state	% aged persons reportin g illness	aged person with illness own perception about current state of health				aged person without illness own perception about current state of health			
		excellen t / very good	goo d / fair	poo r	total (incl . n.r.)	excellen t / very good	goo d / fair	poo r	total (incl . n.r.)
Maharashtr	35	2	68	28	100	11	74	13	100

[48] In Senior Citizens Guide, Policy Research and Development Department, Revised Edition, 2016, 65 Pp

a									
India	31	2	59	37	100	8	73	13	100

Source: National Sample Survey, 60th Round, (2004)

Table No-3.5- Per cent distribution of aged women with illness or otherwise by their perception about current state of health in State of Maharashtra and India

state	% aged persons reporting illness	aged person with illness own perception about current state of health				aged person without illness own perception about current state of health			
		excellent / very good	good / fair	poor	total (incl. n.r.)	excellent / very good	good / fair	poor	total (incl. n.r.)
Maharashtra	35	1	65	31	100	6	81	11	100
India	31	2	54	42	100	5	74	17	100

Source: National Sample Survey, 60th Round, (2004)

The proportion of elderly physically fit to move was invariably higher in urban areas as compared to their rural counterpart and higher among men than women in various age-groups **Table No-3.4 and Table No-3.5**.

5) **THE HUMAN RIGHT TO HEALTH AND POOR ELDERLY PEOPLE IN SATARA DISTRICT RIGHT TO HEALTH PROGRAMME APPLIED**

Table No-3.6- Total Population- In India Senior Citizens (60+)

	Persons	**Males**	**Females**	**Rural**	**Urban**
All India	1210.9*	623.3*	587.6*	833.8*	377.1*
In India Senior Citizens (60+)	103.9*	51.1*	52.8*	73.3*	30.6*
Maharashtra	9.3*	8.8*	9.7*	10.3*	7.9*
Satara	3003741✠	1510842✠	1492899✠	2433516✠	570225✠
In Satara Senior Citizens (60+)	482619✠	229706✠	252913✠	338952✠	143667✠
As % of total	8.6*	9.0*	8.2*	8.8*	8.1*

Source: Population Census 2011
***Crore**
✠ Lakh

Table No-3.7-Per cent distribution of aged men with illness or otherwise by their perception about current state of health in State of Maharashtra and India

state	% aged persons reporting illness	aged person with illness own perception about current state of health				aged person without illness own perception about current state of health			
		excellent / very good	good / fair	poor	total (incl. n.r.)	excellent / very good	good / fair	poor	total (incl. n.r.)
Satara	27	3	61	18	100	16	78	11	100
Maharashtra	35	2	68	28	100	11	74	13	100
India	31	2	59	37	100	8	73	13	100

Source: Satara Sample Survey

Table No-3.8- Per cent distribution of aged women with illness or otherwise by their perception about current state of health in State of Maharashtra and India

State	% Aged persons reporting illness	Aged person with illness own perception about current state of health				aged person without illness own perception about current state of health			
		excellent / very good	good / fair	poor	total (incl. n.r.)	excellent / very good	good / fair	poor	total (incl. n.r.)
Satara	10	2	63	23	100	7	68	9	100
Maharashtra	35	2	68	28	100	11	74	13	100
India	31	2	59	37	100	8	73	13	100

Source: Satara Sample Survey.

The proportion of elderly physically fit to move was invariably higher in urban areas as compared to their rural counterpart and higher among men than women in various age-groups. Direct observations made at the City, Taluka, and Village and household level in Satara to ascertain the socio economic conditions and opportunities available etc. Main sources of data, on various aspects of social sector programmes implemented were collected from a variety of sources by adopting various social research methods. This includes personal interaction with number of offices to collect required information by scanning through different records, documents, reports etc in case of elderly person (Table No-3.6 to Table No 3.8).

OLD AGE HOME AT SATARA CITY

i) Matoshree Old Age Home, Mahagaon, Satara

Members of Matoshree old Age Home, Mahagaon, Satara

Matoshree Old Age Home, Mahagaon, Satara

ii) Samamta Old Age Home

Samta Old Age Home wae was Establish in the year 2012. It is situated at rahimatpur raod, kodoli in satara. Its is run by Mr Suresh Shrirang Mane andMrs Sangita Suresh Mane. This Old age home was started with a thought of helping and Care taking of ola age Person. Samata old age home has two storey building and with different section, attached with necessary hygienic facilities as well.

Table No-3.9- Old age home in Satara

Name of Old age home	Male	Female	Total
Matoshree Old Age Home, Mahagaon, Satara	21	13	34
Samamta Old Age Home	19	8	**27**

Source: Satara Sample Survey

Group discussions was held and conducted the at Matoshree old age home and Samamta Old Age Home. In this the researcher take appraisal techniques where Interaction among elderly person in a group, which stimulated for qualitative research. Discussions were also held with the relevant Caretaker on aspects relating to programme implementation for elderly person (Table No-3.9).

Direct observations made at the Matoshree old age home, mahagoan, Satara and Samamta Old Age Home. To ascertain the socio economic conditions and opportunities available etc at place. Main sources of data, on various aspects of Government programmes implemented were collected from a variety of sources by adopting various social research methodologies on elderly person. This includes personal interaction with number of elderly person to collect required information by scanning through different records, documents, reports etc.

Male and female respondents were interviewed in the selected Old age home. Spiritual leaders, teachers, village level officials and different Social workers and Social activists were also consulted to the elderly person in Matoshree old age home and Samamta Old Age Home. Special attention has been put on the trustworthiness, depth and correctness of the responses from the selected respondents to the extent possible for proper analysis and interpretation of the data as well.

The first reaction of the elderly person in Matoshree old age home and Samamta Old Age Home when approached for filling up the domestic question was that 'nobody does anything for us as we are poor, so many people come to take interview, research but nothing happens in the situation. There is no change in our health situation and condition. So why should we talk to you people'. Some of them especially elderly women were ready to talk with Researcher. However, after long persuasions, Researcher was able to collect information from elderly women also. Many of them did not even understand the concept of Right to health of elderly people. They were unaware about enforcement of Senior Citizen Act, 2007.

The non-governmental/voluntary organizations like Matoshree old age home substantially contribute towards the welfare of the elderly person and society. NGO working for the cause and care of the elderly person to reach out to as many elderly destitute as possible and addressing community right to health and healthcare issues at a local level.

6) STATUTORY FRAMEWORK FOR ELDERLY PEOPLE

A) Constitutional Provisions

In Constitution of India, entry 24 in list III of schedule VII deals with the Welfare of Labour, including conditions of work, provident funds, liability for workmen's compensation, invalidity and Old age pension and maternity benefits. Further, Item No. 9 of the State List and item 20, 23 and 24 of Concurrent List relates to old age pension, social security and social insurance, and economic and social planning. Article 41[49] of Directive Principles of State Policy has particular relevance to Old Age Social Security. According to this Article, "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 case of undeserved want.

B) Personal Laws:

The moral duty to maintain parents is recognized by all people. However, so far as law is concerned, the position and extent of such liability varies from community to community.

a) Hindu Laws:

The statutory provision for maintenance of parents under Hindu personal law is contained in Section 20(3) of the Hindu Adoption and Maintenance Act, 1956. This Act is the first personal law statute in India, which imposes an obligation on the children to maintain their parents. As is evident from the wording of the section, the obligation to maintain parents is not confined to sons only; the daughters also have an equal duty towards parents. It is important to note that only those parents who are financially unable to maintain themselves from any source, are entitled to seek maintenance under this Act.

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[49] **Article 41** Provides for "Right to work, Right to education and Right to public assistance in case of unemployment, old age, sickness and disablement and in other cases of undeserved want".

b) Muslim Law:

Under the Muslim law also children have a duty to maintain their aged parents. According to Mulla (Muslim title applied to a scholar or religious leader):

(i) Children in easy circumstances are bound to maintain their poor parents, although the latter may be able to earn something for themselves.

(ii) A son in stressed circumstances is bound to maintain his mother, if the mother is poor, though she may not be infirm.

(iii) A son, although poor, is earning something, is bound to support his father who earns nothing. According to the Muslim law, both sons and daughters have a duty to maintain their parents under the Muslim law. The obligation, however, is dependent on their having the means to do so.

c) Christian and Parsi Law:

The Christians and Parsis have no personal laws providing for maintenance for the parents. Parents who wish to seek maintenance have to apply under provisions of the Criminal Procedure Code.

d) The Code of Criminal Procedure (Cr.P.C):

The Cr.P.C 1973 is a secular law and governs persons belonging to all religions and communities. Daughters, including married daughters, also have a duty to maintain their parents. The provision for maintenance of parents under the code was introduced for the first time in Section 125(1) of the Code of Criminal Procedure in 1973. As per the code if any person having sufficient means neglects or refuses to maintain his father or mother, unable to maintain himself or herself, a Magistrate of the first class may, upon proof of such neglect or refusal, order such person to make a monthly allowance

for the maintenance of his father or mother, at a monthly rate as the magistrate thinks fit, and to pay the same to such person as the Magistrate may from time to time direct.

C) Government Policies and Schemes for Older Persons

Over the years, the government has launched various schemes and policies for older persons. These schemes and policies are meant to promote the health, well-being and independence of senior citizens around the country. Some of these programmes have been enumerated below:

a) National Policy for Older Persons

The central government came out with the National Policy for Older Persons in 1999 to promote the health, safety, social security and well being of senior citizens in India. The Policy recognizes a person aged 60 years and above as a senior citizen. This policy strives to encourage families to take care of their older family members. It also enables and supports voluntary and non-governmental organizations to supplement the care provided by the family and provide care and protection to vulnerable elderly people.

The policy has identified a number of areas of intervention financial security, healthcare and nutrition, shelter, education, welfare, protection of life and properly etc. for the wellbeing of older persons in the country. The main objective of this policy is to make older people fully independent citizens.

This policy has resulted in the launch of new schemes such as-

1. Strengthening of primary health care system to enable it to meet the health care needs of older persons

2. Training and orientation to medical and paramedical personnel in health care of the elderly.

3. Promotion of the concept of healthy ageing.

4. Assistance to societies for production and distribution of material on geriatric care.

5. Provision of separate queues and reservation of beds for elderly patients in hospitals.

6. Extended coverage under the Antyodaya Scheme with emphasis on provision of food at subsidized rates for the benefit of older persons especially the destitute and marginalized sections[50].

b) Integrated Programme for Older Persons:

Implemented by the Ministry of Social Justice & Empowerment this scheme provides financial assistance up to 90 per cent of the project cost to non-governmental organizations or NGOs as on March 31, 2007. This money is used to establish and maintain old age homes, day care centres, mobile medicare units and to provide non-institutional services to older persons.

The Scheme of Integrated Programme for Older Persons (IPOP) is being implemented since 1992. Under the Scheme financial assistance up to 90% of the project cost is provided to Non-Governmental Organizations for running and maintenance of old age homes, day care centres and mobile medicare units. The Scheme has been revised w.e.f. 1.4.2008. Besides an increase in amount of financial assistance for existing projects, Governments/ Panchayati Raj Institutions/ Local Bodies have been made eligible for getting financial assistance. Several innovative projects have also been added as being eligible for assistance under the Scheme. Some of these are:

- Maintenance of Respite and Continuous Care Homes,

[50] Elderly People, National Human Rights Commission India, 2011

- Day Care Centres for Alzheimer's Disease/ Dementia Patients,
- Physiotherapy Clinics for older persons,
- Help-lines and Counseling Centres for older persons,
- Sensitizing programmes for children particularly in Schools and Colleges,
- Regional Resource and Training Centres,
- Training of Caregivers to the Older Persons,
- Awareness Generation Programmes for Older Persons and Caregivers,
- Formation of Senior Citizens Associations etc.

The eligibility criteria for beneficiaries of some important activities/ projects supported under the Scheme are[51]:

- Old Age Homes - for destitute older persons,
- Mobile Medicare Units - for older persons living in slums, rural and inaccessible areas where proper health facilities are not available Respite Care Homes and Continuous Care Homes - for older persons seriously ill requiring continuous nursing care and respite.

The physical and financial achievements under the Scheme during the last five years are given below:

Table No-3.10- The physical and financial achievements under the Scheme

Year Expd	BE	RE	Expd	Expd as % of RE	Number of assisted		
					NGOs	Projects	Beneficiaries
2007-08	22.00	22.00	16.12	72.3	391	660	43,563
2008-09	22.00	22.00	17.72	80.6	304	437	32,560
2009-10	22.00	22.00	19.72	89.6	362	559	33100
2010-11	40.00	22.00	20.67	93.9	359	595	38785
2011-12	40.00	-	0.15	-	-	-	-
Total of RE for		**128.00**	-	-	-	-	-

[51] Elderly People, National Human Rights Commission India, 2011

first 4 years + BE for 2011-12						

Source- National Human Rights Commission India, 2011
***(Rs. in crore)**

c) **National Council for Older Persons:**

A National Council for Older Persons (NCOP) has been constituted by the Ministry of Social Justice and Empowerment to operationalize the National Policy on Older Persons. The basic objectives of the NCOP are to:

- Advise the Government on policies and programmes for older persons,
- Provide feedback to the Government on the implementation of the National Policy on Older Persons as well as on specific programme initiatives for older persons advocate the best interests of older persons,
- Provide a nodal point at the national level for redressing the grievances of older persons which are of an individual nature provide lobby for concessions,
- Rebates and discounts for older persons both with the Government as well as with the corporate sector represent the collective opinion of older persons to the Government suggest steps to make old age productive and interesting suggest measures to enhance the quality of inter-generational relationships,
- Undertake any other work or activity in the best interest of older persons.

d) Ministry of Health & Family Welfare Central Government Health Scheme provides pensioners of central government offices the facility to obtain medicines for chronic ailments up to three months at a stretch. More details on Central Government Health Scheme. The Ministry of Health and Family Welfare provides for (i) separate queues for older persons in government hospitals and

(ii) geriatric clinic in several government hospitals. The Ministry has taken a new initiative called the National Programme for the Health Care for the Elderly (NPHCE) in the Eleventh Five Year Plan. The programme has been implemented from the year 2010-11 with an approved outlay of 288 crore for the remaining period of the 11th Five Year Plan (i.e for 2010-11 and 2011-12). The objectives of the programme are to:

- Provide preventive, curative and rehabilitative services to the elderly persons at various level of health care delivery system of the country,
- Strengthen referral system,
- Develop specialized man power and
- Promote research in the field of diseases related to old age.

