REHOMING PUBLIC HEALTH: HAMMERING RESEARCH INTO POLICY USING COMPARATIVE MODELS OF HEALTHCARE

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ABSTRACT

The paper shall introduce the concept of Right to Health care and the entitlement of citizens to it by a virtue of their existence. It shall deal with the concept under variegated international treatises and obligations of party states. The research study seeks to present the existing health care mechanisms offered by different countries. A comparative analysis of these systems shall be presented which shall incorporate the advantages and lacunae thereof. The analysis shall assist the researcher to exact at a system suited to the needs of the Indian diaspora. A revamped tax structure and revenue policy shall be accorded as the goal of this research work. The author recognizes the paramount importance of such structure wherein each citizen shall have the Right to receive health aid without expending a fortune. The author seeks to present a health care system, which permeates even through the marginalized segments of the population.

The paper shall further champion such a system by resorting to human rights and constitutional philosophy. It shall analyze the role of India as a welfare state and providing affordable health care as a critical characteristic of the Indian constitution. The research paper seeks to advocate for removing the capitalist, profit-making aspect from health care and present it as a system, which is accessible, approachable, affordable and available to all.

I. INTRODUCTION

"To keep the body in good health is a duty, otherwise we shall not be able to keep our mind strong and clear" – Gautam Buddha

Health is perhaps one of the few subjects which permeates and affects us all. The following research study seeks to explore the right of citizens to healthcare. The term "right" is often used in the arguments, which focus on healthcare. It exerts authority, simplicity and emotions, which arms the potential to connect with citizens. Through the following study, we shall undertake the intricacies and implications of such a right.

A historical background and subsequent conceptualization using international instruments and treaties shall be undertaken to provide a thorough context. It is imperative to understand the healthcare policies from various systems for eliciting ground realities. Thereafter, we shall traverse and investigate the healthcare system of India. It shall be

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analysed whether India can take steps to ameliorate the situation of medical care. Our goal is to extrapolate whether a Right to Healthcare is warranted from a constitutional standpoint and the principle of welfare state. The research design shall be regarded as an amalgamation of the explanatory and exploratory model to assist the purposes of the study.

II. INTERNATIONAL BACKDROP AND CONCEPTUALIZATION

It is stated that the contemporary idea of RHC gained public consciousness in 19th century Europe.[1] It saw the rise of public health measures owing to unhealthy working and living conditions of a nascent industrialized society.[2] Creation of various international institutions helped in the conceptualization of the idea. Article 55 of the UN Charter requires the states to seek solutions for health problems through international cooperation. Article 25 of the UDHR recognized a "standard of living adequate for the well-being" of a person.[3]Article 12 of the ICESCR recognizes the highest standard of physical and mental health as a right and also prescribes offshoots to attain the same.[4] The international consciousness and recognition of public health also led to the creation of the World Health Organization ("WHO") in 1946. The preamble of the Constitution of WHO regarded Right to Health as a "Fundamental Right" and evolved the concept into an inalienable right.[5] It stated basic principles, which required adherence from party states to attain the highest possible standard of physical and mental health. The treatises mentioned above are not exhaustive and each seems to propagate a similar idea based on extending health care to each member of society without assuming financial hardship. A majority of the nations are signatories or have ratified these international instruments. But mere acknowledgement has not garnered acceptable results. It is estimated that over half of the world's population does not have full coverage of essential health services.[6]In 2018, over 19.4 million children did not

[1] Institute of Medicine, *The Future of Public Health*, 120 (1st ed., 1988).

[2] *The Right to Health*, Icelandic Human Rights Centre, available at http://www.humanrights.is/en/human-rights-education-project/human-rights-concepts-ideas-and-fora/substantive-human-rights/the-right-to-health, last seen on 26/12/2019.

[3] U.N. General Assembly, *Universal Declaration of Human Rights*, Res. 3/217, Sess. 3, U.N. Document A/RES/217(III), 76, (10/12/1948), available at https://undocs.org/A/RES/217(III), last seen on 26/12/2019.

[4] U.N. General Assembly, *International Covenant on Economic, Social and Cultural Rights*, Res. 21/2200A, Sess. 21, U.N. Document A/RES/21/2200A, 6, (16/12/1966), available at https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx, last seen on 26/12/2019.

[5] *Constitution of the WHO,* World Health Organization, available at https://www.who.int/governance/eb/who_constitution_en.pdf, last seen on 19/3/2020.

[6] *Universal Health Coverage*, World Health Organization, available at https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc), last seen on 26/12/2019.

receive essential immunization to prevent them from life-threatening diseases.[7] 785 million people lack basic drinking water service.[8]An estimated 1 out of every 10 people contract illness from consuming contaminated food.[9] These statistics portray a grim reality, which grossly departs from the principles prescribed by the international treaties. It is stated that these jarring figures necessitate framing of a sacrosanct right, which prevents eruption of a global health crisis. It is argued that although the following research work primarily focuses on the Indian condition, it does not forbid adopting the concept as an international standard.

For the purposes of this study it is imperative to conceptualize a standard, which adheres to international norms and benchmarks. The author shall take the concept of 'right' as propounded by John Stuart Mill for formulation. Mill deliberates on the question of rights and their relationship with utility and explains that a right is violated when there is a wrong done and that wrong can be assigned to a certain person.[10] He assigns a utilitarian idea which would cast a duty upon the state to ensure that such rights are not violated.[11] If such an idea is espoused by the legislature, it would cast a duty upon the state to protect the health of its citizens. It is stated that a right based on the definition of Mill would obligate the State to protect the health of its citizens.[12]Each instrument mentioned above obligates the party states to ensure standards of health for their citizens. But contemporary times have witnessed the creation of a global order, which focuses primarily on corporate and financial interests rather than the interests of the population.[13] Herein, the idea of social protection offered by the state exhibits no relevance. It is suggested that the protective role of the state has to be revived to ensure that people do not perish under the garb of profit maximization. Governments need to adopt a 'reconstructionist' agenda to rejuvenate their role in the health sector without undermining the liberalist approach. This agenda shall theorize and include: (1) Right to Access; (2)

[7] *Immunization Coverage*, World Health Organization, available at https://www.who.int/news-room/fact-sheets/detail/immunization-coverage, last seen on 26/12/2019.
[8] *Drinking Water*, World Health Organization, available at https://www.who.int/news-room/fact-sheets/detail/drinking-water, last seen on 26/12/2019.
[9] *Food Safety*, World Health Organization, available at https://www.who.int/news-room/fact-sheets/detail/food-safety, last seen on 26/12/2019.
[10] David O. Brink, *Mill's Ambivalence about Rights*, 90 Boston University Law Review 1669, 1670 (2008).
[11] David Lyons, *Rights, Welfare and Mill's Moral Theory*, 107 (1994).
[12] T.S. Szasz, *Right to Health*, 57 Georgetown Law Journal 734, 749 (1969).
[13] Ibid, at 209.

Right to a minimum level of care; and (3) Right to participate in health decisions, which affect the individual.[14]

III. PUBLIC HEALTH INITIATIVES: A ROSE-TINTED REALITY?

"The foundation of success in life is good health"- P.T. Barnum

In the following section, the researcher seeks to analyse the different public health measures nations have adopted. It seeks to present the comparative understanding of health initiatives across states to carve out a plan tailored to the needs of the Indian diaspora. The rationale behind selecting these nations is the discernible distinction in the systems of governance and policy formulation followed by each of them.

