

Right To Health – Whether It Has Been Denied To Commoners In India?

*Dr. Manidipa Chatterjee

(Assistant Professor, Institute of Business Management of National Council of Education Bengal, under
Jadavpur University, Kolkata, India)

Corresponding Author: Dr. Manidipa Chatterjee

Abstract: *Though India is having a population of 1.34 billion, its dysfunctional Public health system continues to pose a grave threat to the health of common Indian patients. Though country's booming Private healthcare industry serves the wealthy and a growing upper middle class but still majority of the poor and low income group citizens are denied accessibility to quality health care in India. Keeping in mind the "Right to health" as a Fundamental Right of every citizen irrespective of caste, creed, religion, economic and social status, this paper attempted to investigate how far and to what extent accessibility towards "Right to health" has been protected for commoners. Mostly through various secondary sources comparisons have been made between Indian Public and Private health care delivery system as well as India's position with respect to other developing and developed nation in terms of health care spending as a percentage of GDP. Facts, figures and case studies also substantiated the fact that there exist lot of gap between the policy formulation and implementation both at the Central and State level. Good Governance, appropriate vision to use Information Technology, active and joint Public-Private Partnership are some of the recommendations that are pointed out as the need of the hour in order to make the term "Right to health" more meaningful for commoners' in India.*

Keywords: *Right to health, Health care delivery system, Public Private Partnership*

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I. INTRODUCTION

According to WHO organization "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease." In recent years, this statement also means 'socially and economically productive life'. By explicitly including the mental and social dimensions of well being, WHO (World Health Organization) had radically expanded the scope of health as an extension of the roles and responsibilities of the health care professionals and their relationships to the larger society.

The Constitution of India not only provides for the "Right to health" as a Fundamental Right but directs the state to take steps to improve the condition of health care of the people. Thus the preamble to the Constitution of India, inter alia, seeks to secure for all its citizens justice-social and economic. It provides a framework for the achievement of the objectives laid down in the preamble. The preamble has been amplified and elaborated in the Directive Principles of State policy. Some of the articles like Art.38, Art 39(e), Art 41, 42, 47 are all depicting that it is the primary duty of the State to look after the health and well being of all its citizens including workers, mother, adolescent, children and old age people including the physically disabled or handicapped so that every body under the Constitution of India should get accessibility to primary health care provisions securing just and human conditions of work and protecting all from health hazards and environmental pollution.

Despite India's impressive economic progress, its dysfunctional Public health system continues to pose a grave threat to the health of Indian patients. India has a large population of about 1.34 billion people. The country's thriving Private healthcare industry serves the wealthy and a growing upper middle class. Life expectancy has risen to about 68 years from 58 over the last two decades. However, the majority of the population is still are poor and resides in rural areas and cannot afford private healthcare. Most of the population relies on the country's overstretched and under-funded Public health system. Efforts to double national healthcare expenditures fell short in the past.

II. OBJECTIVE OF THE PAPER

In this paper a brief attempt has been made to find out the present Public health care system and how far common and poor people in India are getting accessibility to their basic health care needs.

III. METHODOLOGY

Mostly the facts and figures are taken from secondary data sources i.e. with the help of case studies, various literature reviews from journal, websites and newspaper clippings.

IV. BACKGROUND OF THE STUDY

a) Right to Adequate health and Human Right Movement

The Universal Declaration of Human Rights (UDHR) articulates right to adequate health in Article 25:

“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...”

UDHR Article 25 contends that states must also take action to ensure that all citizens enjoy an adequate standard of living. It recognizes food, clothing, housing, health care and social services as essential components of a standard of living adequate for health and well-being. Defining the precise standards that must evaluate these components is difficult since states with different economic and social histories and capacities have different understandings of an “adequate standard of living”.

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) defines the right to adequate health in a relative fashion:

“... the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

In this statement however it is not clear whether the “highest attainable standard” should be assessed with respect to the economic infrastructure of a single nation or with respect to the global community. Certainly, in some cases the highest attainable standard of living that a nation can provide does not satisfy the existing consensus on the minimum health-related rights to which all people are entitled (i.e., vaccines, physical therapies, geriatric care). Partially because many governments in developing world cannot provide adequate health care and living conditions for all their citizens, their populations suffer disproportionately from various diseases that can only be prevented or cured in developed nations. As for example according to the current World Health Organization (WHO) estimates 1.7 million people die annually in developing countries from diseases resulting from water pollution and inadequate sanitation.