The basic strategies of the programme are to:

- Strengthening of 8 Regional Geriatric Centres,
- Dedicated facilities at district hospital including 10 bedded wards,
- Dedicated services at PHC/ CHC level,
- Primary health care approach.

The major components of the programme are:

- To establish geriatric department in all the existing 8 Regional Geriatrics Centres
- Strengthening healthcare facilities for elderly at various levels of 100 identified districts in 21 States of the country.

- Regional Institutions to provide technical support to geriatric units at district hospitals whereas district hospitals will supervise and coordinate the activities down below at CHC, PHC and sub-centres[52].

e) Health Care And Nutrition For Elderly Person

In recognition of the health conditions of the elderly, emphasis is laid on increasing their access to quality health care services. This includes long-term management of illness as well as provision of nursing care, provision of quality affordable health services through subsidised user charges, insurance, etc. and utilising the significant reach of the primary health care system in providing preventive, promotive, restorative and rehabilitative health services. Medical and paramedical personnel need to be trained at primary, secondary as well as tertiary facilities on the specifics of geriatric care. In addition efforts need to be made to promote health insurance for people with differing needs and vulnerabilities, which may be subsidised by the state for specific eligible categories of older persons.

i. Subsidy for the health care needs of the elderly poor and graded system of user charges for others

ii. Provision of primary health services and health insurance to address preventive, curative, restorative and rehabilitative needs of older persons and geriatric care at secondary and tertiary levels

iii. Tax relief, grants, land grant at concessional rates to NGOs and private hospitals to provide economical and specialised care for older persons

[52] Elderly People, National Human Rights Commission India, 2011

iv. Setting up geriatric wards and conducting training and orientation programmes for geriatric care

v. Expansion of mental health services and counselling facilities for the elderly having mental health problems.[53]

7) CONCLUSION

- Systematic and analytical studies on the needs of the elderly in India and Maharashtra as well, both urban and rural, are required to Primary substance to for Protection right to health care of elderly people with Special reference to Satara.
- The increasing number of older persons in India. Government is failure to put a strain on health care and social care systems in the country. Old age comes with lot of with advancing age, old persons have to cope with health and associated problems some of which may be chronic, of a multiple nature, require constant attention and carry the risk of disability and consequent loss of autonomy. Some health problems, especially when accompanied by impaired functional capacity; require long term management of illness at time, and of nursing care. In case of large number of elderly persons in the population, the country needs more health and medical services, facilities and resources. More number of hospitals, doctors, nurses is required. Government spending on health care is increased with the increase of average age of population.
- Right to Health needs of older persons need to given high priority with affordable health services. It will be necessary to have a cautious with the public

[53] By S Irudaya Rajan, U S Mishra, In The National Policy for Older Persons: Critical Issues in Implementation, December 2011.

health services, health services provided by not for profit organizations including trusts and charities, and private medical care. While the first of these will require greater State participation given some assistance, concessions and relief, encouraged right to health care of elderly people.

- The primary health care system it is basic structure of public health care. It need strengthened and oriented to be able to meet the health care needs of older persons as well public health services, preventive, curative, restorative and rehabilitative, will be considerably expanded and strengthened and geriatric care facilities with proper distribution of services in rural and urban areas, and much better health administration and delivery systems elderly people.
- Problems of accessibility and use of right to health services by the elderly arise due to distance, absence of escort and transportation services. Difficulties in reaching a public health care facility need to addressed through mobile health services, special camps and ambulance services by charitable institutions without profit health care organizations.
- Trusts, charitable societies and voluntary agencies need to promote, encouraged and assisted by way of grants, tax relief and land at subsidized rates to provide free beds, medicines and treatment to the very poor elder citizens and reasonable user charges for the rest of the population.
- Widowhood among women even before reaching old age results in a serious disadvantaged experience of old age.
- Lack of food is a major cause of poor health, priority for elderly in these circumstances receiving nutritional supplements is highly desirable.

- The concept of right to health need to promote for Betterment elderly people. It is necessary to educate older persons and their families that diseases are not a corollary of advancing age nor is a particular chronological age the starting point for decline in right to health. On the contrary, preventive health care and early diagnosis can keep a person in reasonable good health and prevent disability.
- Health education programmes need to strengthened by making use of media and social media, folk media and other communication channels which reach out to different category of the population. The capacity to deal with with illness and manage domistic Health care. Right to health need to be developed targeting the younger and middle age groups to inform them how life styles during early years affect health status in later years. Messages on how to stay healthy for the entire life. The physical exercise, regular habits, reduction of stress, regular medical checkup, on yoga, meditation and methods of relaxation will be developed and transmitted to the Society.
- Mental health services need to expanded and strengthened. Families need to provide counselling facilities and information on the care and treatment of older persons having mental health problems.
- At this age of their life, the senior citizens need to be taken care of and made to feel special. They are a treasure to our society.

CHAPTER IV

A STUDY ON RIGHT TO HEALTH AS A BASIC HUMAN RIGHT WITH SPECIAL REFERENCE TO SATARA DISTRICT

INTRODUCTION:

The every State has an important role to play in Encounter for the poor Right to health status of people. We cannot ignore the fact that the poor Right to health status of people in our country is mainly due to poverty and inadequate health budget our government. The inflexible government policy deprives people from right to health. Absence of good health means deprivation Right to Life As Well.

Right to Health Means, Healthy mind and Healthy body it may have intrinsic value in terms of fulfilling ambition for enlightenment, self improvement and social interaction with Right to Health. Development of basic human capabilities has such as ability to live long and to escape preventable illnesses and the quality of life that the people can enjoy. The consequences of neglecting preventive right to healthcare were apparent by Society time to time.

A) PROFILE OF THE SATARA DISTRICT

Satara district is located in the south western part of the state of Maharashtra and lies between 17.5° to 18.11°North Latitudes and 73.33° to 74.54° East Longitudes.[54] (Figure No-4.1) According to 2011 census the District Satara covers an area of 10480 sq. kilometers and has a population of 30,03,900[55] out of the total geographical area of 10484 sq. kilometer, 10123.5 sq. kilometers is rural and 360.5 sq kilometers is urban

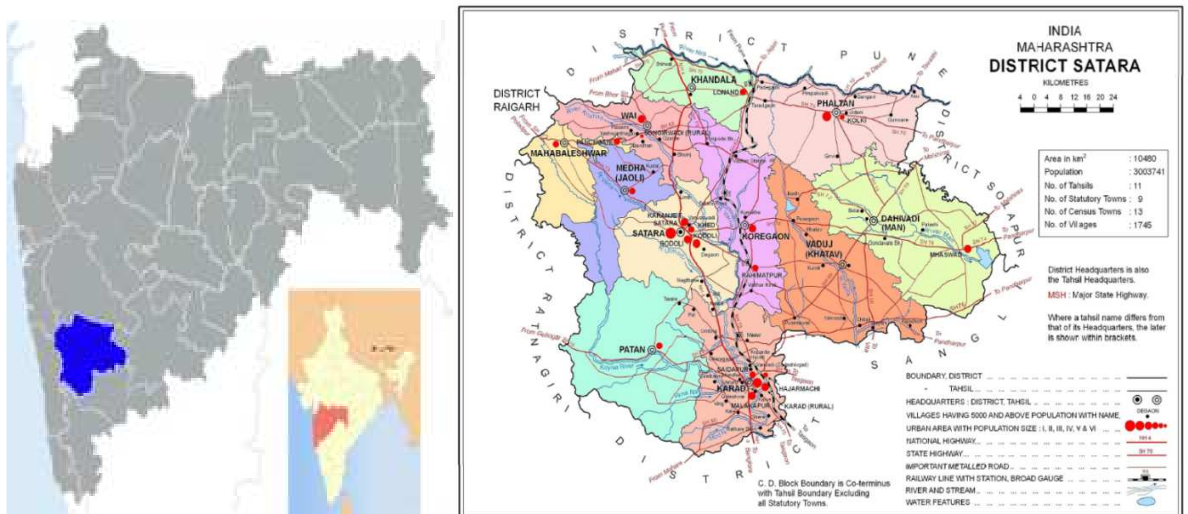
[54] By Government of Maharashtra in District Disaster Management Plan Satara District 2011, District Disaster Management Authority – Satara, P. 8.
[55] Survey by census of India: (2011)

area. It occupies 2.7% (Figure No-4.3) part of the Maharashtra state and 9.3% (Figure No-4.2) of the total Population of the India.

The Satara town is located on the National Highway No. 4 with The district headquarters Satara is well connected to the state Capital Mumbai (260 km to the north west), and the major towns of Pune and Kolhapur by the Mumbai Bangalore National Highway No. 4. There is one railway line -Mumbai to Kolhapur- which passes through Satara district. The total distance in satara district is 124 KM at Satara railway station of the south central railway at a distance of three kilometers.

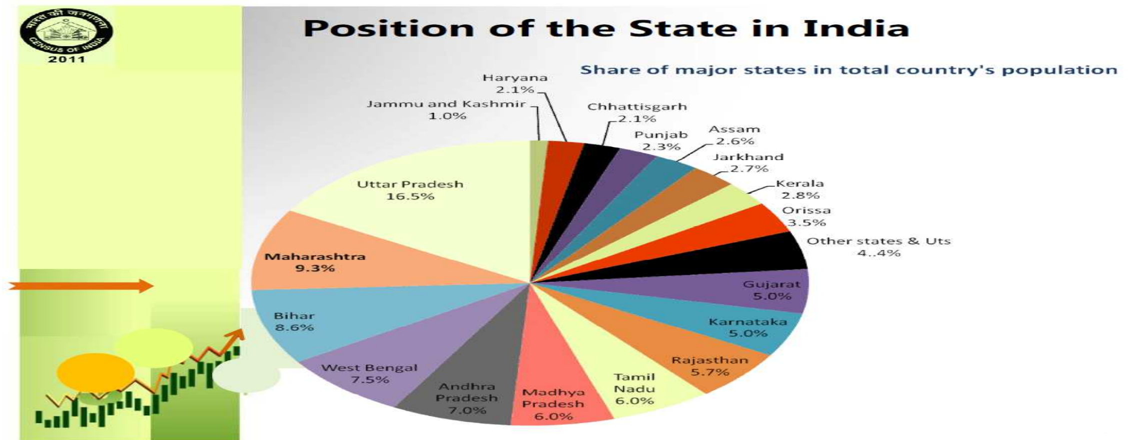
The district is divided into seven Sub Division and eleven administrative sub units (Tahsils) - Satara, Wai, Khandala, Koregaon, Phaltan, Khatav, Man, Karad, Patan, Jawali and Mahabaleshwar.

Figure No- 4.1 India, Maharashtra and Satara District



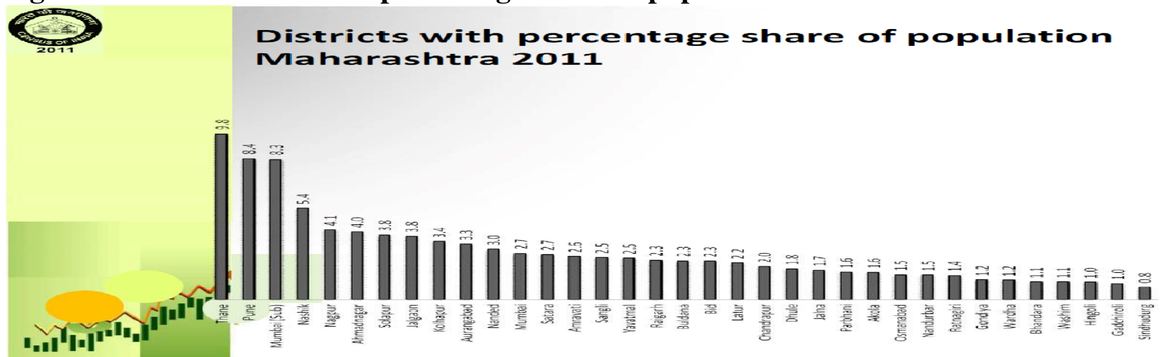
Source- *Survey by Census of India: Maharashtra series 28 Part XII-B (2011)*

Figure No-4.2- Share of major states in total country's population



Source- *Survey by Census of India: (2011)*

Figure No-4.3 Districts with percentage share of population Maharashtra 2011

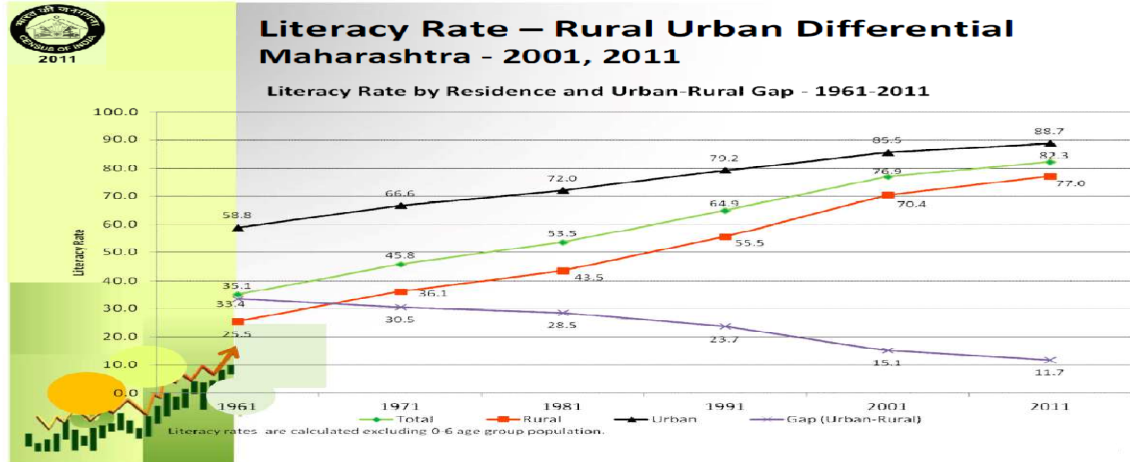


Source- Survey by Census of India: (2011)

B) LITERACY AND EDUCATION PROFILE OF SATARA DISTRICT:-

The percentage of literacy in Satara district increased substantially from 33.4% in 1961 to 84.20% in 2011. The female literacy rose from 21.16% in 1961 to 76.3% in 2011. The male literacy rose from 47.41% in 1961 to 88.40% in 2011. The latest 2011 figures revealed that 84.20% of the total population in the district is literate against the state average literacy rate of 82.90% (Figure No–4.4).