1. USA: Does the American Dream accommodate Health Care?

The US has been particularly vocal when it comes to championing human rights around the world. It has projected itself as the white knight whose mission is to protect the sanctity of these rights. But the condition of health care as a human right in the US seems to derogate from the principles it boasts to endorse.

Prima facie, the statistics portray a favourable reality. The USA spends more money on health than any other nation.[15] These expenditures are borne by public authorities (Federal, State and Local), as well as private insurance and individual payments.[16] This fragmentation of the medical care system breeds inconvenience, unnecessary and less than complete care for the consumer.[17] It has been argued by the American Bar Association that the system adopted by the USA is not of health care but of health insurance, which does not culminate into a right[18]The following table(s) illustrates the situation of the American Health Care for the year 2018:

[14] J. Binder, *Government and the Right to Health Care*, 10 Journal of Health and Human Resources Administration 174, 177 (1987).
[15] G.J. Scheiber, J.P. Poullier & L.M. Greenwald, *Health Care systems in twenty-four countries*, 10 Health Affiliation (Millwood) 22, 23 (1991).
[16] N.D. Lew, G. Greenberg & K. Kinchen, *A layman's guide to the U.S. health care system*, 14 Health Care Financial Review 151, 152 (1992).
[17] D.L. Madison, *The Structure of American Health Care Services*, 31 Public Administration Review 518, 520 (1971).
[18] Mary Gerisch, *Health Care As a Human Right*, American Bar Association, available at https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/health-care-as-a-human-right/, last seen on 27/12/2019.

Type of Coverage	**% of Population Covered**
Any Health Plan	91.5
Uninsured	8.5

Type of Coverage		**% of Population Covered**	
Any Private Based Plan		67.3	
1.	**Employment Based**	55.1	
2.	**Direct Purchase**	10.8	
3.	**TRICARE**	2.6	

Type of Coverage		**% of Population Coverage**	
Any Public Plan		34.4	
1.	**Medicare**	17.8	
2.	**Medicaid**	17.9	
3.	**VA/CHAMPVA**	1.0	

Source: United States Census Bureau[19]

The data illustrates that most of the population is covered under some health plan. But this does not mean that the state provides for such insurance. Each of these plans requires a close scrutiny to determine whether the health care of America fulfils the promise of serving its citizens.

Private Health Plans

The data depicted above shows that the vast majority of the population relies on Private health plans. It is evident that there is a stronger tilt towards the Employer-provided health benefits. It is pertinent to mention that even though the scheme is voluntary, the predilection exists for a reason. It is because when employers pay wages in the form of health benefits, it is neither subject to personal income tax nor the Social security tax.[20] It results from decisions that were taken during World War II with no thought to how they would impact health care.[21] It leads to a disadvantage for the people purchasing health insurance on their own as it narrows the market and makes it expensive.[22] Such high expenditures have the potential to hurt the economy.[23]Even if an employee enjoys coverage under a plan, the coverage may be subject to pre-existing clauses. It may not provide for all-inclusive coverage and cost containment limits the access of care to an individual.[24] These are in the form of limitations in non-hospital services such as visits to the physician or inpatient services such as mental health care and treatment for alcohol and drug abuse.[25]

There exists a consensus among most non-economists that the major chunk of liability of health insurance is borne by the employer.[26] It projects the system as one based on the concept of welfare. But it is not representative of empirical evidence and facts. Workers bear the large proportion of healthcare costs through reduced wages.[27] But one also needs to factor in the rising costs of healthcare in America. The health

[19] *Health Insurance Coverage in the United States: 2018*, United States Census Bureau, available at https://www.census.gov/library/publications/2019/demo/p60-267.html, last seen on 27/12/2019.
[20] Supra 13.
[21] J.V. Kennedy, *Fixing American Health Care*, The New Atlantis 47, 48 (2008).
[22] Ibid, at 49.
[23] B.M.J. *Crisis in American Health Care*, 300 British Medical Journal 765, 765 (1990).
[24] W.J. Wiatrowski, *Who really has access to employer-provided health benefits?* 118 Monthly Labor Review 36, 41-42 (1995).
[25] T.P. Burke & R.S. Jain, *Trends in employer-provided health benefits*, 114 Monthly Labor Review 24, 27-28 (1991).
[26] L.J. Blumberg, *Who pays for Employee-sponsored health insurance?*18 Health Affairs 58, 59 (1991).
[27] Ibid.

care spending increased by 4.6 percent in 2018.[28] Since the major chunk of the burden falls on the workers, it is reasonable to conclude that the workers will bear most of the burden of this rise in the form of inflation-eroded wages.[29]

The disproportionality of increase in deductibles and wages has led to unaffordability of Employee-sponsored Health Schemes in certain sectors. In the survey by Kaiser Foundation, it was found that there has been an increase in the amount of premiums without inflation.[30] It has resulted in the rise of Worker Contributions without a commensurate increase in the wages.[31] It is estimated that deductibles have risen from $826 to $1,655 on average.[32]It is leading to a steady evaporation of the disposable income of a worker thereby pulverizing the economy. The exhortation of Employee-based plans was bed-rocked on the principle of 'welfare capitalism'. But a scrutiny of the situation reveals an alternative reality. It comprises a grim actuality, which focuses on the quantity of people who are insured rather than quality of care. To further strengthen the arguments pointed by the researcher, reliance is placed upon the case of *Burnwell* v. *Hobby Lobby Stores*[33]. It allowed for an employer to deny reproductive medical coverage to workers if it did not align with the religious ideology of the employer on reproductive rights.

The statements made by the researcher have the potential to be misconstrued. The health insurance system of America is not a complete failure. It at least offers some degree of coverage to the majority of the nation. But, as pointed out, it needs to adopt a system of 'care' rather than 'insurance'. Care should not be interpreted as an empty locution. It should denote a holistic idea, which focuses on affordability and accessibility, which permeates all classes without any regard to financial standards. It should strive to create a public-private partnership with powerful built-in incentives to control costs with improving quality.[34] The

[28] *Historical|CMS*, Centers for Medicare & Medicaid Services, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and Reports/NationalHealthExpendData/NationalHealthAccountsHistorical, last seen on 30/12/2019.
[29] B.D. Sommers, *Who really pays for health insurance? The incidence of Employer-provided health insurance with sticky nominal wages*, 5 International Journal of Health Care Finance and Economics 89, 93 (2005).
[30] *2019 Employer Health Benefits Survey*, The Henry J. Kaiser Family Foundation, available at https://www.kff.org/report-section/ehbs-2019-summary-of-findings/#figurea, last seen on 30/12/2019.
[31] Ibid.
[32] *Health Insurance premiums increased more than wages this year*, CNBC, available at https://www.cnbc.com/2019/09/26/health-insurance-premiums-increased-more-than-wages-this-year.html, last seen on 30/12/2019.
[33] Burnwell v. Hobby Lobby Stores, 573 U.S. 682 (2014, Supreme Court of the United States).
[34] J. Hacker, *The Health Care for America Plan*, 16 New Labor Forum 30, 32 (2007).

goal should be to increase drug coverage without sole reliance on private plans.[35] Moreover, it is time to obviate the administrative burden caused to the employer in providing health insurance.

Public Health Plans

Even though the vast majority of the nation does not subscribe to the Public Health Plans, it forms the fulcrum of the debate. A nation, which seeks to adopt the doctrine of 'care', has to give due recognition to these initiatives. It is no secret that America symbolizes the bellwether of capitalism but it does not dilute the importance of these plans. They cater to a part of the society which is unable to subscribe to a Private Health Plan. It can be the people who do not have the financial means or who do not form a part of the workforce to be eligible for an Employee-sponsored plan. The Public Health Plans have three distinctions in America: Medicare, Medicaid and VA.