Thus unlike many other International Rights the right to adequate health is not contained in a single specific treaty, but is influenced from various treaties and resolutions. While the treaty language varies across UN documents but the three key concepts are:

- States have the responsibility to guarantee their citizens the right to adequate health. When for whatever reason they are unable to do so, the international community must assume that responsibility.
- States have the responsibility to ensure that none of their citizens are deprived of this right by state action.
- These rights are guaranteed to all citizens, regardless of race, religion, gender, age, or social standing in the community, or other status.

This above final point deserves special consideration since discrimination is practiced against people in all nations of the world in ways that may not be immediately visible. A person’s race, sex, religion and social standing can affect the quality of care he or she receives. Sometimes a state or a health care facility explicitly denies care members of a specific group; at other times such discrimination is a matter of practice rather than official policy. In addition, the poor in both developed and developing countries may be denied health care because they cannot afford it. The concentration of health facilities in cities excludes many rural people. Finally, minority religious and racial groups are often forced—intentionally or due to their own poverty—to live in areas where substandard sanitation and filthy water damage human health. The very young and the very old, both of which have special needs, are especially vulnerable to the effects of poor health care. Thus the right to adequate health operates directly or indirectly as a prerequisite to all other human rights recognized in treaties; to deny someone health care is to deny all rights of the individuals.

V. PRESENT STATUS OF THE PUBLIC VIS-A-VIS PRIVATE HEALTH CARE SYSTEM IN INDIA

Today Healthcare has become one of India’s largest sectors - both in terms of revenue and employment. Healthcare comprises hospitals, patient’s care, medical devices, clinical trials, outsourcing, telemedicine, medical tourism, health insurance and medical equipments. The Indian healthcare sector is growing at a brisk pace due to its strengthening coverage, services and increasing expenditure by Public as well Private players. India's competitive advantage lies in its large pool of well-trained medical professionals. India is

also cost competitive compared to its peers in Asia and Western countries as for example the cost of surgery in India is about one-tenth of that in the US or Western Europe.

The overall Indian healthcare market today is worth US\$ 100 billion and is expected to grow to US\$ 280 billion by 2020, a compound annual growth rate (CAGR) of 22.9 per cent. Healthcare delivery which includes hospitals, nursing homes and diagnostics centers and pharmaceuticals constitutes 65% cent of the overall market. There is a significant scope for enhancing healthcare services considering that healthcare spending as a percentage of Gross Domestic Product (GDP) is rising both at the Central and State level. Again Indian medical tourism industry is pegged at US\$ 3 billion per annum, with tourist arrivals estimated at 230,000 and is expected to reach US\$ 6 billion by 2018, with the number of people arriving in the country for medical treatment set to be doubled over the next four years.

With greater number of private hospitals getting accredited and receiving recognition, and greater awareness on the need to develop their quality to meet international standards some states like Kerala aims to become India's healthcare hub in five years. This is mostly visible among the expanding private health care sector.

Let us focused on some of the following case studies collected from different sources and literature and newspaper clippings:

a) Cases: The following are the incidences which were reported in the year 2016:

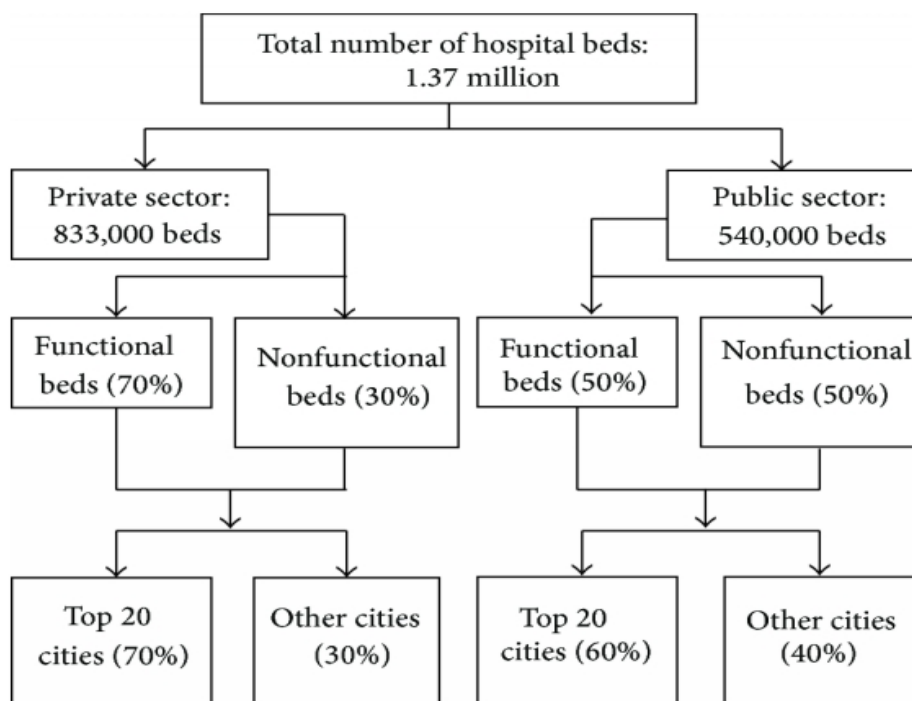
- *September 2 2016— A man in Odisha's Malkangiri district walked 6 km with his seven-year-old daughter's body as the ambulance transporting them to the hospital left them midway after learning that the girl has died.*
- *August 30 — A man lost his ailing 12-year-old son on his shoulder after the state-run Lala Lajpat Rai Hospital in Kanpur sent him to a children's hospital, 250 metres away, without providing an ambulance, stretcher or wheelchair.*
- *August 27 — A man was forced off a bus with his five-day-old baby and mother-in-law, after his ailing wife died in the vehicle in MP's Damoh district.*
- *August 25 — Pulling his sobbing daughter, a tribal man in Odisha's Kalahandi district carried his dead wife for more than 10km because he had no money for transport and the government hospital, where she died, refused him an ambulance.*
- *The scenario at one of the premier Government Hospital in North Delhi is pitiable with chaos at the gynecology ward, hundreds crowding the floor, young women in labor pain and their families, all scrambling for space as they wait for their turn. There are open dustbins with possibly infectious medical waste, plastic bottles, broken windows, all inside the labor ward. Sources in the hospital say the medical staff is grappling with shortage of basic resources like beds, surgical gloves and saline drips, something denied by the medical superintendent.*
- *In one of the study by Bajpai (2014) on challenges confronting public hospitals in India the author had the opportunity of monitoring various health care facilities primarily in the states of Uttarakhand and Uttar Pradesh, while working as a consultant with the National Health Systems Resource Center, a technical advisory body of the Government of India under the Ministry of Health and Family Welfare. The UPA (United Progressive Alliance) Government launched the ambitious "National Rural Health Mission" (NRHM) in 2005 to bolster the rural health infrastructure. After completion of the first phase in 2012 the mission was then in the second phase of its implementation. To begin with, the mission was meant to bring the EAG (Empowered Action Group) states which lagged far behind the rest of the country in health infrastructure, at par with the rest of the country. According to the opinion of the author, the main challenges confronting the Public hospitals today are as follows:*
 - *deficient infrastructure*
 - *deficient manpower*
 - *unmanageable patient load*
 - *equivocal quality of services*
 - *high out of pocket expenditure*

As a result, many of the Government run hospitals are outdated, understaffed, and not hygienic. Patients in public hospitals frequently sleep two to a bed. Hospitals have low supplies of medical devices, forcing many patient families to buy their own. Some families have claimed to spend up to several thousand rupees of their own money on medical supplies. In addition, many of the hospital supplies are not properly sanitized. Hence, bacterial contamination is a very common phenomenon. Even in the many Government facilities, millions of square feet of space is left unutilized across India, expensive medical equipment, lack of qualified healthcare professionals etc are adding to the –woe, Yet it is not seen that enough initiatives that are

happening to address holistically in this regards . Negligence of the maintenance of hospitals in Delhi has led to their grim state. Apart from the dirt and filth, the hospitals lack basic infrastructure and medicines. "Everything...medicines, cotton, bottles, there's scarcity of everything" said a doctor. These Government hospitals tell the same story of most government hospitals in the national capital.

VI. COMPARISON OF HEALTH CARE FACILITIES OF INDIA COMPARED TO OTHER COUNTRIES

A comparison of availability of hospital beds per 1000 population between India and some of the much poorer countries than India shows the insufficiency of country's health infrastructure.



Source: (R. Mehta, B. Gulshan, A. P. Singh, and M. Khejriwal, "A Peek into the Future of Healthcare: Trends for 2010, Technopak perspective: A quarterly report," Quoted in 'High Level Expert Group Report on Universal Health Coverage for India, Instituted by Planning Commission of India, 2010).