Figure No–4.4. Literacy Rate Rural urban Differential Maharashtra-2001, 2011



Source- Survey by census of India: (2011)

Table No-4.1- Healthcare Statistics in India at Glance

	Healthcare Expenditure (% GDP)	Doctors (per 1000)	Hospital Beds (per 1000)	Infant Mortality (per 1000)
India	0.8%	0.7	0.8	71
World	2.6%	1.5	3.3	54
Developed Nations	6.1%	2.8	7.2	6

Source: Accessible Healthcare – A Reality Check, Philips Healthcare India, 2009.

Figure No-4.5- **Health at Glance of Maharashtra**

16. Health -		(1971)	(1981)	(1991)	(2001)	(2011)	(2012)
Hospitals	N.A.	299	530	768	1,102	1368	1,393
Dispensaries	N.A.	1,372	1,776	1,896	1,544	3012	3,087
Beds per lakh of population	N.A.	88	114	144	106	103	106
							(2011)
Birth rate @	34.7	32.2	28.5	26.2	20.7	16.7	16.7
Death rate @	13.8	12.3	9.6	8.2	7.5	6.3	6.3
Infant mortality rate @	86	105	79	60	45	25	25

Source- *Economic Survey of Maharashtra 2012-2013*

C) STATE PROVIDED HEALTH CARE

The Indian Context on Right to health development was guided by two principles-with three consequences. The first principle was State responsibility for health care and Health Services, The second was free medical care for all (and not merely to those unable to pay), The consequences was inadequate priority to public

health, poor investment in safe water and Right to Health on and to the neglect of the key role of personal hygiene in good health, end in the persistence of diseases like Cholera (Figure No-4.5).

The second consequences relating to substantially unrealized goals of National Health Policy (NHP)1983 due to funding difficulties from compression of public expenditures on right to health and from organizational inadequacies in Health services. The ambitious of NPP - 2000 goals and strategies have however been formulated in the hope that the gaps and the inadequate right to Health, It would be removed by decided action. The Urban and rural health structure was strengthened, funded and managed efficiently in all States by 2005. This can produce many considerably changes over the next twenty years in neglected aspects or rural Right to health and of vulnerable sector. The third set of consequences appears to be the inability to develop and integrate plural systems of medicine and the failure to assign practical roles to the Public sector and to give public duties to professionals Human Resource (Table 4.1).

To set right these gaps demanded patient redefinition of the state's role keeping the focus on right to health. But in the last decade there has been a Right to Health Facing governance styles and much influential to reduce the state role in health in order to enforce overall firmness of public Health which reduces Right to Health deficits. People have therefore been forced to switch between weak and efficient public services and expensive private provision or at the limit forego care entirely except in life threatening situations, in such cases sliding into indebtedness.[56]

[56] By R. Srinivisan, In- Health Care In India - Vision 2020 Issues And Prospects

The Public Health Department is the main authority in Maharashtra which plans and impalements public health programmes and schemes on the line with the National Health Policy of the Government of India. Some of the objectives of the Public Health Department of the Government of Maharashtra are:[57]

(1) To provide adequate and qualitative preventive and curative health care to the people of the State.

(2) To ensure greater access to primary health care by bringing medical institutions as close to the people as possible or through mobile health units.

(3) To improve maternal and child health with a view to reducing maternal and infant mortality.

(4) To improve hospital services at the secondary levels both in terms of infrastructure and personnel.

(5) To give training to doctors, nurses and other paramedical staff to meet the needs of health care in the State by upgrading their skills and knowledge.

(6) To implement various national health programmes and evaluation of their achievements and success.

(7) To give health education for improving knowledge, attitude and behaviour of the community.

Table 4.2 Number of Health Sub-Centres in Maharashtra

Number of Sub-centres		
Tribal	**Non-tribal**	**Total**
2075	8504	10579

Source: Official web-site of Government of Maharashtra, retrieved on 10th February 2012.

[57] Government of Maharashtra (2011), Public Health Department, Directorate of Health Services, retrieved from the official web-site www.maha.arogya.gov.in as on 23rd October.

It can be seen in the Table No 4.2 that there are altogether 10579 sub-centres in Maharashtra of which 2075 sub-centres are located in tribal areas while the remaining 8504 sub-centres are in the non-tribal areas which shows lack of Health Services.

Above mentioned information in Figure No 4.1 to 4.5 is important to conduct this research. Satara district is mostly cover with hilly area; small population is there in Satara compared with metropolitan city like Pune and Mumbai. At Satara, Phaltan and Karad there is District, Sub-Dist Hospital. So that other Health policy and programmes are implemented by the Government of Maharashtra and other local authority in each Taluka of Satara District, Maharashtra. Hence for representative sample researcher had concentrated on Satara city, Phaltan and Karad.

There has an available healthcare service in rural and urban areas of Satara District. The rural-urban disparities in health outcomes in India and Maharashtra are often attributed to urban bias in allocation of Health resources and location of healthcare services. Above mention Statistics clearly show that the bed population ratio is higher in urban areas and that those regional inequalities have not seen any significant decline over time. This regional inequity is there in both the public Health Sector as well as in the private health sector. There is a strong need to have an effective National Health policy to provide effective health services to sufficient and develop Right to Health in India.

D) RIGHT TO HEALTH PROFILE OF THE TOWN:

Civil Hospital Satara: In Satara district, the Civil Hospital, Satara is the main Government Hospital at the headquarters. It is owned, staffed, financed and controlled by Government. There are also three other Government medical institutions in this district each at Karad and Phaltan. Besides, there are also a number of Government-

aided dispensaries which are scattered throughout the district. The aided dispensaries are mostly owned and managed by municipalities and the District Local Board, Satara.

The Civil Hospital, Satara, is situated on the main road on the eastern side of the town. It is an old type structure with an accommodation for 222 beds. It is well-equipped. There is an X-ray plant with screening arrangement of 100 milli ampere. There is equipped Laboratory conducted by a qualified and laboratory technician. There is an Out Patient Department with separate blocks for male and female patients, and a dispensary. There is also a maternity ward with eight beds and separate wards for lunatics and tetanus patients. The patients with the infectious diseases are kept separately in the segregation ward outside the hospital compound at a distance of about 100 yards. There is also a T.B. Ward for accommodating 8 patients.

In addition to the Civil Hospital there are 18 Government hospitals and dispensaries in this district, *viz.,* (1) Sub-Dist Hospital Karad with 100 Bed, and (2) Sub-Dist Hospital Phaltan with 50 Bed. The dispensaries are at Kaledhon, Undale, Koregon, Mahabaleshwar, Dahivadi, Debevadi, Patan, Wai, Vaduj, Gondwale, Pimpoda, Kandala, Somrdi, Medha, Aundh. Of these the dispensary at Medha is ayurvedic. The Karad municipality maintains its own dispensary.

There are 71 primary health centers (PHCs), Primary Health Sub Centre about 400, Anganwadis 640. (Table No-4.3) centres in the district located at 71 places *viz.,* Kudal, Helwak, Parli, Kaledhon, Kiwal, Bahule, Pusegaon, Pimpode Bk., Kukudwad, Dhom, Undale, Limb, Chinchner-Vandan, Vaduj, Mhopre, Chaphal, Uchat, Rethare Bk., Girvi, Jawle and Kinhai etc. Primary Health Sub Centre about 400 with 640 Anganwadis In Satara District.

Table No- 4.3- Medical and Public Health Facilities in Satara District (1951 – 2011)

Sr. No	Item	1951	1961	1971	1981	1991	2001	2009	2011
1	No. of Hospitals	2	2	7	14	13	13	18	18
2	No. of primary Health centers	7	7	16	18	69	69	71	71
3	No. of Dispensari es	30	31	33	39	57	22	17	17
4	No. of Doctors	43	52	71	150	214	255	262	262 3257*
5	No. of Beds	148	234	889	1072	1070	1124	1290	1290
6	No. of Indoor Patients	2,820	7,079	1,20,121	1,38,000	9,87,000	-	1,36, 900	-
7	No, of Outdoor Patients	3,17,113	3,53,512	5,35,165	6,98,000	9,16,400	-	19,8 7,60 0	-

*Health Service personnel

Table No-4.4- Population Per Public Health Facility in 1991, 2001 and 2011

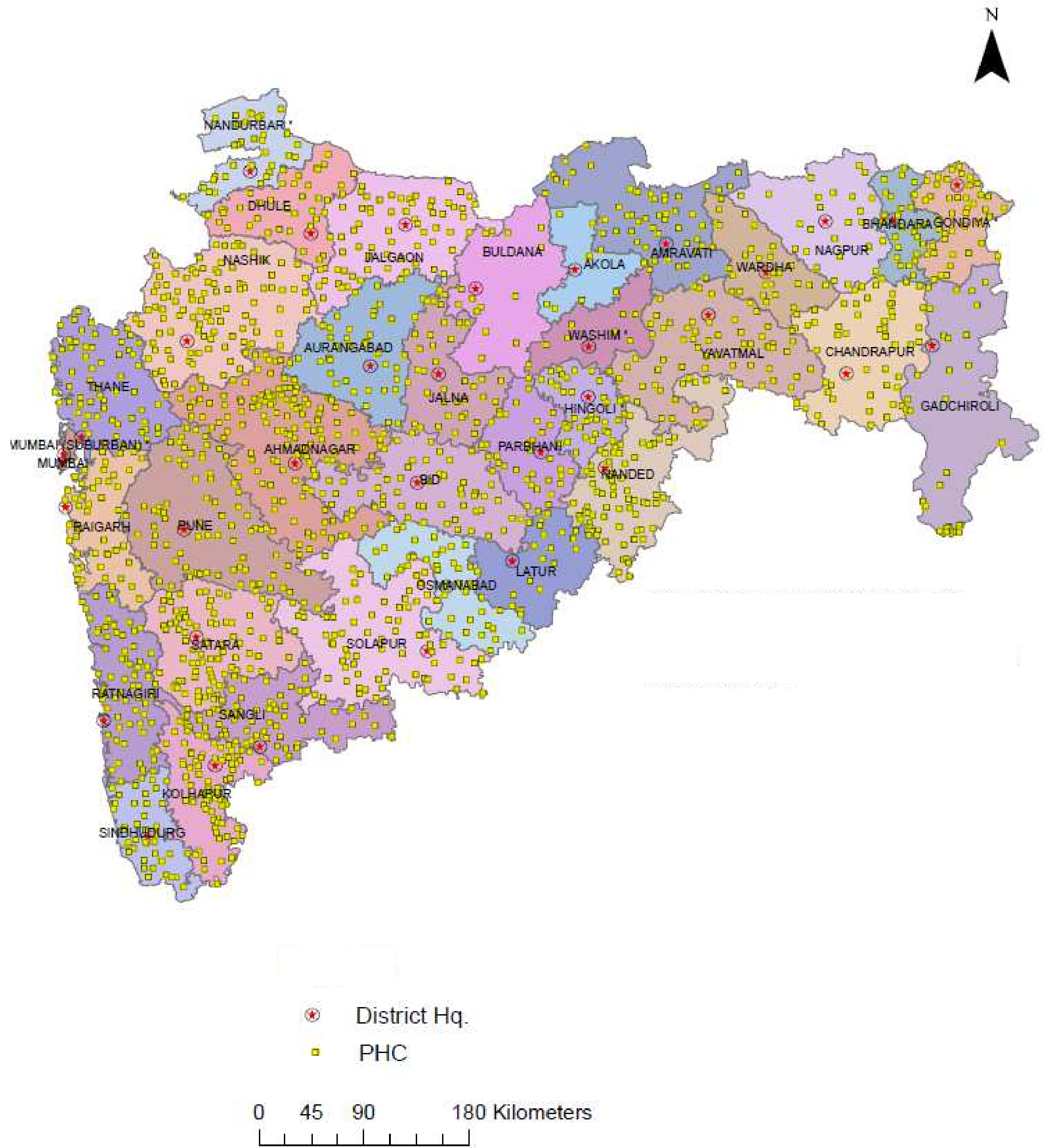
District	Population Per Sub Centre		Population per PHC			Population per RH		
	2000	2010-11	1990-91	2001-02	2010-11	1990-91	2001-02	2010-11
Satara	7,802	6,804	30,950	33,956	38,334	1,77,961	2,41,087	1,51,206

Source: Government of Maharashtra-1991-2011

RHs are 30-bedded referral hospitals which provide specialized services, including advanced medical and surgical care and cases comes from Various PHCs in Satara are usually referred in this research. Government norms require one RH for every five PHCs. The average population served by RH is 177,533.[58] Population ratios for RHs have improved slightly, particularly during the last decade of Satara region showing the highest improvement for this indicator (Table No-4.4).