MEDICARE: It provides health coverage for the aged and people with certain disabilities.[36] These people do not form a part of the workforce and are not subject to any employee-sponsored health plans. It is primarily funded by taxes of the workforce and transferred for the benefit of the aged beneficiaries.[37] As of 2019, employees contribute about 7.65% of their pay checks to programs relating to Social Security (6.2%) and Medicare (1.45%).[38] It offers subsidized treatment to people with certain ailments such as ALS or permanent kidney failure. It has several parts: Part A covers hospitals and nursing facilities; Part B covers preventive services such as doctor visits, diagnostic tests; Part C is known as Medicare Advantage, which offers additional benefits; and Part D covers prescription drugs.[39] Since it is funded by federal taxes, people often are under the impression that Medicare is free. But any such assertion shall be regarded as a myth.

It is true that the initial limb of Medicare (Part A) is free of cost; however, the remaining portions do not form a part of the complimentary services. It requires beneficiaries to share a portion of their costs through

[35] Ibid, at 33.
[36] Supra 13.
[37] Ibid.
[38] *Medicare Definition*, Investopedia, available at https://www.investopedia.com/terms/m/medicare.asp, last seen on 3/1/2020.
[39] *How Does Medicare work?*, The Motley Fool, available at https://www.fool.com/retirement/general/2016/05/22/how-does-medicare-work.aspx, last seen on 3/1/2020.

premiums, deductibles and coinsurance.[40] It shall be stated that Medicare only pays for slightly more than half of healthcare costs.[41]

For the purposes of the research work, analysing the tax structure is of paramount importance. Medicare is funded from three sources: 43% from General Revenue; 36% from payroll tax contributions; and beneficiary premiums contribute about 15% of the expenditure.[42] A major chunk of 15% of the total federal budget has been allotted to Medicare amounting to $605 billion.[43] The fund allocation to Medicare is certainly laudable, but it begs the question: whether it gets the job done? We shall undertake a swift analysis of the problems associated with the system to construct a better alternative for India.

It incurs large out-of-pocket expenses for services not covered by Medicare, such as prescription drugs, dental care and nursing home care.[44] The promulgation of Medicare has led to expansion of health coverage. It has been shown that an increase in insurance health coverage will lead to an increase in physicians' fees.[45] The same has been the situation in the USA. The federal government is significantly overpaying managed care companies to help Medicare to subsist.[46]The real problem in the American health care is high costs for everyone resulting in insufficient coverage for the elderly.[47] Medicare requires restructuring while retaining the risk pooling and redistributive functions.[48] Despite the several lacunae associated with the system, the researcher indubitably asserts that Medicare at least offers some sort of an alternative to Private Insurance. The system needs to lay more stress on the "care" aspect indoctrinated in its terminology.

MEDICAID: It offers health coverage for the poorer sections of the American society. As mentioned above, the financing of Medicare relied

[40] M.A. Scala-Foley, J.T. Caruso, R. Ramos & S.C. Reinhard, *Making Sense of Medicare: The Top 10 Myths about Medicare*, 104 The American Journal of Nursing 34, 34 (2004).
[41] M.A. Scala-Foley, J.T. Caruso, R. Ramos & S.C. Reinhard, *Making Sense of Medicare: Medicare's Hidden Price Tag*, 104 The American Journal of Nursing 32, 33 (2004).
[42] *The Facts on Medicare Spending and Financing*, Kaiser Family Foundation, available at https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/, last seen 3/1/2020.
[43] Ibid.
[44] K. Davis & D. Rowland, *Medicare Financing Reform: A New Medicare Premium*, 62 The Milbank Memorial Fund Quarterly: Health and Society 300, 304 (1984).
[45] L. Huang, *Controlling inflation of Medicare Physcians' Fees*, 3 Policy Analysis 325, 325 (1977).
[46] J. O'Keefe & J.A. Lamphere, *Saving Medicare*, 14 Issues in Science and Technology 65, 69 (1998).
[47] T. Marmor, J. Oberlander& J. White, *Medicare and the Federal Budget: Misdiagnosed Problems, inadequate solutions*, 30 Journal of Policy and Management 928, 931 (2011).
[48] K. Swartz, *Medicare Reform Should be More Than Federal Budget Reform- And It Should be Done Soon*, 34 Inquiry 5, 7 (1997).

upon the Federal Budget; it is not the case with Medicaid. Both the Federal and State government jointly fund Medicaid.[49] The share of the Medicaid funding received by the states varies on the level of poverty in the state. It suggests that the poorer states shall receive a higher match from the Federal Government.[50] In any case federal funding for the same would not go below the floor of 50%. Hence, an aggregate of 62.5% of funding was received by the states for funding Medicaid.[51] The costs attributed to the Federal government are lessened as the two authorities share the costs. Moreover, it acts as the largest federal revenue for states.[52]

The discernible inquisition, which follows, is the liability of state funding. How can the states fund their share of the remaining Medicaid expenditure? Most states use the provider taxes and intergovernmental transfers to fund the remaining of the outlay.[53]The Provider taxes are taxes imposed on health care providers such as inpatient hospital services and nursing facilities.[54] A paragon for the same can be taken as Colorado, which used its hospital provider fees to extend services to parents and children.[55]They have instituted at least one provider tax for funding. The Affordable Care Act ("ACA")[56] also has its own positive financial benefits for the state. It stated that the states, which expand under the ACA, would receive 100% federal funding for covering the newly eligible with gradual reduction to 90% starting in 2020.[57] It has been extrapolated that expansion under the ACA leads to budget savings, revenue gains and also contributes towards overall economic growth.[58]

[49] Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does it work and what are the implications?*, Kaiser Family Foundation, available at https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/, last seen on 23/3/2020.
[50] Supra 13.
[51] *Federal and State Share of Medicaid Spending*, The Henry J. Kaiser Family Foundation, available at https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/, last seen on 4/1/2020.
[52] Robin Rudowitz, Kendal Orgera & Elizabeth Hinton, *Medicaid Financing: The Basics – Issue Brief*, The Henry J. Kaiser Family Foundation, https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/, last seen on 4/1/2020.
[53] Ibid.
[54] Ibid.
[55]*States and Medicaid Provider Taxes or Fees*, The Henry J. Kaiser Family Foundation, available at https://www.kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/, last seen on 4/1/2020.
[56] Patient Protection and Affordable Care Act (Act of March 23 2010), (Unites States).
[57] G.M. Kenney, V. Lynch, J. Haley & M. Huntress, *Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act*, Inquiry 231, 231 (2012).
[58] Madeline Guth, Rachel Garfield & Robin Rudowitz, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, The Henry J. Kaiser Family Foundation, available at https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/, last seen on 4/1/2020.