One can clearly conclude from the flow chart above that there is a concentration of available beds in a tiny proportion of bigger cities. If the same beds were to be more equitably distributed between cities and between urban and rural areas, availability of the same infrastructure would have gone a longer way in reducing the curative needs of the people.

The deficiency of specialists in rural healthcare is as high as more than 90 percent in Chhattisgarh, Jharkhand, and Rajasthan, while being at nearly 86 percent in Uttarakhand, and Odisha. For example, the total rural population of Bihar was 92.07 million as per 2011 census, whereas the total number of required doctors (specialists and GDMOs) in rural health set-was only 2773. This would amount to only 0.3 doctors per 10,000 rural populations which by no standard is desirable. Even after seven years of implementation of NRHM (National Rural Health Mission), there remains a wide gap in the availability of doctors in the rural areas between the non-EAG states and EAG states but in the former, it is 2.25 times more. (Source: based on data taken from RHS Bulletin, 2012)

These deficiencies of human resources like various categories of paramedical personnel in the public rural healthcare system occurs at all levels on one hand, there is unwillingness of doctors and other health personnel to serve in rural areas; and on the other hand, even in the urban areas, there is the dominance for profit making private health sector, thereby putting their services beyond the reach of the majority of poor in the country

Secondary or tertiary level Public hospital in bigger cities is today saturated due to a heavy rush of patients. The huge unplanned increase of Indian cities had resulted in urbanization of rural poverty causing

expansion of slums and marginal populations starved of health and other basic amenities. Deficiency of urban health infrastructure, overcrowding in hospitals, lack of outreach poor health care delivery system, social exclusion, unavailability or ignorance of information for accessing modern health care facilities and lack of purchasing power of the people are some of the issues that have been identified as challenges to urban healthcare in the country. The growing dominance of private healthcare has resulted in developing certain services of public hospitals. Some of the steps in this direction have been outsourcing of many services in public hospitals such as security, laundry, cleaning, kitchen services and in some cases even the diagnostic and curative facilities on Public-Private Partnership (PPP) mode.

a) Average Spending on Health Care in Major States in India:

Inspite of Prime Minister Narendra Modi’s announcement of Rs 24,000-crore national health protection scheme little has changed in reality. Since health is a state subject, wide disparities exist in delivery and access of health care between states, rural and urban population. So allocation for health sector has risen marginally or remained stagnant over the past six years across states — average of 4.4% of the annual health spending of India’s 17 largest states.

Major States in India	Average Annual Health spending as a % of total spending between 2010-11 to 2015-2016
Delhi	10.1
Haryana	3.6
Bihar Orissa	3.6
Madhya Pradesh	3.9
Maharashtra	3.9
Jharkhand	4.0
Karnataka	4.2
Chattisgarh	4.2
Punjab	4.2
Andhra Pradesh	4.4
Tamil Nadu	4.5
West Bengal	4.6
Gujarat	4.9
Uttar Pradesh	4.9
Rajasthan	5.4
Kerala	5.4
Goa	5.7

(Source: Budget Document of the State Government, World Bank Report)

From the above table it is revealed that Delhi remains India’s best performing state, where the average spending is 10.1% of its total spending since 2010-11. The National Capital and Rajasthan are the only two states where health outlay had increased by 2% or more of their total spending since 2011. Apart from it, most other states, feels that there is no need to allocate more. According to Bihar health Secretary J. Srivastava, increasing health spending from 3.3% in 2011 to 4.1% in 2015-16 considerably improved the delivery system and according to him where the average daily patient footfall in the out-patient departments (OPD) of Government-run hospitals was 10,408 in 2016, which was only 39 in 2005 which further established the success of implementation of health care delivery system to poor people in Bihar. Among the states Harayana’s average health spending in proportion to state budget (2010-11) was the worst.

b) India’s Position in Health Care in Comparison with Other Countries as a Percentage of GDP

Again the following table shows India’s health spending as a % of GDP was only 4.7% and ranked 163 among 204 listed countries.