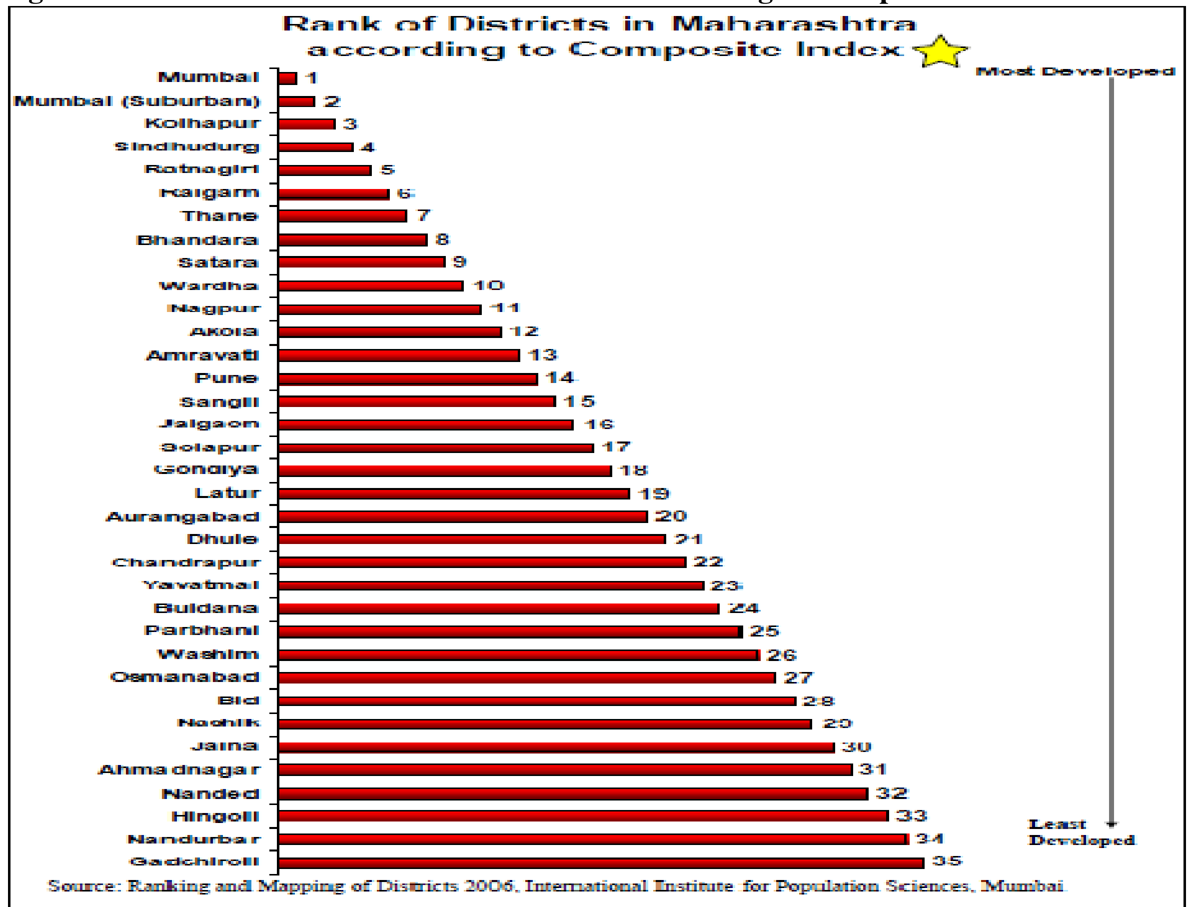
[58] The data about RH reported from http://www.maha-arogya.gov.in/ and the data for population is from ORGI, 2011, Primary Census Abstract.

Figure No-4.6-Spatial Distribution of PHC's in Maharashtra



Source - "Jaansankhya Stirata Kosh" RGI, SOI-2011, Map composed by NIC

Figure No-4.7 Rank of District In Maharashtra According to Composite Index



Source- "Jaansankhya Stirata Kosh"-*(Composite Index is the average of the above 13 indices-2011)*

Above Said Ranking is based upon a 2006 International Institute for Population Sciences, Mumbai report titled "Ranking and Mapping of Districts - Based on Socio - Economic and Demographic Indicators" using the 13 Indicators. This is based on a rural survey and excludes urban area. Indicators used are as follows (Figure No-4.7):

I. Percentage of Population 0-6 Years

II. Birth Order Three And Above

III. Birth below Age 20

IV. Complete Immunization Coverage

V. Dropout from Full Immunization

VI. Female Literacy Rate

VII. Households Using Safe Drinking Water

VIII. Households with Toilet Facility

IX. Percentage of Electrified Households

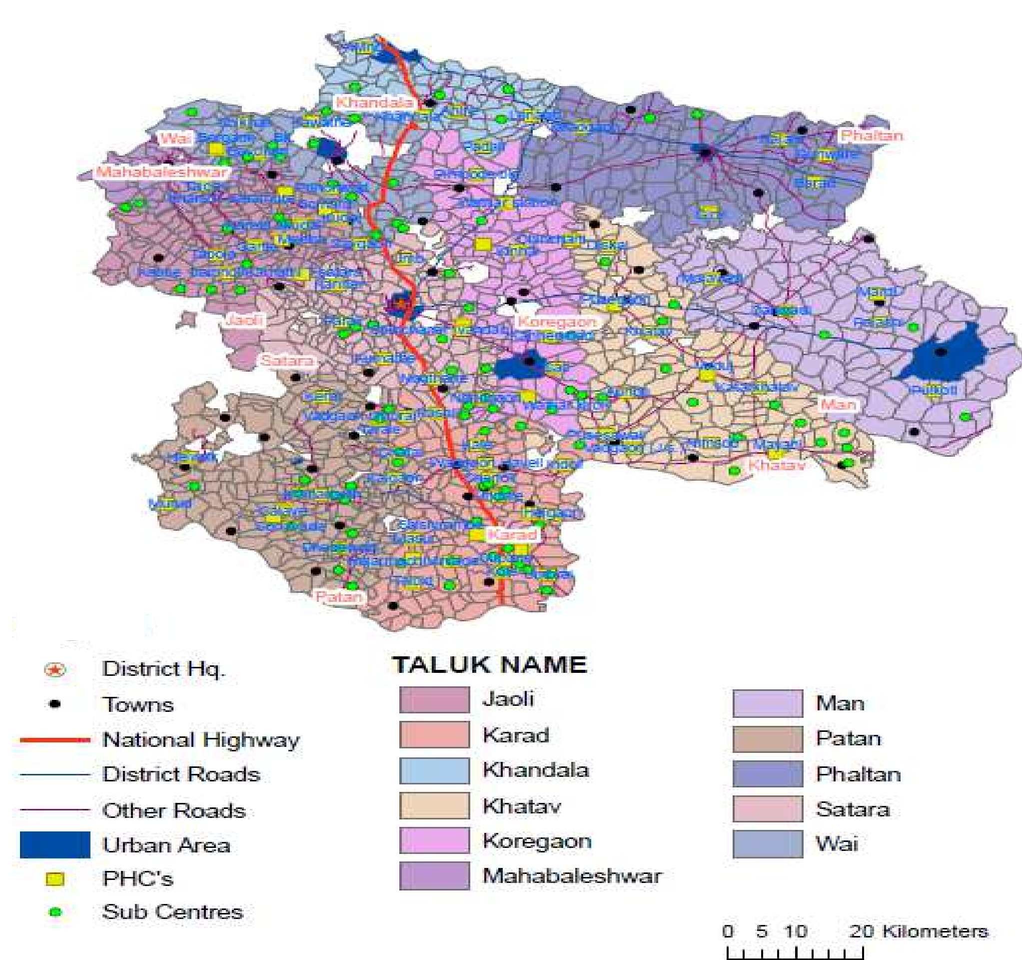
X. Women Receiving 2 TT Injections

XI. Women Receiving 3 or More ANC Visits

XII. Under 5 Mortality Rate

XIII. Contraceptive Prevalence Rate

Figure No-4.8 **Health Facilities in District Satara, Maharashtra**



Source - "Jaansankhya Stirata Kosh" RGI, SOI-2011, Map composed by NIC

A Satara District and sub District hospital has the following functions:

1) It provides effective, affordable health care services (curative including specialist services, preventive and primitives) for a defined population, with their full participation and in co-operation with agencies in the district that have similar concern. It covers both urban population (Sub-divisional head quarter town) and the rural population of the sub division.
2) Function as a referral centre for the public health institutions below the tehseel/taluka level such as Community Health Centers, Primary Health Centers and Sub-centers.
3) Provide education and training for primary health care staff.

Objectives of Indian Public Health Standards (IPHS) for Sub-district Hospitals

The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of the people of the district. The specific objectives of IPHS for Sub-district Hospitals are:

- To provide comprehensive secondary health care (specialist and referral services) to the community through the Sub-district Hospital.
- To achieve and maintain an acceptable standard of quality of care.
- To make the services more responsive and sensitive to the needs of the people of the Sub-district/Sub-division and act as the First Referral Unit (FRU) for the hospitals/centers from which the cases are referred to the Sub-district hospitals[59].

But the health care facilities for overwhelming majority of people in India are poor, both quantitatively and qualitatively. As per the most recent available estimates,

[59] Indian Public Health Standards (IPHS), Guidelines for Sub-District/Sub-Divisional Hospitals, Revised 2012

urban areas have only 4.48 hospitals, 6.16 dispensaries and 308 beds per one lakh of (Urban) population and these figures are far from adequate by any acceptable standard but seem to be much better than the corresponding figures for rural areas. For the rural areas the situation is much worse with 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and just 44 beds per one lakh of (Rural) population[60]. Not only the progress of the country in the health sector in the 68 years after Independence has been grossly inadequate but it may well be the case that there has been a slowing down in many respects in the recent years. Numerous indicators can be cited, apart from those mentioned above, to drive home on this point. For instance, for the country as a whole, number of beds per lakh of population, which had increased from 32 in 1951 to 83 in 1982, was only 93 in 1998. Similarly the number of doctors per lakh of population increased from 17 in 1951 to 47 in 1991, but stood at 52 in 1998[61].

Table No-4.5- Institutional Deliveries

	Place of Delivery and Assistance Characteristics by Satara District			
State and District	**Percentage of Women Who Had Institutional Deliveries**	**Deliveries At Home**	**Home Delivery Assisted by Skilled Persons**	**Percentage of Safe Deliveries**
Maharashtra	63.5%	35.9%	5.7%	69.2%
Satara	87.4%	12.3%	3.5%	90.9%

Source: IIPS (2010) from Maharashtra Human Development Report 2012

The place of delivery is one of the main determinants of maternal and neonatal survival. It is also a key indicator of the demand for public health facilities for maternal health. Under the Eleventh Plan, the basic social interventions needed to encourage

[60] By Ravi Duggal, T. R. Dilip, Prashant Raymus on "Health And Healthcare In Maharashtra", Published In 2005

[61] By Praveen Jha in "Current Government Policies towards Health, Education and Poverty Alleviation in India: An Evaluation".

institutional deliveries under the NRHM included the need for providing training to traditional birth attendants (TBA) and reductions in travel time to two hours for emergency obstetric care. To achieve reductions in infant and neonatal mortality, home-based neonatal care was also sought to be encouraged. At the aggregate level, the percentage of safe deliveries saw an improvement in both rural and urban areas In Satara (Table No-4.5). The percentage of safe deliveries was found Higher in Satara District 90.9%, As per Public Health Department of Government of Maharashtra the safe 69.2%. The per cent is the safe deliveries in the Satara District having the most per cent of safe deliveries 90.9% against State.

Access to maternity care services Researcher done research in Satara District Thus, in spite of the large and wide health network in the District, access and utilization of maternity care showed more better inclusion of the poor and social groups such class of society. To this end, the involvement of ASHAs in improving the coverage and participation in various mother and childcare programmes in the Satara District needs to be enhanced on a priority basis by the Government of Maharashtra.

Table No-4.6- Percentage of Women Who Received any Ante Natal Care and Full Antenatal Care, by Districts: Maharashtra (2007–08)

State and District	Place of Ante Natal Care			Any Ante Natal Care	Full Antenatal Care
	Government Health Facility	Private Health Facility	Community-Based Services		
Maharashtra	43.8%	46.1%	3.1%	91.8%	33.9%
Satara	27.4%	74.6%	1.3%	98.8%	55.5%

Source: IIPS (2010)

Antenatal care is a crucial component of health-care services for ensuring maternal and child survival and is also a determinant of the quality of health services. Antenatal care is provided by a doctor, an ANM or other health professional and comprises

physical health check-ups, checking the position and the growth of the foetus and giving the required number of tetanus toxoid (TT) injections at recommended intervals during pregnancy. It is suggested that each mother have at least three check-ups as part of antenatal care to safeguard her from pregnancy related complications in Satara District 55.5% Against State is 33.9% (Table No-4.6). Requires with good nutrition, iron–folic acid tablets as well.

Source: Field survey (Hospital Staff)

In all 162 providers were interviewed for the Research study (Table No-4.7) consisting of 100% employees from Satara District. The information was collected from 50 assistant. Doctors and Housemen, 8 Medical Social Worker, 3 Pharmacists, 7 Technicians, 41 Nurses / Brothers, 8 Office Staff and 45 class - IV employees of the Satara Civil Hospitals, Sub-Dist Hospital Karad, Sub-Dist Hospital Phaltan. The following Table No-4.7 gives the break - up of providers interviewed for the study from employees –

Table No-4.7- Number and type of providers interviewed for the study from employees

Type of Provider / Sector	Total Number	Satara Civil Hospitals	Sub-Dist Hospital Karad	Sub-Dist Hospital Phaltan	Per cent
Civil Hospital	3	1	1	1	100%
Designation					
Medical social worker	8	4	2	2	4.93%
Asst. doctor	38	23	8	7	23.45%
Houseman	12	7	3	2	7.40%
Pharmacist	3	1	1	1	1.85%
Lab. technician	4	2	1	1	2.46%
X-ray technician	3	1	1	1	1.85%
Clerk	8	4	2	2	4.93%
Nurse	34	23	7	4	20.98%

Brother	7	3	3	1	4.32%
Ayah	26	17	5	4	16.04%
Ward boy	14	9	3	2	8.64%
Watchman	2	1	1	0	1.23%
Ambulance driver	3	1	1	1	1.85%
Total	**162**	**96**	**38**	**28**	**100%**

Source: Field survey (Patient)

In all 207 providers were interviewed for the study (Table-No-4.8) consisting of 100% Patient from Satara District. The information was collected from 147 Male, 60 Female, 148 Hindu, 43 Buddhist, 13 Muslim, 3 Christian. The following Table No-4.7 gives the break - up of providers interviewed for the study from Patient

Table No- 4.8- Distribution of Providers by Patient Characteristics

Patient Characteristics	Number of Patient	Satara Civil Hospitals	Sub-Dist Hospital Karad	Sub-Dist Hospital Phaltan	Per cent
Gender composition					
Male	147	83	38	26	71.01%
Female	60	33	12	15	28.99%
Total	**207**	**116**	**50**	**41**	**100%**
Age					
18-30 years	55	31	13	11	26.57%
31-40 years	63	33	15	15	30.43%
41-50 years	42	17	13	12	20.28%
51-60 years	37	19	8	10	17.87%
61-90 years	10	6	3	1	4.85%
Total	**207**	**106**	**52**	**49**	**100%**
Religion					
Hindu	148	73	41	34	71.49%
Buddhist	43	27	9	7	20.77%
Muslim	13	7	4	2	6.28%
Christian	3	2	0	1	1.46%
Total	**207**	**109**	**54**	**44**	**100%**

Source: Researcher’s Field Survey.