The expansion of services under the ACA coupled with Medicaid also deserves attention, as it is commendable. It is significantly important for persons with disabilities. It not only covers people with physical disabilities but also extends its umbrella to bring people diagnosed with mental illnesses and substance abuse disorders.[59] Studies have also suggested that Medicaid not only improves access to health care but also leads to measurable difference in certain health outcomes.[60] It has been found that the quality of care in Medicaid is equal to that provided in traditional fee-for-service plans and beneficiaries have also expressed satisfaction with the same.[61]

Although the public has expressed positive opinion towards Medicaid, it is also a system fraught with complications. A careful literature review is needed to shed light on these complications. These criticisms form the base of the American social welfare system, which has been described as "unusual", "wayward" or "deviant".[62] Firstly, the federal matching rate designed to equalize the ability of state to help it to provide health services to the poor has not met its objectives of redistribution. The current matching formula is based on the concept of state per capita income. The General Accounting Office has recommended shifting to a formula of the taxing capacity of the state and number of people living in poverty.[63] Dwelling on the said point, creation of right federal financial incentives for states to curtail or expand Medicaid spending is also the need of the hour.[64]

It has problems relating to coverage of the medical treatments. There are situations wherein sections, which belong to the low-income strata, have been denied coverage under the provision. To be eligible for coverage the families need to fall under a certain income standard set by different states. As a result, the program, which is meant to cater to the medical needs of the poorer groups, is not able to cover these individuals. Several cases have also been detected wherein the blanket of Medicaid has extended to people who do not fall under the criteria of low-income

[59] C.M. Grogan & S. Park, *The Politics of Medicaid: Most Americans are connected to the Program, Support Its Expansion, and Do Not View It as Stigmatizing*, 95 The Milbank Quarterly 749, 755 (2017).
[60] V. Sunkara& S. Rosenbaum, *The Constitution and Public's Health: The Consequences of the US Supreme Court's Medicaid Decision in NFIB v Sebelius*, 131 Public Health Reports 844, 846 (2016).
[61] *The Impact of Medicaid Managed Care on the Uninsured*, 110 Harvard Law Review 751, 758 (1997).
[62] S.K. Schneider, *The Impact of Welfare Reform on Medicaid*, 28 Publius 161, 165 (1998).
[63] R.J. Buchanan, J.C. Cappelleri & R.L. Ohsfeldt, *The Social Environment and Medicaid Expenditures: Factors influencing the Level of State Medicaid Spending*, 51 Public Administration Review 67, 71 (1991).
[64] T.W. Grannemann & M.V. Pauly, *Reform Medicaid First: Laying the foundation for National Health Care Reform*, 24 (1st ed., 2009).

because of the formula set by the State Government. Hence, state governments need to construct and conduct tests for income, assets and family composition similar to those of public assistance programs.[65] They have to ensure that the delivery of health welfare is not uneven and reaches the target mass i.e., the poorer sections of the society.

Since its inception, Medicaid has gone through landmark changes. The passing of any Act has its own political implications. After its promulgation, the US Supreme Court ruled that states expansion of the policy to their region is voluntary.[66] This allowed political interests to undermine and overshadow public welfare. For example, Republican governors disallowed the expansion of policy to their states and some ended up severely criticizing it. Currently, 14 states have not expanded the metamorphosed Medicaid to their state.[67] This leads to a gap wherein states where there is favourable public opinion towards the law are denied the benefit under the same. ACA set off an ideological warfare among which the people, especially the poor and the downtrodden are the sole victims. Since the advent of the Trump Presidency, the administration has tried to repeal the law and failed in its attempt. But it has been successful in bruising the key aspects of the law. An example can be seen in its elimination of the "Individual Mandate" clause. The clause imposed a penalty on the citizens of the country who had not subscribed to any health insurance. It imposed a mandate on the people to subscribe to health insurance or be subject to penalty. But the Trump administration has reduced the penalty to $0.[68] Thus, it has opened the doors for proliferation of uninsured people giving them no mandate to subscribe to a health plan.

It shall be clarified that the researcher does not promote the ACA. But it would be unwise of anyone to completely disregard the benefits it entails for the poor. It is accepted that the plan is fraught with its own complications. They require close scrutiny and discernible changes. Notwithstanding the faults, it is asserted that the promulgation of the ACA was a step in the right direction. The intent of the legislature to provide healthcare for the poor and the needy is imbibed in the text of the Act. The provisions of the ACA would make a guiding principle for any country, which wants to provide health care to its poorer classes.

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[65] K. Davis, *Achievements and Problems of Medicaid*, 91 Public Health Reports 309, 313 (1976).

[66] C. Brecher & S. Rose, *Medicaid's Next Metamorphosis*, 73 Public Administration Review 60, 62 (2013).

[67] *Affordable Care Act Medicaid Expansion*, National Conference of State Legislatures, available at https://www.ncsl.org/research/health/affordable-care-act-expansion.aspx, last seen on 5/1/2020.

[68] *Trump is trying hard to thwart Obamacare. How's that going?,* NPR, available at https://www.npr.org/sections/health-shots/2019/10/14/768731628/trump-is-trying-hard-to-thwart-obamacare-hows-that-going, last seen on 5/1/2020.

2. Canada: The Light-Bearer for Publicly Funded Health Care Systems?

In the following section, we seek to analyse the health care system of Canada. The Canadian model of health care follows a need-based ideology rather than focusing on the ability to pay. Based on the socialist notion, it lays paramount reliance on the publicly funded health care system. Firstly, we shall undertake the task to understand the financing of the system based on the principle of "layering".

Canada spends 7.7% of its GDP on Public health expenditure and 2.8% is spent on Private health expenditure.[69] This stands in stark contrast to its immediate neighbour, America where both expenditures are almost equal i.e., 8.4% (Private) and 8.5% (Public).[70] As stated above the financing is based on the concept of layering of services. For better understanding, the researcher has constructed a table using relevant literature[71]:

Layer Number	**Service(s) Provided**	**Financing**
1.	It comprises necessary hospital services such as diagnostic and physician services. [This is otherwise termed as 'Medicare']	Financing is done through general tax revenues and provided as free at the point of service as required by the Canadian Health Care Act.
2.	It contains outpatient prescription drugs, home care and institutional long-term	It is done through a mix of public and private insurance coverage and out-of-pocket payments.

[69] *Core Indicators-Visualization*, PAHO, available at https://www.paho.org/data/index.php/en/indicators/visualization.html, last accessed on 5/1/2020. ["PAHO stands for Pan-American Health Organization is an association of WHO. It extracts data from the American Continents relating to all health indicators."]
[70] Ibid.
[71] D. Martin, A.P. Miller et al, *Canada's universal healthcare system: achieving its potential*, 391 Lancet 1715, 1721 (2018).

	care. Different provinces and territories have a diverse mix of health care in this layer.	
3.	It includes dental care and outpatient physiotherapy and routine eye care for senior citizens.	Financed almost entirely using private sources using supplemental insurance such as employer sponsored insurance schemes.

The Canadian model adheres to the dictum of decentralization. It is the primary job of the provinces to provide its citizens with healthcare. The bills of providing healthcare vastly go to the provinces. The Federal government was unable to attain any sort of consensus with the provinces; hence it introduced a plan that no province could refuse. It agreed to pay half of the costs of the hospitals and doctors contingent on the fact that the provinces agree to some basic principles.[72] The Federal government used its spending capacity to accommodate the provinces, which helped Canadian healthcare usher in a uniform National Plan.