COUNTRIES	Health spending as a % of GDP with rank	
US	17.1% (1)	Top Three Rank
Marshall Islands	17.1% (2)	
Tavalu	16.5% (3)	
East Timor	1.5% (204)	Bottom Three Rank
Laos	1.9% (203)	
Turkmenistan	2.1% (202)	
Nepal	5.8% (121)	India and its Neighbours
China	5.5% (135)	

India	4.7% (163)	
Srilanka	3.5% (186)	
Bangladesh	2.8% (196)	
Pakistan	2.6% (199)	

(Source: Budget Documents of the State Government, World Bank)

A report published by Global Burden of Disease (GBD) in The Lancet (*source* <http://thelancet.com/gbd>) revealed that India has recorded a poor health care index than several neighboring Asian nations, including Bangladesh, Bhutan, Sri Lanka and China in last 25 years. The data, in the report, takes a look at 195 countries, between the years 1990-2015, and assesses the measuring mortality rates from 32 diseases which should not be fatal in presence of effective medical care.

The results also showed that India, in spite of socio-economic growth in the given time-period, has not managed to achieve its goals in health care sector. India's health care index has seen an increase of 14.1 in last 25 years, going up from 30.7 in 1990 to 44.8 in 2015, but the numbers are much lesser than Sri Lanka (72.8), Bangladesh (51.7), Bhutan (52.7) and Nepal (50.8). The report shows that India has performed the worst in preventing deaths by Neonatal disorders, with an index rate of 14.

In dealing with rheumatic heart diseases, India has scored an index of 25; in tuberculosis an index of 26 and in chronic kidney diseases an index of 20. Diabetes (38), Appendicitis (38) and Peptic ulcer disease (39) are other major area of concerns for India's health department. Pakistan and Afghanistan remain the only SAARC nations to have a lower ranking than India with a healthcare index of 43.1 and 32.5 respectively, as per the report. Thus accessibility of health care and right to get all health care facilities are still a long way to go for commoners and poor income group citizens of this country compared to other developing nations other than Pakistan & Afghanistan.

c) India's Overall Position in Health Care Compared to China

China and India are similarly huge nations currently experiencing rapid economic growth, urbanization and widening inequalities between rich and poor. They are dissimilar in terms of their political regimes, policies for population growth and ethnic composition and heterogeneity. The study by Dummer & Cook (2009) compares health care in China and India within the framework of the epidemiological transition model and against the backdrop of globalization. This study identifies similarities and differences in health situation. According to this study for both countries, infectious diseases of the past and the present emerging infectious diseases and chronic illnesses associated with ageing societies are major problem areas, although the burden of infectious diseases is much higher in India.

Whilst globalization contributes to widening inequalities in health care in both countries--particularly with respect to increasing disparities between urban and rural areas and between rich and poor but there is evidence that local circumstances are important, especially with respect to the structure and financing of health care and the implementation of health policy. For example, India has huge problems providing even rudimentary health care to its large population of urban slum dwellers whilst China is struggling to re-establish universal rural health insurance system. In terms of funding access to health care, the Chinese state had traditionally supported most costs, whereas private insurance had always played a major role in India, although recent changes in China have seen the burgeoning of Private health care system.

China arguably, had more success than India in improving population health, although recent reforms have severely impacted upon the ability of the Chinese health care system to operate effectively. Both countries are experiencing a decline in the amount of Government funding for health care and this is a major issue that has to be addressed by both Nation.

VII. SUGGESTIONS

- Government had announced several programme to increase the access to affordable drugs are praiseworthy but the outcomes are yet to be seen. At the state level the introduction of centralized procurement system in Delhi and some other states resulted in the drop in drug prices and increased drug availability in public health care facilities. Central Government attempted to regulate the prices of some essential medicines through DPCO (Drug Price Control Order) with the aim of decreasing monthly drug bill burden of the patient, suffering from chronic life – style disorders. Thus supply of the free drugs and diagnostics needs to be substantiated through proper supply chain management.
- India is still facing the challenges to give access to new innovation drugs, complex regulatory mechanism, and compliance to quality and sub-optimal infrastructure. Quality control needs to be strengthened to counter spurious drugs and at the same time regulatory hurdles hindering innovation needs to be reduced.
- Today due to rapid urbanization, increase of aging population and growing uses of tobacco and alcohol there is a growing burden of Non-communicable diseases (NCD) like cardio-vascular disorder (21%),

chronic respiratory diseases (12%), Cancer (7%) and Diabetes (2%) are today leading causes of increased mortality and morbidity among the masses which is much ahead of death due to injuries & communicable diseases, maternal, prenatal and nutritional condition. Patients have to bear huge cost of treatment from NCD diseases which is almost double that of communicable diseases. It is estimated that Indian Economy set out to lose 4.58 trillion USD before 2030 due to NCD and mental health condition.