A sample of 207 patients selected randomly from three government hospitals in Satara District under study was interviewed to have in-depth investigation and analysis

of the problem under research consideration. The distribution of sample so selected has been explained in the above table.

The researcher found it difficult to collect information from illiterate and some aged Patients. Some respondents from Satara Government hospital refused to part with information due to their cruel and prolonged illness. Thus, wherever Patients refused to part with information or where the researcher found it difficult to extract information as same, such Patients were substituted with other Patients. The technique used to collect sample for the present research.

Table No-4.9-Awareness about free Medical Services in Government Hospitals

Sr. No.	Awareness about free Services in Public Hospitals	Number of Patients	Number of Patients Percentage
1	Yes	207	100%
2	No	00	0

Source: Field data.

The Researcher found in the field survey that all the selected Patients for the present study were aware about the free medical services provided by the Government Hospitals in Satara District. In all government hospitals the state managed as well as municipality managed with all medical services and health services are provided free and at a very negligible cost to Patients. In government hospitals, patients visiting out-patient department are required to pay a real charge of Rs. 10 for registration of case paper. All consultancy services and medicines are provided free of charge Patients, subject to their availability.

Since before few years, the Government has introduced user-fees for providing Health services to inpatients in order to meet operative costs of hospital. However, these

charges have been opposed by Patients, Media, Governmental, Non-Government Organisations. Thus, if a patient approaches a government hospital for treatment of common ailments, all medical services are provided free of cost to them. In the survey, all 207 Patients had knowledge of free medical services provided by the government hospitals at Satara. It was revealed in the survey that awareness of various services and facilities provided by the government is the prerequisite for various welfare schemes launched by the government of Maharashtra. In the absence of adequate awareness among masses, the success of any welfare scheme remains a distant dream for Right to Health (Table No-4.9).

Table No-4.10-Reply of Patients on Availability of Testing and Evaluation Facilities in Government Hospitals

Sr. No.	Availability of Testing and Evaluation Facilities in Government Hospitals	Number of Patients	Number of Patients Percentage
1	Yes	59	**28.51%**
2	No	148	**71.49%**
3	Total	207	**100%**

Source: Field data.

The Researcher found at field area huge sum of money have been invested by the government in upgrading infrastructural and testing facilities in government hospitals, their poor maintenance is one of the reasons, frequent breakdowns. Again adequate medicines are not available in stock all the time. Even for basic testing facilities like X-ray and ECG, patients have to access private clinics. 71.49% of the Patients complained that it is costly to access government hospitals as many essential testing facilities and medicines are not adequately available in government hospitals.

Patients fined that they could get hospitalization on emergency basis in government hospitals, 71.49% of the Patients reported that government hospitals lacked adequate infrastructure and evaluation and testing facilities. It was reported that X-ray machines and ECG facilities are often out of order. Many advanced testing facilities are not available in these hospitals and even if those facilities are available, most of the time they are not provided for the lack of staff or other issues. Researcher fined that most of these machines are purchased through government rate contracts they generally supply substandard machines and instruments and there is no maintenance contract for these machines. For efficient functioning, these machines need regular up keeping and maintenance. Under these circumstances, they have to recommend their patients to private hospitals and clinics for testing and evaluation (Table No-4.10).

Table No-4.11- Reply of Patients on Long Waiting Time at Government Hospitals

Sr. No.	Long Waiting Time at Government Hospitals	Number of Patients	Percentage
1	Yes	199	96.14%
2	No	08	03.86%
	Total	207	100%

Source: Field data.

It was open in the survey that:

- 96.14% of the patients have count as long waiting time at government hospitals to be one of the reasons.
- 3.86% of the patients do not think so.

It can be concluded above Said fact that majority of the Urban and Rural Satara District not prefer the services of Government hospitals due to long waiting hours. This conclusion has been further confirmed by 96.14% of the patients by replying long

waiting time to be one of the cause that to stop them from interring into government hospitals. According to these patients, there is forceful rush of patients in out-patient departments of the Satara government hospitals, Karad Sub district Hospital and Phaltan Sub district Hospital, resulting in long queues and waiting time for patient (Table No-4.11).

Table No-4.12- Reply of Patients on Access of Self or Any Family Member in the Public Hospital for only Major Illness

Sr. No.	Access of Self or any Family Member to a Hospital for Treatment of Major Illness	Number of Patients	Percentage
1	Yes	182	87.92
2	No	25	12.08
	Total	**207**	**100%**

Source: Field data.

It was open in the field survey that:

- Family members of 87.92% of the patients have been access to hospital for only treatment of major illness in Satara District.
- No family member of 12.08% of the patients was hospitalised at any time for only treatment of any major illness in Satara District.

It can be concluded from the above reply that majority of the patients (87.92%) have got themselves or any of their family member admitted to a hospital for only treatment of any major illness at government hospital. This is further ratified by 87.92% of the patients replying that either they themselves or someone in their connections had undergone hospitalisation in government hospitals at Satara district. This question was asked in order to seek their replies on quality of usages in Satara government hospitals, Karad Sub district hospital and Phaltan Sub district hospital (Table No-4.12).

E) PHYSICAL INFRASTRUCTURE PROFILE OF MAHARASHTRA AND SATARA:

The healthcare services are divided under State list and Concurrent list in India. While some items such as public health and hospitals fall in the State list, others such as population control and family welfare, medical education, and quality control of drugs are included in the Concurrent list. The Union Ministry of Health and Family Welfare (UMHFW) is the central authority responsible for implementation of various programmes and schemes in areas of family welfare, prevention, and control of major diseases. In the case of health the term infrastructure takes on a wider role than mere physical infrastructure. Healthcare centres, dispensaries, or hospitals need to be manned by well trained staff with a service perspective. In this chapter we include medical staff in our ambit of discussion on Urban and Rural health infrastructure.

Table No-4.13- Human Resource for Health in Maharashtra

Category	Sanctioned	Filled	Vacant	Percentage of Vacancy as against Sanctioned Posts
Maharashtra Medical Health Services Grade A and B	8,558	6,993	1,565	18.3
General State Services Grade A and Grade B	515	217	298	57.7
Health Assistants (Male and Female)	3,842	3,454	388	10.1
Multipurpose Health Workers (Male and Female)	17,903	15,458	2,445	13.7
Additional 2nd ANM at Sub-Centre	6,617	6,617	0	0
Staff Nurse at PHC	1,350	809	541	40.1

LHV at PHC	1,129	923	206	18.3
ANM	787	672	115	14.6

Source: Government of Maharashtra-2012.

The sanctioned government staff positions lying vacant further aggravate the problem (Table No-4.13). The shortage of ANMs at sub-centres and staff nurses at PHCs needs to be filled, especially for improving the quality of services being provided in the State. The short-staffing of specialists in IPHS hospitals is also a cause for concern (NRHM 2011). The unavailability of such specialists in the public health-care system is poor, with them having to either forgo specialized health care or incur high out-of pocket expenditure for the same by the poor and needy person.

Figure No-4.9- Public Health Expenditure: Maharashtra

Year	Plan			Non-Plan			Total		
	Grant Received	Expenditure	Percentage of Expenditure	Grant Received	Expenditure	Percentage of Expenditure	Grant Received	Expenditure	Percentage of Expenditure
2006–07	4,183.7	2,775.7	66	10,209.6	10,503.1	103	14,393.2	13,278.8	92
2007–08	6,347.8	4,635.7	73	11,075.6	11,145.7	101	17,423.4	15,781.4	91
2008–09	7,353.7	5,512.1	75	12,541.6	13,248.2	106	19,895.3	18,760.3	94
2009–10	8,294.5	4,826.5	58	16,853.4	16,744.2	99	25,148.0	21,570.7	86
2010–11	6,700.8	6,283.1	94	20,038.4	19,823.1	99	26,739.2	26,106.2	98
2011–12	5,804.7	5,701.3	98	22,855.5	22,343.3	98	28,660.2	28,044.6	98

Source: Government of Maharashtra (2012b).
Note: Amounts are indicated in Rupees (millions).

The expenditure of the government on health care is seen have increased from 13,278.8 million in 2006–07 to 28,044.6 million in 2011–12 in absolute terms (Figure No-4.9). The percentage of the total expenditure (Plan and Non-Plan) also seems to be increasing, from 92 per cent in 2006–07 to 98 per cent in 2011–12.

Table No-4.14 Budgetary Allocation of the Government of Maharashtra for Health Sector During 11th Plan 2007-12

(Rs. in Lakhs)

	11th Plan Outlay	2006-07	2007-08	2008-09	2009-10	2010-11
Maharashtra	496884	33123	52298	110150	88992	26,739.2

Total of All States	6103802	757127	824386	1029238	1196722	1201639

Source: Health, Family Welfare & Nutrition Division, Planning Commission of India.

The per capita health expenditure of all states in India is only Rs. 279 p.a. and that of Maharashtra stood at Rs. Rs. 286 p.a., a little more than the national average. The per capita health expenditure of Mizoram is highest at Rs. 1555 followed by Arunachal Pradesh at Rs. Rs. 1425 and Goa at Rs. 1388 (Table No-4.14).

Table No-4.15 Per Capita Health Expenditure: Urban

	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Maharashtra	**146**	**143**	**158**	**167**	**175**	**174**
Satara	158	181	173	216	207	187

Source: Based on information obtained from the Indian Audit & Accounts Department, Office of The Accountant General (AG) Maharashtra, 2001–07.
Note: Amounts are expressed in Rupees.

Table No-4.16 Per Capita Health Expenditure: Rural

	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07
Maharashtra	**146**	**143**	**158**	**167**	**175**	**174**
Satara	97	113	103	110	128	149

Source: Based on information obtained from the Indian Audit & Accounts Department, Office of The Accountant General (AG) Maharashtra, 2001–07.
Note: Amounts are expressed in Rupees.

Using disaggregated budget data accessed from the districts from 2001–07, it is possible to understand the relative priority given to investments in public health. Per capita health expenditure for rural and urban populations between 2001–02 and 2006–07 across Satara district indicated that it was higher for the urban population per se than for the rural population. Further, rural per capita health expenditure shows in Satara districts have per capita health expenditures lesser than the state average (Table No-4.15 and 4.16).

Current PHC CHC budgets may have to be increased by 10% per year for five years to draw level. The proposal in the Draft NHP 2006 is timely that State health expenditures be raised to 7% by 2011 and to 8% of State budgets thereafter. Indeed the target could be stepped up progressively to 10% by 2025. it also suggests that Central funding should constitute 25% of total public expenditure in health against the present 15%. The peripheral level at the sub center has not been (and may not now ever be) integrated with the rest of the health system having become dedicated solely to reproduction goals. The immediate task would be to look deepening the range of work done at all levels of existing centers and in particular strengthen the referral links and fuller and flexible utilization of PHC/CHCs. Tamil Nadu is an instance where a review showed that out of 1400 PHCs 94% functioned in their own buildings and had electricity, 98% of ANMs and 95% of pharmacists were in position. On an average every PHC treated about 100 patients 224 out of the 250 open 24 hour PHCs had ambulances. What this illustrates is that every State must look for imaginative uses to which existing structures can be put to fuller use such as making 24 hours services open or trauma facilities in PHCs on highway locations etc.[62]

i) HEALTH INFRASTRUCTURE OF MAHARASHTRA - The State has health infrastructure and trained health personnel in public, private and voluntary sectors which provide basic as well as advanced health services. Public health services aims at providing reliable, accountable, adequate, qualitative, preventive and curative health care to the people of the State with focus on improving maternal and child health.

The Public Health Department is the main authority in Maharashtra which plans and impalements public health programmes and schemes on the line with the National

[62] By R. Srinivisan, In- Health Care In India - Vision 2020 Issues And Prospects

Health Policy of the Government of India. Some of the objectives of the Public Health Department of the Government of Maharashtra are:

a) To provide adequate and qualitative preventive and curative health care to the people of the State.

b) To ensure greater access to primary health care by bringing medical institutions as close to the people as possible or through mobile health units.

c) To improve maternal and child health with a view to reducing maternal and infant mortality.

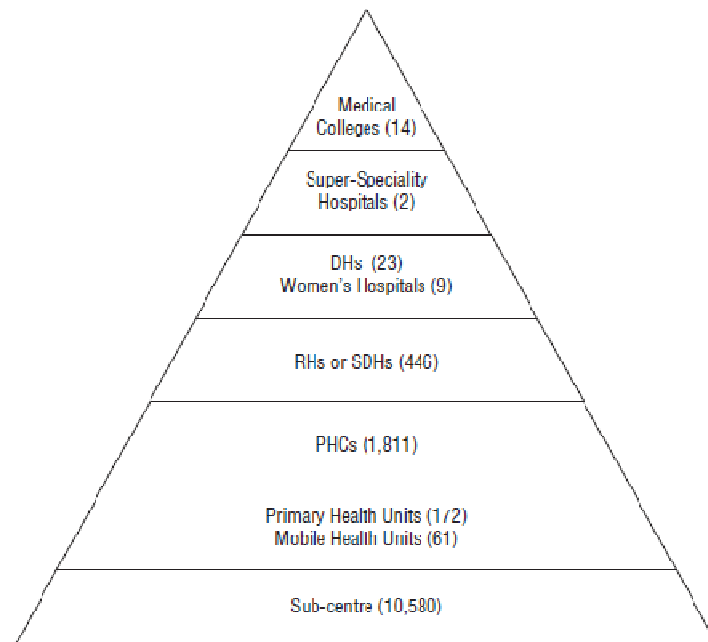
d) To improve hospital services at the secondary levels both in terms of infrastructure and personnel.

e) To give training to doctors, nurses and other paramedical staff to meet the needs of health care in the State by upgrading their skills and knowledge.

f) To implement various national health programmes and evaluation of their achievements and success.

g) To give health education for improving knowledge, attitude and behaviour of the community.

Figure No-4.10 Public Health Care Infrastructure: Maharashtra (2012)



Source: Public Health Department, GoM, Annual Report, 2011–12.