Understanding of funding and administrative methods is critical for building a model for the Indian population. The funding is generated primarily through corporate and personal income taxes. Some provinces also use other financial sources such as sales tax and lottery proceeds.[73] In order to avail health one must apply for a health card.[74] New residents to any province/territory shall apply for health coverage.[75] It is estimated that expenditure on healthcare shall amount to 11.6% of Canadian GDP in 2019.[76] 70% of this expenditure is borne by the Public sector and the rest is covered by the Private sector.[77] It also stands in stark contrast with its immediate neighbour. Canada discourages private financing

[72] P. Armstrong & H. Armstrong, *Decentralized Healthcare in Canada*, 318 British Medical Journal 1201, 1201 (1999).
[73] *Health Care Funding*, Canadian Health Care, available at http://www.canadian-healthcare.org/page8.html, last seen on 5/1/2020.
[74] *Provincial Health Insurance*, Canadian Health Care, available at http://www.canadian-healthcare.org/page3.html, last seen on 5/1/2020.
[75] Ibid.
[76] *National Health Expenditure Trends 1975-2019*, Canadian Institute for Health Information, available at https://www.cihi.ca/en/national-health-expenditure-trends-1975-to-2019, last seen 5/1/2020.
[77] *Who is paying for these services?*, Canadian Institute for Health Information, available at https://www.cihi.ca/en/who-is-paying-for-these-services, last seen on 5/1/2020.

alternatives to Medicare and the people cite justifications for the same. The primary argument asserted by them is based on the notion that privatization shall lead to creation of a 'health divide'. Primarily, this divide would exist on the basis of services provided to the beneficiary. It leads to the creation of two basic parties on the basis of their economic status i.e., Gods and Clods. The reason lies in the typical model of a private healthcare system; the distribution of services is based on the ability to pay for the services.[78] The Canadian system seeks to bridge this divide and create a system wherein benefits of healthcare are accessible to all despite their economic situation. Any differences in the timelessness and scope of access by income level would violate a strict egalitarian criterion.[79]

The Canadian system has tried to remove the profit maximization aspect from the health care sector. Most of the hospitals in Canada operate on a non-profit basis and receive payments from their respective provincial governments.[80] It is an indisputable fact that Canadians receive medical care without financial barriers and this achievement has made Canadian healthcare system a popular model for the world.[81]Although the system is publicly funded, most of the services are provided privately. Most of the hospitals are non-profit private societies or corporations. Even long-term institutional care is owned by variegated non-profit, state-owned or for-profit with different mixes in different provinces.[82] They have rid the medical industry of their voracity for profits and hammered a system, which exudes healthcare as a right for its citizens.

The Canadian system of healthcare also assumes the role of the frontrunner in maintaining healthcare on a global scale. It is one of the few states, which has shown adherence to the principles advocated by the WHO. The nation has contributed to negating the concept of self-interest. It has sought to replace it with the humanitarian grounds of moral and assistance. It emanates such adherence by ensuring that Canada and other actors under Canadian jurisdiction do not deny the fulfilment of Universal Human Rights including the Right to Health.[83] In

[78] K. Bedard, J. Dorland et al, *Needs-based Health Care Funding: Implications for Resource Distribution in Ontario*, 33 The Canadian Journal of Economics 981, 983 (2000).
[79] S. Globerman & A. Vining, *A Policy Perspective on "Mixed" Health Care Financial Systems of Business and Economics*, 65 Journal of Risk and Insurance 57, 60 (1998).
[80] E. Vayda, *The Canadian Healthcare System: An Overview*, 7 Journal of Public Health Policy 205, 206 (1986).
[81] M. Livingston, *Update on Healthcare in Canada: What's Right, What's Wrong, What's Left*, 19 Journal of Public Health Policy 267, 268 (1998).
[82] S. Lewis, C. Donaldson *et al*, *The Future of Health Care in Canada*, 323 British Medical Journal 926, 927 (2001).
[83] D. McCoy, R. Labonte & J. Orbinski, *Global Health Watch Canada? Mobilizing the Canadian Public Health Community Around a Global Health Advocacy Agenda*, 97 Canadian Journal of Public Health 142, 142 (2006).

lieu of several studies and empirical studies, this universal coverage of physician services ameliorates the socioeconomic differences in mortality.[84]

Although the Canadian system has its merits, it is short of a perfect setup. As is the case with any policy-inducted system, it has its own shortcomings. The Canadian system has the potential of leading to monopolization. The existence of public monopoly over healthcare impedes innovation in the delivery of healthcare. The Canadian system has failed to incorporate new techniques such as Managed Care, which has elicited commendable results in the USA.[85] It also affects the technological innovations in healthcare. Technology is as important to healthcare as it is to any other sector.[86] Lack of innovations in healthcare technology would stymie the growth of essential technological advancements, which prevent premature death and disability. There have been suggestions made by several research assessments to introduce agencies to identify new healthcare technologies and disseminate such information to the provincial governments and the healthcare providers.[87]A public-funded system may also suffer from financial difficulties. The Canadian Healthcare system has witnessed a bumpy history. During the evolution, which ultimately led to the Canadian Healthcare Act [**"**CHA**"**], it suffered from serious economic breakdowns. CHA also did little to resolve the underlying fiscal problems associated with the system and curtailed the tools available to the provinces for dealing with them.[88] There are no disputes to the fact that Canada spends a considerable amount of GDP on its healthcare. If one spends such an extravagant amount, it is expected that efficiency of services be guaranteed. But studies conclude that Canadian Healthcare is highly inefficient in terms of wait listing its patients.[89] There have been suggestions made in this regard to introduce new practices and increase inputs.[90] Canada manages to spend too much to gain too little. Despite spending more than most countries in the OECD, it sits at best in the middle of the pack when it comes to health outcomes and measurable

[84] P.J. Veugelers & AM Yip, *Socioeconomic Disparities in Health Care Use: Universal Coverage Reduce Inequalities in Health?*, 57 Journal of Epidemiology and Community Health 424, 427 (2003).
[85] H.S. Webber, *The Failure of Healthcare reform: An Essay Review*, 69 Social Service Review 309, 312 (1995).
[86] D.E. Angus, *Technological Innovations in Health Care: The Need for Technological Assessment*, 79 Canadian Journal of Public Health 414, 414 (1988).
[87] D. Feeny & G. Stoddart, *Toward Improved Health Technology Policy in Canada: A Proposal for the National Health Technology Assessment Council*, 14 Canadian Public Policy 254, 262 (1988).
[88] J. Jordan, *Federalism and Health Care Cost Containment in Comparative Perspective*, 39 Publius 164, 180 (2009).
[89] A. Abeney & K. Yu, *Measuring the Efficiency of the Canadian Health Care System*, 41 Canadian Public Policy 320, 325 (2015).
[90] Ibid.

satisfaction with the system.[91] It seems as if Canada can no longer afford to pay for its healthcare and significant changes have to be made. The proposed solutions would increment American features and thus, attract American problems with healthcare. Therein lies the challenge of replacing or appending features of a foreign system while avoiding the inherent problems associated with the foreign policy.[92]

Therefore, any assertions, which champion the Canadian healthcare as a "perfect" system, would be a fallacy. But the researcher exhibits no qualms in appreciating the results it has elicited for the Canadians. The analysis of the system gives an impression of the efforts of the government to provide healthcare to its citizens despite financial considerations. The intent of the legislature is also unquestionable in this regard and we hope that the system attains the perfection it deserves.

IV. HAMMERING A HEALTHCARE POLICY FOR INDIA: CAN BHARAT FULFIL THE OBLIGATIONS TOWARDS ITS CITIZENS?

"There's nothing more important than our good health – that's our principal capital asset."- Arlen Specter

India strives to attain welfare for its citizens.[93]It aims to frame policies, which ensure the health and strength of workers, men and women and prevent the abuse of tender age of children.[94] It directs the states to regard improvement of public health of its citizens as a primary goal.[95] The Ministry of Health and Family Welfare ["MoHFW"] is accountable for the attainment of these goals. The Vision, Mission and Objective statement released by the MoHFW should draw the attention of every citizen of India. It seeks to attain the highest possible standard of well-being through preventive and promotive health care and universal access to good quality of health services.[96] But, such ambitious goals warrant a reality check to extrapolate whether these are just meaningless assertions, or efforts are being taken to fulfil them.