- Though Central Government had launched various schemes like National Cancer Control Programme, National Tobacco Control Programme, National Programme for Prevention and Control of Cancer, Diabetes, CVD & stroke (NPCDCS) and National Programme for health care of the elderly (NPHCE), but there is a need for strong monitoring and evaluation of these schemes.
- The staffing problem is acute in health care sector today in India. Currently there is only one doctor per 1700 people in India, where as WHO stipulates a minimum ratio of 1:1000. There are around 6 to 6.5 lakh doctors available where as an additional 4 lakhs doctors would be required by 2020 to fulfill the health care goal. Again majority of the medical colleges and educational institutions are located in the urban areas and mere 4.6% of the total seats are located in the rural areas. Concrete steps need to be identified for improvement in the availability of doctors, nurses and paramedical staff. Need to introduce more infrastructure and beds in Government hospitals as well as more Government Medical colleges need to be constructed specially in the remote part of the country which can give quality medical education at par with International Standard of Health Care.
- Need for discussion around universal health insurance scheme for the masses and restructuring of the Government insurance scheme to ensure smooth implementation and payment process is the need of the hour.
- Strengthening of the public health facilities, joint effort through PPP model (Public Private Partnership) in establishing Clinical Practice guidelines like Indian Public Health standard (IPHS) and integrating NCD (non-communicable diseases) training into training curriculum of the health force can be a major step towards making health services more accessible for the commoners.
- More uses of ICT tools, patient's survey, survey of medical and paramedical professional and integration of IT with health care on the part of the Government will enable to find the reasons for dysfunctional areas of health care services there by planning for their remedies. This can help in modifying the existing health care policies which will make health care services more accessible to the people of India residing at the remotest corner of the country.

VIII. CONCLUSION

Today in India private health care facilities is almost out of reach of the average and poor Indian due to their high cost. As a result there are several cases of medical negligence and over billing that are noticed in private hospitals not only in India in many of the states throughout the country.

Recently at least a proactive endeavour has been taken by one such state in India i.e. West Bengal through the introduction of the West Bengal Clinical Establishment (Registration, Regulation & Transparency) Bill, 2017. This bill is aimed at setting up a commission in West Bengal that will look into the incidence of medical negligence and over-billing of some private hospitals in the state. The commission will be Government appointed. Though the effort is really praiseworthy but since Government hospitals and doctors are not coming under its purview, many private health care groups in West Bengal put up their objection and this issue is still debatable. According to some private players and doctors it is unfair and unethical to exclude the Government hospitals and doctors since majority i.e. 70% of the patient of West Bengal are mostly coming from lower socio-economic background and are compelled to admit critical patient to Government hospitals due to the high treatment cost of the private players. According to them the rate of the medical negligence and unethical practices are more in Government hospitals, so they suggested that Government hospitals staff and doctors in West Bengal should also come under the purview of this bill.

But many other who supported this bill claim that shortages of health care infrastructure at primary, secondary and tertiary level, along with insufficient staffing can be one such major causes of Government hospitals not being able to admit some patients due to over-crowding and bed unavailability rather than some incidence of medical negligence or individual unethical practices. Again in case of private health care in India regulatory hurdles, lack of physical and tax incentives, high cost of infrastructure including land and medical devices leads to higher delivery cost and high cost of operations in order to maintain the quality. These again make private health care totally unaffordable for the average to low income group people.

But this is not the right time to create commotion and delusion between private and public health care facilities but this is the high time for more integration & collaboration between the two sides of health Care system. So, large health care funding program, social security, transparency in terms of price control of drugs and its delivery, good governance, appropriate vision of the Government to use Information Technology and

active joint Public-Private Partnership (PPP) models are the need of the hour that can transform Indian Health care system to a new dimension and make the term “Right to health” more meaningful for commoners’ in India

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Dr. Manidipa Chatterjee, presently working as an Assistant Professor at Institute of Business Management of National Council of Education Bengal, under Jadavpur University, Kolkata, India. She had done her Ph.D. in the area of Organization Behaviour from University of Calcutta, Department of Commerce. Her specialization and

teaching areas are in the area of Human Resource Management, Industrial Relation & Organizational Behaviour. She is having a vast academic experience of nearly 13 years in the area of Management Teaching. She is also involved in imparting training and conducting Management Development Programmes in Business Schools and corporate houses. She had already published various research papers in National and International Journals. She had in her credit various best paper awards and medals from International, National Seminar and Symposium from esteemed institute like Benaras Hindu University (BHU), Institute of Management Science (IMS, Noida) , IIM (Lucknow) etc.

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