Health infrastructure and facilities are the second important input indicators that help in assessing the available provisioning of effective and timely health care to the population. Maharashtra has an extensive network of health-care delivery institutions, infrastructure and manpower, reaching out to some of the remote areas in the state (Figure No-4.10). There is basically a three-tier public health system that includes community health centres (CHCs), PHCs and sub-centres, RHs, district hospitals (DHs), sub-district hospitals (SDHs) in rural and semi-urban areas. In addition to the public health institutions, private nursing homes and NGOs also are involved in providing health-care services in the state.

Figure No 4.11- Public health infrastructure in the State

(December, 2015)

Type of health institution	No.
Sub-Centres	10,580
Mobile medical units	13
Primary health centres	1,811
Rural hospitals (30 beds)	360
Sub district hospitals with capacity of	
a) 50 beds	58
b) 100 beds	28
General hospitals	4
Orthopedic hospitals	1
District hospitals	23
Super speciality hospitals	2
Mental health institutes	4
Women hospitals	11
TB hospitals	4
Leprosy Hospitals	4
Health and family welfare training institutions	8

Source : Directorate of Health Services, GoM

Source- Directorate of Health Services, GOM

The GoM has created three-tier health infrastructure to provide comprehensive health services to the people especially in rural areas. The primary tier comprises of Sub-Centres, Primary Health Centres (PHC) and Community Health Centres (CHC). The sub-district hospitals spread across rural & semi-urban areas and district based hospitals constitute secondary tier. Whereas, medical colleges with well equipped super-speciality hospitals provide both basic and advanced treatments in all fields of medicine and surgery at tertiary level located in major cities. The details of public health infrastructure in the State are given in Figure No 4.11. Whereas, the detailed series of medical facilities available (public and government aided)[63].

[63] Economic Survey of Maharashtra 2015-16

Figure No-4.12- The Doctor Population Ratio

Year	Number of allopathy RMPs	Estimated doctor population ratio$
2011	63,731	1:1775
2012	67,636	1:1693
2013	73,847	1:1569
2014	79,399	1:1477
2015	83,668	1:1418

$ estimation based on population projected by CSO, GoI

Source : Directorate of Medical Education and Research, GoM

Source- Directorate of Medical Education and Research, GOM

The State has been leading in health care manpower and providing trained doctors to meet its health care needs. The State has the largest number of medical colleges both in allopathic and Indian system of medicine. Based on the data of Registered Medical Practitioners (RMP) in the State for Allopathic, Ayurveda, Unani, and Homeopathy estimated doctor population ratio was 1:1775 in 2011, 1:1693 in 2012, 1:1569 in 2013 and same was 1:1477 in 2014 and 1:1418 in 2015. Figure No-4.12 gives the doctor population ratio for allopathic RMPs in the State[64].

The current conditions of physical infrastructure, staff, access, and usage are laid out here before identifying critical gaps and requirements in infrastructure and services. Issues related to institutions, financing, and policy are discussed in the context of these critical need gaps and the potential role of the private sector in healthcare provisioning in villages is explored[65].

Primary Health Centres (PHCs) comprise the second tier in rural healthcare structure envisaged to provide integrated curative and preventive healthcare to the rural population with emphasis on preventive and promotive aspects. (Promotive activities

[64] Economic Survey of Maharashtra 2015-16

[65] By Laveesh Bhandari and Siddhartha Dutta in Health infrastructure in rural India

include promotion of better health and hygiene practices, tetanus inoculation of pregnant women, intake of IFA tablets and institutional deliveries.) PHCs are established and maintained by State Governments under the Minimum Needs Programme (MNP)/Basic Minimum Services Programme (BMS). A medical officer is in charge of the PHC supported by fourteen paramedical and other staff. It acts as a referral unit for six sub-centres. It has four to six beds for inpatients. The activities of PHC involve curative, preventive, and Family Welfare Services.

Table No-4.17- Health Infrastructure in Maharashtra 1981-2001

	1981	1986	1991	1995	2001
Hospitals	968	1545	2104	4912	3446
Urban %	89.0	89.1	83.6	88.27	89.7
Private %	68.0	72.6	62.7	61.23	87.7
Dispensaries	3139	7259	9202	8320	5852
Urban %	63.6	90.2	91.3	83.89	57.3
Private %	47.4	79.5	82.4	90.14	86.16
Beds	71294	93938	113838	129229	128076
Urban %	91.5	91.7	89.0	82.27	92.8
Private %	37.4	38.4	34.1	47.82	37.3

Source: Health Information of India, CBHI, Govt. of India, various years

(*Note*: Hospital Figures (prior to 1997) are generally inclusive of CHCs, from 1997 excluding CHCs; Dispensaries figures (prior to 1997) are generally inclusive of PHCs, from 1997 excluding PHCs)

ii) Health Infrastructure in Satara

In Satara city is District place area there are Public and private run hospitals. While many of the hospitals in Satara belong to the private sector, a good number of hospitals and health care centers are run by government in Satara. Satara has a network of 18 Government hospital, 17 municipal dispensaries and Primary Health Sub Centre about 400, Anganwadis 640.

Although, these hospitals provide services to poor patients with 10 charges at negligible user fee, many deserving people refrain from using their services or make use of their services as a measure of last resort. There are several reasons for this. The total number of 400 Primary health sub centers in Satara. All these hospitals taken together can accommodate around 11,000 patients with proper bedding and other facilities. Table No-4.17 tells the 2001 shows health infrastructure – private and public and Table No 4.2 Show in the Satara district Public Health Facilities in Satara District.

Table No-4.18- District-wise number of medical institutions and beds per one lakh population, Maharashtra

Satara	Medical Institutions						Beds					
	1961	1971	1981	1991	2000	2011	1961	1971	1981	1991	2000	2011
	0.8	1.3	1.6	3.6	3.3	-	47	19	70	57	51	43

Source: Supplied by Bureau of Economics and Statistics, Government of Maharashtra and Survey by census of India

Table No-4.19- Availability of health care infrastructure facilities in Maharashtra by districts

Satara	Population served per					% in Public sector		% in Urban areas		
	Hospitals	Dispensaries	ISM	All Medical Inst.	Beds	Hospitals	Dispensaries	Hospitals	Dispensaries	Beds
	13703	184016	143124	11710	615	33.7	11.6	95.1	99.5	83.4

Source: Computed on the basis of information in Statistical Abstract of Maharashtra State 1993-94 & 1994-95, Mumbai: Directorate of Economics and Statistics, Government of Maharashtra.

The availability of hospitals and beds Maharashtra and Satara is per 100,000 of population has shown a constant increase. In Satara districts also reported an increase in the population per hospital bed in the public sector over the last decade (Table No-4.18 and 4.19), indicating the need to improve the ratio of such health services on a priority basis.

Table No-4.20 Intake Capacity of Municipal Hospitals and Number of Daily Out-Patients

Hospital	Number of Beds	Daily Out-Patients
Civil Hospital, Satara	222	1279
Sub-Dist Hospital Karad	100	363
Sub-Dist Hospital Phaltan	50	204

Source: Field data.

It was observed by researcher in the field survey that the civil hospitals in Satara District provide services to the inpatients and outpatients with and without supplying medicines to them. The patients, who travel from a long way to these hospitals, only to be attended by the doctors, end up spending towards medicine prescribed and travelling. This when compared to the visit to a private hospital in the Satara district they charge Rs. 100 as fees and with provide medicine, is more than the money spent to benefit public health services in government hospitals. They not only save on the money but these Public Hospitals time saving too are convenient which ables the workers to utilise the whole day for their daily works (Table No-4.20).

Table No- 4.21- Replied of Patients on Accessibility of Testing and Evaluation Facilities in Government Hospitals

Sr. No.	Accessibility of Testing and Evaluation Facilities in Government Hospitals	Number of Patients	Percentage
1	Yes	58	28.01%
2	No	149	71.99%
	Total	207	100%

Source: Field data.

It was open in the field survey that by Researcher:

- 28.1% of the patients replied that Government hospitals at Satara District were well equipped with all testing and evaluation facilities.

- 71.99% of the patients replied that Government hospitals at Satara District lacked adequate infrastructure for testing and evaluation purposes.

Although 71.99% of the patients replied that government hospitals at Satara District lacked adequate infrastructure and evaluation and testing facilities. It was observed that X-ray machines and ECG facilities are often out of order. Many advanced testing facilities are not available in Satara District hospitals and even if those facilities are available, most of the time they are not provided for the lack of staff. When inquired reason for such breakdowns, the hospital staff reported that there is heavy pressure of patients on these machines and therefore, they are used round the clock. They also reported that most of these machines are purchased through government rate contracts which generally supply substandard machines and instruments and there is no maintenance contract for these machines. For efficient functioning, these machines need regular upkeeping and maintenance (Table No- 4.21).

Table No- 4.22- Replied of Patients on Standards of Cleanliness, Food, Sanitation and Hygiene in Government Hospitals

Sr. No.	Standards of Cleanliness, Food, Sanitation and Hygiene in Government Hospitals	Number of Patients	Percentage
1	Excellent	17	08.21%
2	Good	42	20.29%
3	Satisfactory	127	61.35 %
4	Poor	21	10.15 %
	Total	207	100 %

Source: Field data.

It was established in the survey that by Researcher:

- The patients 08.21% to calculate standards of cleanliness, food, sanitation and hygiene in government hospitals to be excellent in Satara District.
- 20.29% of the patients experienced cleanliness, sanitation and hygiene standards in government hospitals to be good in Satara District.
- 61.35% of the patients rated cleanliness, sanitation and hygiene standards in government hospitals to be satisfactory in Satara District while 10.15% of them rated them to be poor.

On an average, most of the patients (61.35%) found the standards of cleanliness, food, sanitation and hygiene in Government hospitals to be satisfactory in Satara District. While government hospitals are charitable institutions and in many cases refrain from adopting "scientific cleaning practices" as it comes at a price, patients were found to be satisfied with the standards of cleanliness and sanitation maintained by the government hospitals at Satara District (Table No-4.22).

Table No-4.23- Reply of Patients on Services of Doctors in Government Hospitals

Sr. No.	Services of Doctors in Government Hospitals	Number of Patients	Percentage
1	Excellent	38	18.36%
2	Good	82	39.61%
3	Satisfactory	51	24.63%
4	Poor	36	17.40%
	Total	207	100%

Source: Field data.

When Researcher asked about the quality of services of doctors in government hospitals at Satara District, it was reported that:

- 18.36% of the patients found quality of doctors in government hospitals at Satara District to be excellent.
- 39.61% of the patients rated the services of doctors in government hospitals at Satara District to be good.
- 24.63% of the patients considered services of Doctors of government at Satara District to be satisfactory.
- 17.40% of the patients attributed the services of doctors in government hospitals at Satara District to be poor.

The researches above analysis reflects that more than half the patients (57.97%) who visited a Government hospital at Satara District for treatment found the quality of services of doctors and their approach towards patients to be above average with 18.36% of the patients rating it to be excellent and 39.61% rating it to be good. Empirical evidences show that patients are generally satisfied with the quality of services of government doctors at Satara District and in many cases people have complaints against other staff and absence of infrastructural facilities in hospitals. In the said survey researcher find, 17.40% of the patients who were dissatisfied with the services of doctors in Government hospitals at Satara District were inpatients. Accessibility of a doctor is a vital factor, especially in case of emergency (Table No-4.23).

Table No-4.24- Reply of Patients on Services of Nurses and Administrative Staff in Government Hospitals

Sr. No.	Services of Nurses and Administrative Staff in Government Hospitals	Number of Patients	Percentage
1	Excellent	08	03.87%
2	Good	25	12.08%

3	Satisfactory	135	65.21%
4	Poor	39	18.84%
	Total	207	100%

Source: Field data.

When Researcher asked about quality of nurses and administrative staff in government hospitals at Satara District, the following replies were obtained from patients:

- The patients 03.87% rated the services of nurses and administrative staff in government hospitals at Satara District to be excellent.
- 12.08% of the patients considered the services of nurses and administrative staff in government hospitals at Satara District to be good.
- 65.21% of the patients have rated the services provided by the nurses and administrative staff in government hospitals at Satara District to be satisfactory.
- 18.84% of the patients found the services of nurses and administrative staff in government hospitals at Satara District to be poor.

On a whole, services of nurses and administrative staff in Government hospitals at Satara District found to be satisfactory which is supported by the reply of 80% of the patients. 18.84% of the patients who rated the quality of services of nurses and administrative staff to be poor reported that the nurses and administrative staff in government hospitals at Satara District behave

arrogantly and are insensitive and unsympathetic to the needs of patients (Table No- 4.24).

Table No-4.25- Percentage of Households Having Tap Water as a Source of Drinking Water, by Districts and Maharashtra (2001 and 2011)

	Tap Water		*Change*
State and District	2001	2011	
Maharashtra	64	67.9	3.9
Satara	69.2	73.4	4.2

Source: Government of India (2011) from Maharashtra Human Development Report 2012

Access to clean drinking water and sanitation has far-reaching implications for health outcomes as well as for the right to health. In this context, focus needs to be placed on the source of drinking water, its availability in sufficient quantities and the right to the water source. Data on the access to water and its availability from the household census of 2011 reveals that in Maharashtra, Satara Districts have shown improvements in the proportion of households having access to tap water by over 4.2% points over the decade 2001–11 (Table No-4.25).

Table No-4.26- Percentage of Households Having Latrines within Their Premises

	Latrine within Premises	
State and District	2001	2011
Maharashtra	36.0	53.1
Satara	24.2	71.1

Source: Government of India (2011) from Maharashtra Human Development Report 2012

In the said Researcher facilitates with Census data which look at the proportion of households having a latrine facility and it is found that in 2011 is 53 per cent. The households in Maharashtra had a latrine facility within their premises. In Satara proportion of households having a latrine facility is within

their premises in the year 24.2% which increase in the year 71.1% is pointing towards 46.9 Increase which is useful way in which such facilities could be made available for common use as well as to promote cleanliness, hygiene and sanitation in the Satara District. Access to latrine facilities within the household premises has shown an improvement by social groups for the state and Satara District, which is an important development as it points towards inclusion in the availability or provisioning of sanitation amenities (Table No-4.26).