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[91] N. Smith, C. Mitton & P. Kershaw, *The reallocation challenge: Containing Canadian medical care spending to invest in the social determinants of health*, 107 Canadian Journal of Public Health 130, 130 (2016).
[92] R.A. Spasoff, *Health Department Administration of the Canadian Health Program*, 16 Journal of Public Health Policy 141, 149 (1995).
[93] Art. 38 (1), the Constitution of India.
[94] Art. 39 (e), the Constitution of India.
[95] Art. 47, the Constitution of India.
[96] *Vision, Mission and Objective Statement of MoHFW*, Ministry of Health & Family Welfare, available at https://main.mohfw.gov.in/sites/default/files/Vision%2C%20Mission%20and%20Objective%20Statement%20for%20MoHFW%2024092019.pdf, last seen on 11/1/2020.

The researcher does not want to stress on the health indicators of the country. It seeks to analyse the financial and coverage aspects for the citizens. India is no stranger to economic inequality. The top 1% of the Indian population controls about 73% of its wealth.[97] This would suggest that accessibility to health services is also unequal. Now, has the government restructured its finances to allay the situation? The numbers seem to portray a resounding NO.

As a percentage of GDP, public expenditure on health is 1.02%.[98] According to the report, there is only one doctor for every 11,000 people and only Rs. 3 is spent on an average Indian's healthcare.[99] The public health expenditure is below the average expenditure on health in low-income countries.[100] These numbers represent the tip of the iceberg of the health crisis in India. It sheds light on the abysmal situation of health accessibility to India. But it raises the question whether steps can be taken to ensure that people are not denied medical care despite their financial conditions. It begs the question, whether the government can fulfil their obligations towards the goal of a welfare state? It also poses an ethical question of whether the citizens deserve more in the aspect of health care. The researcher in the upcoming section undertakes the job of hammering out a plan for India to restructure its economic policies to focus on the aspect of health care. The primary goal is to create a system wherein services can be offered to the people who do not enjoy the financial capacity to afford medical care for themselves.

3. Raising the Bar of Health Care: Creating an Institutional Framework

The following study primarily focuses on creating public health outlets and a framework for attaining health care standards for its citizens. The plan is to create a holistic framework wherein all citizens can reap the benefits.

Offering Primary/Emergency Health Care

Audacious plans are seldom realistic. At the current stage, there is no tangible plan for India to achieve Universal Health Coverage. It would be

[97] *Income inequality gets worse; India's top 1% bag 73% of the country's wealth, says Oxfam*, Business Today, (30/01/2019) available at https://www.businesstoday.in/current/economy-politics/oxfam-india-wealth-report-income-inequality-richests-poor/story/268541.html, last seen on 11/1/2020.

[98] Ministry of Health and Family Welfare, Government of India, *National Health Profile 2018*, available at www.indiaenvironemntportal.org.in/files/file/NHP 2018.pdf, last seen on 11/1/2020.

[99] *National Health Profile 2018: Here's how India is healthwise*, The Indian Express (25/06/2-18), available at https://indianexpress.com/article/india/national-health-profile-2018-heres-how-well-india-is-health-wise-5228742/, last seen on 11/1/2020.

[100] Supra 88, at 188.

highly unrealistic for the government to undertake a plan, which would offer entire health coverage for its citizens. Hence, to bring the country in the path for offering medical coverage, we submit that the initial step would be to offer primary health services [**"**PHC**"**] to its citizens.

The current primary healthcare system is extremely rigid, making it unable to respond effectively to local realities and needs.[101]Therefore, a complete overhaul of the system is warranted. Starting with the financial aspect, it is a no-brainer that the nation needs to accord more importance to its health sector. Hence, the first step would be to pump more money into the system. Every country which aims to or provides UHC spends between 5-9% of their GDP on healthcare.[102] These governments pay about 75% of their medical care and control the balance of primary care and special care.[103] Although the per capita expenditure on health has increased in India, it still remains discernibly low in comparison to other countries.[104] India's neighbours, such as Sri Lanka, Myanmar and Indonesia are spending far more on healthcare than India.[105] Funding need not be redirected from current allocations to preventive care, but India can make health spending a priority like Defence.[106] In light of the same, we recommend increasing the expenditure of GDP to a more appropriate percentage in the aspect of health care i.e., at least 5% of GDP.[107] But, a sudden proliferation in the same is unrealistic; hence a gradual increase is recommended. The goal should be to attain such expenditure and proportionate budget allocation by the year 2025.

Secondly, reforming the tax structure and expanding the tax base is also recommended. A fiscal expansion for health can utilize alternate sources of domestic revenue mobilization.[108]Currently, the lower tax rate of 25% is only applicable to companies having an annual turnover of Rs. 250 crores. The 2019 budget, titled "Budget for New India 2019" expands the

[101] H.T. Pandve & T.K. Pandve, *Primary healthcare system in India: Evolution and challenges*, 1 International Journal of Health System and Disaster Management 125, 127 (2013).
[102] R. Duggal, *Challenges in Financing Healthcare*, 47 Economic and Political Weekly 22, 23 (2012).
[103] R. Gendler, *An American Physician's foray into Scandinavian healthcare*, 44 Scandinavian Journal of Public Health 225, 226 (2016).
[104] H. Chandna, *At 1.28% of GDP, India's expenditure on health is still low although higher than before,* The Print, available at https://theprint.in/health/at-1-28-gdp-india-expenditure-on-health-still-low-although-higher-than-before/313702/, last seen on 23/3/2020.
[105] R. Kaul, India's public expenditure on healthcare continues to remain lowest globally, Hindustan Times, available at https://www.hindustantimes.com/india-news/india-s-public-health-spending-lagging-behind/story-6YPZFSfWMVlHGipDXyUEFO.html, last seen on 23/3/2020.
[106] T.S. Ravikumar& G. Abraham, *We need a leap in healthcare spending*, The Hindu (07/02/2019), available at https://www.thehindu.com/opinion/op-ed/we-need-a-leap-in-healthcare-spending/article26196313.ece, last seen on 23/3/2020.
[107] Supra 96, at 23.
[108] S. Garg, *Universal Health Coverage in India: Newer Innovations and the Role of Public Health*, 62 Indian Journal of Public Health 167, 168 (2018).

scope to include all companies of up to Rs. 400 crores.[109] This shall expand the tax receipts for the country and a part of the same could be allocated to the healthcare. Since, the Union is recipient of all corporate taxes[110], the same shall be distributed to the states to setup facilities. But Health is a state subject[111], so the Centre has to work in consonance with the State government to work for their public health. The distribution of the same has to be done by firstly adopting an architectural correction in the current system. That is, if needed, create a separate Public Health Department[112] within the system to handle and distribute revenue among states.

For financing the state aspect, we recommend reallocation of sin taxes i.e., taxes and duties levied on alcohol and tobacco. Such allocation can be done without overburdening the state exchequer. Government can play a much stronger provider role using taxation and special levies to finance such provisions.[113] An additional 2% health cess on these products can increase the costs minimally and provide an additional Rs. 7 billion annually only from tobacco.[114] The same can be done for other products such as Alcohol. It is true that a cess of 0.3% is present for National Health Mission, but the same is allocated to the General Revenue Pool.[115] Such undefined allocation would not prove to be fruitful and strict allocation lines need to be drawn. This can be done by earmarking the receivables into a non-lapsable fund for the specific purpose of health.[116] Funnelling the money obtained from them would prove to be an effective model apart from offering a metaphoric tinge. These can prove to be an ideal vehicle for revenue mobilization, as the institutional framework for collection of the same already exists.[117] These taxes have the potential to generate vast amounts of revenue, which can

[109] *Budget for New India 2019*, Press Information Bureau, available at http://pibphoto.nic.in/documents/Others/sectorwise-Info/tax/tax1.jpg, last seen on 12/1/2020.
[110] Sch. 7, List-I, Entry 85, the Constitution of India.
[111] Sch. 7, List – II, Entry 6, the Constitution of India.
[112] M. George, *Reinstating a 'public health' system under universal health care in India*, 36 Journal of Public Health Policy 15, 19 (2015).
[113] K. Tiruvarur et al, *How to provide Healthcare*, 47 Economic & Political Weekly 4, 5 (2012).
[114] R. Duggal, *Healthcare in India: Changing the Financing Strategy*, 41 Social Policy & Administration 386, 391 (2007).
[115] J.S. Anand, *Can Sin taxes on tobacco solve funding challenges in healthcare system*, Business Standard (16/04/2019), available at https://www.business-standard.com/article/b2b-connect/can-sin-taxes-on-tobacco-solve-funding-challenges-in-healthcare-system-117011000828_1.html, last seen on 22/3/2020.
[116] A.K. Shiva Kumar, *Budgeting for Health: Some Considerations*, 40 Economic & Political Weekly 1391, 1393 (2005).
[117] Ruth Lopert, *The new Syntax for "Sin" taxes: Framing health taxes to strengthen public finances and advance population health,* Centre for Global Development, available at https://www.cgdev.org/blog/new-syntax-sin-taxes-framing-health-taxes-strengthen-public-finances-and-advance-population, last seen on 12/1/2020.

be used to build public health infrastructure, undertaking awareness programs and fund research.[118]

Building on the concept of decentralized planning[119], participation of local bodies to ensure delivery of medical services is paramount. This shall include setting up of redressal mechanisms, ensuring democratic process, defining accountability roles and regular audits to check the use of funds. In order to address the problem of paucity of practitioners, private providers can be contracted on the basis of standardized rates and norms for service delivery.[120]

It is paramount to define as to how the states shall receive the finances from the Centre. It is asserted that the creation of a methodology to determine the distribution of funds between the states is important. It is suggested that an amalgamation of Core Economic Indicators such as the number of people below poverty line (BPL), demographic indicators (Population Density) and Core Health Indicators (Mortality Rates) shall be accounted to construct a methodology. The taxation capacity of the state shall be granted its due importance in the methodology. It would create a "primacy/priority" mechanism wherein states with severe health statistics would be disbursed a larger portion of funding.

Such a system would help to create and maintain medical institutions wherein citizens are provided with primary healthcare without cost. It would be affordable, accessible and available to all despite their income standards. Further, it helps to create a taxation model, which creates additional funds, which would prove helpful in the upcoming section(s).

Affordable Insurance Schemes for Secondary/Higher Healthcare

The people also need to be provided with provisions to finance their special healthcare requirements. These would include treatments, which go beyond the purview of Primary healthcare. Considering the population of India, it is unreasonable to assume that secondary medical care can be made free of cost for everyone. But the costs of secondary healthcare are on the rise and increasingly becoming unaffordable. Therefore, to cover these bills we recommend the institution of affordable insurance schemes.

[118] M.J. Joyner & D.O. Wamer, *The Syntax of Sin Taxes: Putting it together to improve Physical, Social and Fiscal Health*, 88 Mayo Clinic Proceedings 536, 537 (2013).
[119] A. Gupta, *Universal Access to Healthcare: Threats and Opportunities*, 46 Economic and Political Weekly 27, 30 (2011).
[120] A. Phadke, *Planning Healthcare for All?*, 46 Economic and Political Weekly 15, 17 (2011).

Apart from the BPL population, it is found that even the poor can now make small, periodic contributions that can go towards meeting their healthcare needs.[121] But it does not mean that the poor are armed with the financial capacity to subscribe to a private health plan. The health insurance scheme calls for a stratification of the citizens on economic status. Thus, a plan which is based on the financial status of individuals and public sponsorship, is the need of the hour.

There is no need of over-complication of the plan. There should be only one Universal Insurance Scheme [**"**UIS**"**], with stratification of premium amounts based on the economic capabilities. It is suggested that the BPL population should be provided with BPL identity cards, which can be used at every hospital around the country. The risk-pooling and fund-pooling characteristic would be able to distribute the risk over all the people of India. Plus, the higher income classes would pay a higher number of premium amounts but would assume an equitable amount of risk. This Consolidated Health Fund [**"**CHF**"**], which denotes the amount from all the premiums collected, would be used for bill payments for the special needs of the patient(s). But it is recommended that the CHF would not be used to pay the entire amount of the bill. It is suggested that this would cover only 50 – 60 % of the bill of the patient. The table below illustrated how the balance amount of the medical bills would be paid:

Layer Name	**Annual Income (Rs.)**	**Out-of-pocket Payments (% of Remaining Amount)**	**Centre: State (% of contributions in the remaining amount)**
Below Poverty Line	>= 27,000	0	75:25
Lower Income	27,000 – 1,00,000	10	65:25
Lower Middle Income	1,00,000 – 3,00,000	15	65:20

[121] R. Ahuja & I. De, *Health Insurance for the Poor: Need to Strengthen Healthcare Provision*, 39 Economic and Political Weekly 4501, 4501 (2004).

Middle Income	3,00,000 – 6,00,000	17.5	62.5:20
Higher Middle Income	6,00,000 – 10,00,000	20	60:20
Higher Income	10,00,000 and above	22.5	57.5:20
Below Poverty Line	>= 27,000	0	75:25

A plan based on the above model uses the vast population of India towards its benefit, particularly for fund pooling. It is paramount to ensure that people subscribe to such plans. Therefore, basing itself on the "Individual Mandate" clause of the US, there needs to be a provision, which ensures creation of a mandate for the people. The people who do not subscribe to any insurance plan shall be penalized for a certain amount to ensure that citizens subscribe to a plan.

Lastly, a smart card should be issued or the insurance information can also be linked to Aadhar/UIDAI for easy access to the database. It would help to remove any procedural difficulties that usually degrade the viability of such plans. Further, a consumer grievance redressal system shall be setup to address the problems of patients. It would help in identifying problems with the system and build consumer confidence.

Concluding, a clarification is stated that the researcher does not intend to imply that the above-mentioned plan will solve the health crisis of India. But any plan based on the principles and the model would definitely go a long way to ameliorate the current situation.

Funding & Encouraging Medical Research

The importance of innovation in any field cannot be overlooked. These advancements make the system more efficient and also bridge the gaps in the existing ocean of knowledge. It contributes towards discovering uncharted territories and stipulating methods to ease the lives of the individuals. Innovation in the medical field stems from the research undertaken by individuals to venture into the unknown and come up with

pharmaceuticals, technological advancements and methods, which help to form preventive and curative techniques. It is asserted that a country, which seeks to espouse RHC as a Fundamental Right, cannot overshadow the relevance of medical research.