F) ACHIEVEMENT OF OBJECTIVES

1. To study and analyze the legal provision with relation to right to health.

The researcher has primarily relied on secondary sources for establishing this objective. In Chapter II International Aspects on Right to Health by Universal Declaration of Human Rights, 1948 (UDHR) Under Article 25- A standard of living adequate for the health, Food, clothing, housing and medical care and necessary social services, Motherhood and childhood are entitled to special care and assistance its focus on wider aspect of right to health. Right to Health came to be incorporated in the International Covenant on Economic, Social and Cultural Rights (ICESCR) before the UN General Assembly in 1966 and adopted in 1976 under Article 12(2) - The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Prevention, Treatment and control of epidemic, Endemic, Occupational and other diseases, Creation of Medical condition its focus on wider aspect of right to health. The Government of India had appointed a number of committees on Health from time to time to advice to the government on framing policies on Right to health issues in India. The reports of these committees have formed an important Basic Requirement and need

of health planning in India. The Bhore Committee (1946) in which the recommendations of said committee and their effect on health care standards and health parameters have been discuss in the chapter 2. It was concluded that the approach of committee had been beginning of right to health within the state of India.

The Researcher has also analysed the health policies announced by the International Level and National Level – Universal Declaration of Human Rights-1948, International Covenant on Economic, Social and Cultural Rights-(ICESCR), Declaration of Alma-Ata on Primary Health Care-1978, The World Health Organisation-(WHO) and various International Convention and on the National Level The Constitution of India well Focus on Right to Health Under Articles 39(e), 39(f), 42 and 47 and SCHEDULE-7 and The National Health Policy 1982, 1983, The National Nutrition Policy-1993 and National Health Policy- 2002, in the chapter 2. The Bhore Committee- 1946 focus on "Right to Health for All"as one of its objectives as early as 1946, the objective has not been achieved in 68 years of independence. First national health policy was formulated and announced by the Government in the year 1982, after 35 years of independence. The policy had set a target of 2000AD for achieving the object of 'Right to Health for All'. However, the contribution of the policy to the right to health care's of the nation Again it was revised in the year 2002. Right to Health in India has considerably improved during last decade.

These policies of the Government of India and various state governments and local governments have been reviewed and evaluated in chapter 3 and chapter 4 in detail. The research concludes that these reviews of policy reports focus on the gap between the

public speaking and reality. Focus on the framework within which the policies have been formulated. Some of the important observations:

(1) Right to health has been an excessive one side with single-reason driven programmes ran by Government.

(2) In the said Research primary health care has been cheap to just primary level care in Satara district.

(3) The health reports and plans mostly intense on building the health services infrastructure without a sense of future planning.

(4) The outline of plan documents and their implementation have been additional rather than being complete aspects of health.

2. To evaluate and study on factors effecting on degrading health care system in Satara District.

One of the major objectives of the present research work was to find out Right to Health as a Basic human Right with Special Reference to Satara District. It was found that in the urban and rural poor do not use public health service for minor illness while for major illness only they have to access public health services. The researcher also tried to find out the reasons why in Satara District give up from using public health services. In the field survey, it was reported that:

(1) 28.01% of the respondents did take the benefits of free medical services provided by the Civil Hospital Satara.

(2) 100% of the respondents aware about free Services in Public Hospitals and availability of free medical services in Civil Hospital Satara.

(3) 71.99% of the respondents attributed lack of adequate facilities in Civil Hospital Satara.

Thus, quality of services is the accessing the services of Civil Hospital Satara by population in the Satara District. Various factors such as long waiting time, lack of adequate stock of medicine or testing facilities, etc., ultimately in or the other way contribute to increased problem of right to health, population is willing to use so called free of cost services of the government hospitals.

The researcher has personally visited Civil Hospital Satara, Karad and Phaltan to assess the health standards and facilities provided to patients there. It was found that health standards and facilities in public hospitals Excellent with 08.21%, Good with 20.29% and Satisfactory with 61.35% with standards of cleanliness and hygiene. The public hospitals were found to be quality as well as in approach, i.e. treatment of patients. Chapter 4 deals with comparative study of public health care system in the Satara District.

3. To analyze the data collected to assess the compliance, the reasons for the non compliance if any.

There has been vast increase in the population of Satara District during last two decades. However, the number of government hospitals is same. At the same time, most of the budgetary provision for public hospitals is spent on the salary and other revenue expense. Thus, public health infrastructure in the Satara District is inadequate to cater to vast population of the Satara District.

CHAPTER V

CONCLUSION

The Indian Constitution and its basic ideas provide a sound framework for thinking about the right to health. In this framework, the right to health is one of the basic Right to Health is a social rights that are essential to achieve, without which Social democracy is at best incomplete. Indeed, there is an clear sense in which mass lack of food is fundamentally incompatible with democracy in any meaningful sense of the term.

The concept of state's responsibility in right to health care or 'health as a right' is important and therefore, the health policies of Government of India could do little to address the medical needs of the unwell at the primary level. The key limitation is the lack of a public health. There is a need to promote better planning and proper execution of public health policies outside the domain of the Ministry of Health and Family Welfare (MOHFW).

The Government of India has announced free medical facilities for population below poverty line. The scheme encompasses public hospitals and selected private hospitals for free treatment of major diseases without any charges up to certain limit. There is always shortage of basic medicines and equipments. Many government hospitals are understaffed.

The right to health is nowhere near being realised in India. In fact, under nutrition levels in India are along with the highest in the world. Further, the improvement of nutrition indicators over time is very slow. There is also some evidence

of increasing disparities in nutritional achievements (between rural and urban areas as well as between teenagers) in the nineties.

The right to health is a rather complex right that does not with pleasure translate into well defined entitlements and responsibilities. The scope for enforcing it through the courts can be significantly enlarged (e.g. by consolidating legal provisions for the right to health), but serious difficulties are involved in making it fully justifiable. Nevertheless, the right to health can bring new interventions within the realm of possibility in at least three different ways- i) Legal action ii) Democratic practice iii) Public perceptions.

The researcher would like to illustrate these different roles of the right to health with the study demonstrated that the inclusive growth not only fails to protect the poorest of the poor but also creates need and variation. As a mitigating strategy to cope up with the financial shocks, unclear right to health seeking behavior of Person, medical treatment of the other members and end up selling their property; consequently about one fifth of the households falls below the poverty line on account of terrible payments of Hospitals.

If the right to health is to be achieved, it needs to be linked with other Right to Life and social rights as well, such as the right to education, the right to work, the right to information and the right to medical care. These right to health and social rights go together and reinforce each other. Taken in loneliness, each of them has its limitations, and may not even be realisable within the present structure of right to health. This is why it is so important to restore the Directive Principles of the Constitution as well as the visionary conception of democracy that informs them.

One safe conclusion is that there are elements of truth in both arguments. But in the view of the researcher is more complex. Yes, the public sector is, almost by definition, not more responsive to consumer requirements. But its services come at a low cost. Given that most chose the public sector itself, gives us enough indication that the current bunch of services with the requirements of the masses. Despite this however, the fact remains that about less per cent could not access right to health care due to lack of funds. It is here that the government can play the important role, if it cannot ensure accessible delivery by the health department.

It is well known that many doctors are not willing to serve in the rural areas due to lack of facilities even if they are paid high salaries. However, as telecom network is spreading swiftly and the government is keen to provide broadband connectivity to all parts of the country, information technology can be effectively harnessed to improve the delivery of health services in rural area.

The Fundamental right to health and health care has been recognized by the Supreme Court. Though this is a major rise there are number of limitations.

I) Fundamental rights are available only against the State and not against private individuals or organizations.

II) The State is required to enforce this fundamental right which is, however, subject to financial availability.

But the positive outcomes have not been that citizens have been using the fundamental right to get better facilities from State hospitals in India, cast obligations on State doctors and on custodial institutions. Prisoners and mentally ill have been held to be equally endowed with this right.

Even so, various questions remain unanswered. If a poor person has the fundamental right to health and health care can person approach the Court and demand that person should be given free treatment at a Government hospital? To what extent can such a free treatment be demanded? Can it be said that the free treatment extends to providing expensive drugs and procedures free of charge? Can it include complex surgeries? Since the right to health care has been recognized as a fundamental right the answers to all these questions should be in the positive. But looking at the approach in which the Courts have been acting in recent times they are likely to say that yes, it is a fundamental right, but subject to the financial capacity of the State. These are the areas in which in the next few years the Court battles are likely to be fight, all the more so because the State has been moving back from the health sector.

A negative fundamental right casts an obligation on the State not to act in a manner that would deprive the subjects of her fundamental right. On the other hand, a positive fundamental right would mandate the State to take proactive measures to fulfil its obligation. Time has come for the Courts to recognize that the right to health and health care is a positive fundamental right that cannot be conditional upon the any capacity of the State. The activists in the health field will have to use both these strategies to urge the state to provide right to health to all citizens and also to stop the state from unleashing commercialization and privatization of right to health care on the other. The Right to Life as the broader framework, the Court rulings would be useful apparatus for all those who join hands to pursue a vision 'Right to Health for all'.

It is evident that the weakness health care system in India is an issue more than poor government policy making. Given India's complicated history and current Social

situation, the policy approach to health never has worked and most likely never will work. The time has come to shift to a rights-based approach. With constitutional provisions, international laws and active discourse, the opportunity exists to create a consensus on the right to health, and ultimately a universal and comprehensive health care system that fulfills that right. Hopefully, this approach is the start to a new and better life in India.

The government must also review its health policy at regular intervals, possibly every two or three years to assess the impact of different schemes and programmes which are run by Government. The government must identify the areas which are covering behind in healthcare services, and special focus must be provided on such areas. Special attention must also be given to the areas which are hit by epidemics, floods, and other natural disasters, because the chances of the spread of disease are greater in such areas. Suitable preventive measures must also be taken by the government in the form of vaccination and creation of better sanitation facilities to stop the occurrences of diseases.

Health is a social, economic and political issue and above all a human right. Inequity and poverty are the root cause of ill health. The current health scenario favours the urban wealthy class, which is only about 10% of the total population. There is a need to remove regional imbalances in societies. Declining health expenditures have adversely affected health outcomes worsening the today's health scenario. There is a need to restructure the existing health system. The National Health Policies did not achieve their targets thus creating a need for a comprehensive legislative framework. There is a need to restructure the existing health system to lead equity and social justice.

This can be achieved through promulgation of a comprehensive legislative framework, which should create conditions conducive to restore the balance in the health sector. The legislation should be complemented by making ‘Right to Health Care’ a fundamental right, which will be an enforceable right. The ultimate aim of Universal Access to Health Care could be achieved through the restructuring of health finance and introduction of universal coverage of health care.

The researcher finds population ratios for RHs have improved slightly, particularly during the last decade of Satara region showing the highest improvement for this indicator (Table No-4.4) and Satara district indicated that it was higher for the urban population per se than for the rural population. Further, rural per capita health expenditure shows in Satara districts have per capita health expenditures lesser than the state average. The availability of hospitals and beds Maharashtra and Satara is per 43 beds for 1,00,000 of population has shown a constant increase in District satara.

The Researcher found in the field survey that all the selected Patients for the present study were aware about the free medical services provided by the Government Hospitals in Satara District. Researcher also finds some Patients that they could get hospitalization on emergency basis in government hospitals, 71.49% of the Patients reported that government hospitals lacked adequate infrastructure and evaluation and testing facilities and most of the time they are not provided for the lack of staff or other issues.

The Researcher finding in Satara District lacked adequate infrastructure and evaluation and testing facilities. It was observed that X-ray machines and ECG facilities are often out of order. Many advanced testing facilities are not available in Satara

District hospitals and even if those facilities are available, most of the time they are not provided for the lack of staff. There is forceful rush of patients in out-patient departments of the Satara government hospitals, Karad Sub district Hospital and Phaltan Sub district Hospital, resulting in long queues and waiting time for patient. But In Case of an average, most of the patients (61.35%) found the standards of cleanliness, food, sanitation and hygiene in Government hospitals to be satisfactory in Satara District.

The researches analysis reflects that more than half the patients (57.97%) who visited a Government hospital at Satara District for treatment found the quality of services of doctors and their approach towards patients to be above average with 18.36% of the patients rating it to be excellent and 39.61% rating it to be good. Empirical evidences show that patients are generally satisfied with the quality of services of government doctors at Satara District and in many cases people have complaints against other staff and absence of infrastructural facilities in District hospitals.

Thus finally the researcher concludes that, right to health for all. Mere legislation or judicial remedies will not serve the purpose. Strict implementation of all existing laws and regulations will go a long way in strengthening the right to health systems in District, state and National level. It is also take in to consideration that, law alone cannot be change position in social, economical, public opinion but education also play an important role. There has be collective effort where Government, Medical Institutions, Regulating bodies, the medical personnel, health workers, NGO's and individuals, everyone has an efficient role to play for better Right to Life with Right to Health.

CHAPTER VI

SUGGESSIONS

1) **Implementing the Universal Declaration of Human Rights, 1948** (UDHR) of Article 25- Right to a standard of living, including food, clothing, housing and medical care and necessary social services, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care with right to enjoyment." By this Government Hospital can become more active in the delivery of right to health provision.
2) **The right to health is an important component of the right to life is Constitutional linked** with our social, economic and political rights. This rights providing some of the context within which the right to health can stand. The Indian Supreme Court has placed great emphasis on guaranteeing right to health as part of the larger goal of achieving social, economic and political, which is also a fundamental right under Indian constitution.
3) **The Right to Health**, as well as other social, economic and political rights needs to be framed in the context of today's reality. Since the 1948 Universal Declarations of Human Rights, the Right to right to life has found open recognitions in a wide range in the international instruments.
4) **Assembly information, feedback from Society** including Old age person, women and Children Ration with right to health which to gather first hand information and accurate and true report of the situation. This kind of

documentation has been a useful mechanism for Government Hospital in State, as well as in Nation.

5) **Formation of networks** to strengthen right to health by bringing large numbers of individuals, Government organisations together on a particular issue. One such example is the Medico Social Friend for awareness, an all-Maharashtra association with individuals from all backgrounds, who have come together to address the health situation in the state and country.

6) **Providing improved right to health care to persons**- The health care needs of every person but often always ignored. There is because of a shortage of doctors and health care professionals trained to deal with health problem, which greatly affects access in Government Hospital. Even when health care is available, the stigma attached to Government Hospital is creates barriers in access to Right to Health care and support. Towards this goal, to some coverage the Declaration of Alma-Ata on Primary Health Care, 1978 and Bhore Committee (1946) with National Rural Health Mission-2005.