With research incorporated into implementation efforts, healthcare systems become laboratories, producing ecologically valid findings that are generalizable.[122] The researcher warns that a system should not limit the scope of research to just making healthcare efficient. The idea of medical research extends far beyond the scope of such averments. It should be inclusive of making the system more efficient. The problems of the users shall be ruminated over and the subsequent changes should reflect the will of the people and of welfare.

It is suggested that appropriate amounts of funds should be earmarked for research. It should be ensured that overburdening of Central funds is not done on this aspect. Suitable amount of funds should be transferred to the states, and they should be responsible for setting up respective centres for undertaking medical research. These institutions shall be subject to central rules and submit audit reports to ensure proper use of funds.

An erudite nation would also place importance on the role of NGOs and civil societies to lend help to these institutions. Coupled with these institutions, it can make significant contributions to the training of research workers by providing personal support of limited duration to younger researchers and longer-term support for research workers in maintained institutes.[123]As long as an intention of goodwill and welfare plays a pivotal role in fostering relationships, the country would go a long way to eradicate and prevent harmful diseases.

Realisation of the importance of medical research is paramount in the contemporary age. It should be regarded as an investment in the future of a nation. Stressing on the "care" aspect includes research as an integral part of the future of medicine. Thankful to the power of medical research, we are now able to live 10 years more than the average in the 1960s.[124]

Further, it is submitted that research does not only restrict itself to fulfilling the national mandate of healthcare provision. It extends its wings towards contributing to the international development of medical

[122] B.N. Doebbeling & M.E. Flanagan, *Emerging perspectives on Transforming the Healthcare System: Redesign Strategies and Call for Needed Research*, 49 Medical Care 59, 63 (2011).
[123] D.C. Evered, *Charitable Organisations in Medical Research*, 283 British Medical Research 1348, 1349 (1981).
[124] *Participating in Health Research Studies*, Countway Library of Medicine, available at https://guides.library.harvard.edu/healthresearch, last seen on 13/1/2020.

literature.[125] It contributes towards our obligations to various international instruments and treaties. Corporate interests should not bog down the purpose of improvement of health. Any advancement in the field of medicine is the collective asset for all mankind. Therefore, it is the humble submission of the researcher that to truly constitute a holistic perspective of medical care, research cannot be de-prioritized.

V. HEALTHCARE AS A FUNDAMENTAL RIGHT: VINDICATIONS UNDER CONSTITUTIONAL JURISPRUDENCE

"Of all forms of inequality, injustice in healthcare is the most shocking and inhumane"
- Martin Luther King Jr.

As we proceed towards the end of the paper, it is important to analyse the idea from a constitutional standpoint. Before initiating, we submit that the following passages reflect the tectonic part of the study. Without recognition under Constitutional philosophy, the above paragraphs hold little relevance and can never be implemented in letter and spirit.

Healthcare should be viewed as an empowerment mechanism. People should be given a chance to be active participants in their own medical care and should not be relegated to passive recipients.[126] It acts as a positive catalyst in the field of human development. Jarring are those instances wherein people are denied healthcare on the basis of their financial conditions. The aim of a "welfare state" loses its meaning if healthcare is not an essential limb of the same.

The Constitution offers us the "Right to Life" under Article 21.[127] The Hon'ble Supreme Court has held that Right to Health Care is a Fundamental Right under Article 21 read with Articles 39(e), 41 and 43 of the Constitution of India.[128] Health forms the fulcrum of the Right to Live with Human Dignity. This Right to Live with Human Dignity forms an integral concept under Article 21 of the Constitution.[129] It resonates that arbitrary interference with the life and livelihood of a person violates the principles of the Constitution. But, in lack of statutory recognition, these directions by the Hon'ble Apex Court would be deemed as derogation of the directions of the Court and the Constitution.

[125] The Lancet Editorial, *What is the Purpose of Medical Research?* 381 The Lancet 347, 347 (2013).
[126] *Health is Fundamental Right*, World Health Organization, available at https://www.who.int/mediacentre/news/statements/fundamental-human-right/en/, last seen on 13/1/2020.
[127] Art. 21, the Constitution of India.
[128] Consumer Education & Research Centre v. Union of India, (1995) 3 SCC 42.
[129] Bandhua Mukti Morcha v. Union of India, AIR 1984 SC 802.

RHC should not be construed as the Right to remain healthy by ignoring externalities. No government has the potential to offer such a right. Health is often dependent on factors that fall outside the control of humans. Diseases can also be consequences of genetic predispositions. This research study focuses on the role of the State as the provider of healthcare facilities. State can have control over its machinery and shape the political, socio-economic and ecological conditions of health.[130] We stress on the right of every citizen to access an appropriate level of healthcare, which leads to human development. We need to ask ourselves – Does the lauded concept of welfare include healthcare? The Constitution and its subsequent interpretations can be the guiding light of the answer to this question.

The researcher urges the citizens of India to realize their rights. It is time to reflect the humanistic intention of our forefathers in our practices. The exploitation of people has to come to a halt. If we continue practicing our current trends, the Constitution would be relegated to a meaningless set of principles. A complete overhaul is the need of the hour. It is stated that these discernible changes are not going to take place overnight. It requires continuous dedication. It has to emerge from the realization of the dignity and worth of individuals.

A right, which does not enjoy recognition in positive law, would be rendered useless. The researcher submits that non-recognition of RHC is passive discrimination. Freedom of discrimination has been embraced as a right that we can expect government to enforce not only when the government itself acts but also against private actors.[131] It is a humble submission that healthcare shall not be a luxury but a right by the virtue of one's existence.

VI. CONCLUSION

"Disease, sickness, and old age touch every family. Tragedy doesn't ask who you voted for. Healthcare is a basic human right" - Elizabeth Warren

Crippling healthcare plagues contemporary societies. No system of healthcare can attain the status of being a utopian setup wherein people do not perish due to health reasons. But such realities should not act as an impediment from striving to arrive at a higher standard of healthcare. With the fear of reiteration, there should be a large focus on the "Care" aspect of the word. It should not be treated as a term without any meaning. There should be a shared set of principles between healthcare providers, organizations, government and the public to realize the aim of

[130] M. Krennerich, *Healthcare as a Human Rights Issue*, 30 (1st ed., 2017).
[131] A. Barnes & M. McChrystal, *The Various Human Rights in Healthcare*, 25 Human Rights 12, 13 (1998).

achieving the highest standard of healthcare. Cooperation between affected parties is indispensable to establish healthcare as a human right.

There is a need to pool the resources to ensure the delivery of the right to the society. We need to define an adequate package for healthcare, which is ethically justifiable. It is certainly a herculean task but is not impossible. Successful development of such a concept would help the society to advance the debate on how to allocate the healthcare resources.[132] We mention the principles which require ardent adherence to realize the goal of healthcare for all: (1) Healthcare is a human right; (2) It should be practiced to generate the highest standard of health; (3) Delivery systems should focus on prevention of illness and alleviation of disability (4) Cooperation between parties is imperative and; (5) Individuals involved, have the responsibility to continuously increase the standard of quality.[133]

It is perturbing to see that an issue, which affects all despite status, receives such little attention. It is urged that India needs to vacate the driver's seat and check under the hood of its governance because there are things rattling under there, that a simple tape and screw cannot fix.

[132] P.E. Kalb, *Defining an "Adequate" Package of Health Care Benefits*, 140 University of Pennsylvania Law Review 1987, 1998 (1992).
[133] Tavistock Group, *A Shared Statement of Ethical Principles for Those Who Shape and Give Health Care*, 318 British Medical Journal 249, 250 (1999).