7) **Raise awareness and consciousness** about old age person and women's right to health among women, society, Health organisations, Judiciary, Mass Media, State and others. Organising general people's assemblies on Health awareness, meetings with Doctors, workshops on new Health Problems, and lectures for Communities. These were extremely useful in raising public awareness in Large Amount and mobilizing people around right to health issues.

8) **Need of Special Medical Research Centres**- There are very few hospitals which are specialized in the matters of research about the epidemics, hence the

government should establish new medical research centres and hospitals which must be specialized in the treatment of specific diseases and devoted to research in this regard, such as Hematology centers. These special medical research centers must be adequately equipped with the Professional Staff and proper testing facilities with special drugs required to treat. There must be coordination and corporation between this research centers and district level hospitals.

9) **Collection and analysis of data** which is an important tool to verify opinions and making necessary revisions, amendments, etc on right to health. Critiquing policies, programmes, and related documents with the objective of making them comprehensive and gender sensitive. For example, the National Family Health Survey data (2000) showed that among women in the reproductive age group of 15-44 years, deaths occurring due to communicable diseases were more than double the number of deaths due to pregnancy and child birth. This analysis was used to advocate for the need to prioritise and provide facilities and services for communicable diseases[66].

10) **Providing recommendations and suggestions** to improve the existing policies, guidelines, programmes, plans, through participation in meetings and task groups. health movements and other organisations participated in task groups towards identifying gaps and improving the right to Health policy of the National Rural Health Mission.

11) **Health budgets should include and join together infrastructure plans**. simple request for infrastructure funding may face conflict because they are general in nature and do not have effect of directly address right to health problems which

[66] Mohan Rao, EPW, Dec. 2, 2000.

are clear in nature like prevention of spread of infectious diseases, maternal and child health, technical assistants etc.

12) **Decrease urban bias-** right to Health facilities should be developed in the rural sector by public authorities and incentives for the same should be provided to other bodies.

13) Most **Government Hospital facilities have poor infrastructure** in relation to equipment used for medical tests e.g. X-ray, blood tests, and other tests. Such equipment which is mostly imported and very costly. Government can solve this problem. The equipment should be made available in Government hospitals for the public at large with affordable prices.

14) A significant increase is **needed in the number of medical college** and the government should make provisions for better quality of medical professionals to general public.

Questionnaire / Interviewed Patients On “Right To Health As A Basic Human Right With Special Reference To Satara District.”

PATIENT INTERVIEWS

1) **Identification Particulars**

Village:
Taluka:

2) **Patients Profile**

Name of the Patients:

Sex

a) Male b)Female

Age (Tick one)

a) 18-30 years
b) 31-40 years
c) 41-50 years
d) 51-60 years
e) 61-90 years

Marital Status (Tick one)

a) Unmarried
b) Married

Education (Tick one)

a) Illiterate
b) Literate
c) Others (specify……………………..)

Belongs to Religion (Tick one)

a) Hindu
b) Buddhist
c) Muslim
d) Christian

Belongs to Categories (Tick one)

a) General
b) Other Backward Classes
c) Scheduled Caste

d) Scheduled Tribe
e) Minority
f) Other please specify…………………..

Occupation-Present (Tick one)

a) Farmer
b) Worker
c) Businessman
d) Government Employee
e) Retire
f) Others (specify…………………………….)

3) **I would rate on the treatment here I feel (Tick one)**

a) Unhappy
b) Just okay
c) Satisfied
d) Happy
e) Very happy

4) **I would rate on Aware about free Medical Services in Government Hospitals. (Tick one)**

a) Yes
b) No

5) **I would rate on Availability of Testing and Evaluation Facilities in Government Hospitals. (Tick one)**

a) Yes
b) No

6) **I would rate on Long Waiting Time in Government Hospitals. (Tick one)**

a) Yes
b) No

7) **I would rate on Access of Self or Any Family Member in the Public Hospital for only Major Illness. (Tick one)**

a) Yes
b) No

8) **I would rate on Accessibility of Testing and Evaluation Facilities in Government Hospitals. (Tick one)**

a) Yes
b) No

9) I would rate on Standards of Cleanliness, Food, Sanitation and Hygiene in Government Hospitals. (Tick one)

a) Excellent
b) Good
c) Satisfactory
d) Poor

10) I would rate on Services of Doctors in Government Hospitals. (Tick one)

a) Excellent
b) Good
c) Satisfactory
d) Poor

11) I would rate on Services of Nurses and Administrative Staff in Government Hospitals. (Tick one)

a) Excellent
b) Good
c) Satisfactory
d) Poor

12) I would rate the medical care in Government Hospital (Tick one)

a) Very poor
b) Poor
c) Average
d) Good
e) Very good

13) I would rate the overall nursing and therapeutic services in Government Hospital (tick one)

a) Very poor
b) Poor
c) Average
d) Good
e) Very good

14) Would you recommend Government Hospital to other Patients (Tick one)

A) Yes
B) No

If your answer is No, please explain the reason

Questionnaire for Old Age Person

1) **Identification Particulars**

Village:
Taluka:

2) **Old Age Person Profile**

Name of the Old Age Person:

Sex

a) Male b) Female

Age

a) 60-70 years
b) 71-80 years
c) More than 81years

Marital Status

a) Unmarried
b) Married
c) Widowed
d) Separated

Education

a) Illiterate
b) Literate
c) Others (specify……………………..)

Belongs to Religion

a) Hindu
b) Buddhist
c) Muslim
d) Christian

Belongs to Community

a) General
b) Other Backward Classes
c) Scheduled Caste
d) Scheduled Tribe
e) Minority
f) Other please specify….

Occupation-Present

a) Farmer
b) Worker
c) Business
d) Government Employee
e) Retire
f) Others (specify……………………..….)

3) Please tell us about the new Act for Older Persons, Do you know this Act?

a) Yes
b) No

4) Do you know the welfare and development programme implemented for older person in you areas?

a) Yes-1
b) No-2

5) If yes what are they? (Please mark

a) Social Security programme
b) Health programme
c) Old Age Pension
d) Widow pension
e) Physical security is provided
f) Essential services are easily available
g) Entertainment facility are created
h) New Papers and Television accessibility are available
i) People regards the Older people in General
j) Attitude of the younger generation are cooperative and supportive toward the older people
k) Other (specify)…………………..

6) Impact of new legislation for older person

a) Good
b) Bad
c) No comments

7) If yes which type of old age home are good for older people

a) Government run old age homes
b) NGO run old age homes
c) Other (specify)

Signature of the Investigator
Date:

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EXECUTIVE SUMMARY

UGC – MINOR RESEARCH PROJECT

File No. 23-348/12(WRO) dated on 20/02/2013

"A Study On Right To Health As A Basic Human Right With Special Reference To Satara District"

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Period: 15.04.2013 to 10.03.2016

EXECUTIVE SUMMARY REPORT

The right to healthcare is first and foremost a claim to an entitlement, a positive right, not a defensive fence. As advantaged rights are contrasted with privileges, group ideals, communal obligations, or acts of charity, and once legislated they become claims justified by the laws of the state. The emphasis thus needs to shift from 'respect' and 'protect' to focus more on 'fulfil'. For the right to be effective optimal resources that are needed to fulfil the core obligations have to be made available and utilized efficiently.

The study also identifies the factors that lead to non-utilisation of public health services in the Satara District, which has more public health facilities compared to any other parts of the country. This raises the question that although the services may be available, the access to Right to Health is determined by several other factors. In short, the results present a forceful plea for greater attention to the allocation and quality of Right to health care services for poor and needy, accessible to Every Human Being As Part of Human Rights.

Right to life is considered one of the fundamental rights, and health is one of the vital indicators reflecting quality of human life. In this context, it becomes one of the primary responsibilities of the state to provide health care services to all its citizens. India, despite being a signatory to the Alma Ata Declaration of 1978, which promised 'Health for All' by 2000, is far from realising this objective. In India has required an

excellent health care structure that has the potential to reach a large section of the population.

In today scenario, we share several fundamental Right, all of which center on the equal dignity and value of all human beings in universe. In case of human rights and health equity efforts can be strong by growing awareness and understanding of the person in importance of social conditions for Right to health. And right to health is promoting social conditions are an essential prerequisite for right to health.

Come within reach of from the field of Right to health can strengthen efforts to protect and promote the right to health with the highest attainable level of health and care, by extension activity of the government at large, the right to health is the social conditions essential for health public at large, by indicating how to operational these concepts for the purpose of quantity, which is essential for accountability by Government Authority.

Now a day effective steps need take to implement the constitutional obligation upon the state to secure the right to healthcare and strength of people. It was rightly said that nutrition, health & education are the three inputs accepted as significant for the development of human resources. For achieving the Constitutional obligation and also objectives of Right to Health care for all there is a need on the part of the government to mobilize organization and the general public towards their participation for monitoring and implementation of right to health care facilities to needy person of the society at large.

Systematic and analytical studies on the needs of the elderly in India and Maharashtra as well, both urban and rural, are required to Primary substance to for Protection right to health care of elderly people with Special reference to Satara.

The increasing number of older persons in India. Government is failure to put a strain on health care and social care systems in the country. Old age comes with lot of with advancing age, old persons have to cope with health and associated problems some of which may be chronic, of a multiple nature, require constant attention and carry the risk of disability and consequent loss of autonomy. Some health problems, especially when accompanied by impaired functional capacity; require long term management of illness at time, and of nursing care. In case of large number of elderly persons in the

population, the country needs more health and medical services, facilities and resources. More number of hospitals, doctors, nurses is required. Government spending on health care is increased with the increase of average age of population.

Satara district is located in the south western part of the state of Maharashtra and lies between 17.5° to 18.11°North Latitudes and 73.33° to 74.54° East Longitudes. According to 2011 census the District Satara covers an area of 10480 sq. kilometers and has a population of 30,03,900 out of the total geographical area of 10484 sq. kilometer, 10123.5 sq. kilometers is rural and 360.5 sq kilometers is urban area. It occupies 2.7% part of the Maharashtra state and 9.3% of the total Population of the India.

There has been vast increase in the population of Satara District during last two decades. However, the number of government hospitals is same. At the same time, most of the budgetary provision for public hospitals is spent on the salary and other revenue expense. Thus, public health infrastructure in the Satara District is inadequate to cater to vast population of the Satara District.

The researcher has personally visited Civil Hospital Satara, Karad and Phaltan to assess the health standards and facilities provided to patients there. It was found that health standards and facilities in public hospitals Excellent with 08.21%, Good with 20.29% and Satisfactory with 61.35% with standards of cleanliness and hygiene. The public hospitals were found to be quality as well as in approach, i.e. treatment of patients. Chapter 4 deals with comparative study of public health care system in the Satara District.

One of the major objectives of the present research work was to find out Right to Health as a Basic human Right with Special Reference to Satara District. It was found that in the urban and rural poor do not use public health service for minor illness while for major illness only they have to access public health services. The researcher also tried to find out the reasons why in Satara District give up from using public health services. In the field survey, it was reported that:

(1) 28.01% of the respondents did take the benefits of free medical services provided by the Civil Hospital Satara.

(2) 100% of the respondents aware about free Services in Public Hospitals and availability of free medical services in Civil Hospital Satara.

(3) 71.99% of the respondents attributed lack of adequate facilities in Civil Hospital Satara.

Thus, quality of services is the accessing the services of Civil Hospital Satara by population in the Satara District. Various factors such as long waiting time, lack of adequate stock of medicine or testing facilities, etc., ultimately in or the other way contribute to increased problem of right to health, population is willing to use so called free of cost services of the government hospitals.

If the right to health is to be achieved, it needs to be linked with other Right to Life and social rights as well, such as the right to education, the right to work, the right to information and the right to medical care. These right to health and social rights go together and reinforce each other. Taken in loneliness, each of them has its limitations, and may not even be realisable within the present structure of right to health. This is why it is so important to restore the Directive Principles of the Constitution as well as the visionary conception of democracy that informs them.

The researcher finds population ratios for RHs have improved slightly, particularly during the last decade of Satara region showing the highest improvement for this indicator and Satara district indicated that it was higher for the urban population per se than for the rural population. Further, rural per capita health expenditure shows in Satara districts have per capita health expenditures lesser than the state average. The availability of hospitals and beds Maharashtra and Satara is per 43 beds for 1,00,000 of population has shown a constant increase in District Satara.

The Researcher finding in Satara District lacked adequate infrastructure and evaluation and testing facilities. It was observed that X-ray machines and ECG facilities are often out of order. Many advanced testing facilities are not available in Satara District hospitals and even if those facilities are available, most of the time they are not provided for the lack of staff. There is forceful rush of patients in out-patient departments of the Satara government hospitals, Karad Sub district Hospital and Phaltan Sub district Hospital, resulting in long queues and waiting time for patient. But In Case of an average, most of the patients (61.35%) found the standards of cleanliness, food, sanitation and hygiene in Government hospitals to be satisfactory in Satara District.

The researches analysis reflects that more than half the patients (57.97%) who visited a Government hospital at Satara District for treatment found the quality of services of doctors and their approach towards patients to be above average with 18.36% of the patients rating it to be excellent and 39.61% rating it to be good. Empirical evidences show that patients are generally satisfied with the quality of services of government doctors at Satara District and in many cases people have complaints against other staff and absence of infrastructural facilities in District hospitals.
Suggessions As Following

- Implementing the Universal Declaration of Human Rights, 1948
- The right to health is an important component of the right to life is Constitutional linked
- The Right to Health, as well as other social, economic and political rights needs to be framed in the context of today's reality.
- Assembly information, feedback from Society including Old age person, women and Children relation with right to health.
- Formation of networks to strengthen right to health by bringing large numbers of individuals, Government organisations together on a particular issue
- Providing improved right to health care to persons- The health care needs of every person but often always ignored.
- Raise awareness and consciousness about old age person and women's right to health among women, society, Health organisations, Judiciary, Mass Media, State and others.
- Need of Special Medical Research Centres.
- Health budgets should include and join together infrastructure plans.
- The equipment should be made available in Government hospitals for the public at large with affordable prices.
- Needed in the number of medical college.