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Access to Healthcare: The Kerala Model

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ABSTRACT

The Kerala model refers to the practices adopted by the Kerala State to improve the Human Development Index of the people living in the state. The achievements of Kerala in this aspect can be compared with that of the developed countries especially in health care sector. The state has got strong social indicators like high literacy and life expectancy rates, improved access to healthcare, low infant mortality and birth rates. The much-acclaimed Kerala model of development is characterized by the achievements of the state in having strong social indicators like education, healthcare, high life expectancy, low infant mortality rates. This was achieved due to the efforts taken by the state in the creation of productive social infrastructure. The healthcare system prevailing in the state is considered to be the principal factor responsible for attaining high level of health status when compared with the rest of the country. Both modern medicine and AYUSH system of medicine have played a crucial role in providing universal access and availability of health care facilities to the poor sections of the society in Kerala. It is also important to note the role played by the State Government's Health Insurance Schemes like the Karunya Scheme and the Karunya Arogya Suraksha Padhathi (KASP) which was instrumental in making health care accessible to the poor and weaker sections of the society. The most recent example of the success of the 'Kerala Model' can be seen in the successful tackling of the NIPAH outbreaks and also in dealing with the Covid-19 pandemic situation. The state government has successfully tackled both these situations by efficient utilization of the government machinery and human resources available at its disposal. This paper analyses the Kerala model of healthcare and its role in achieving sustainable development goal objectives pertaining to health.

Keywords: *Human Development Index, Infant Mortality, Life Expectancy, Pandemic, Sustainable Development Goals.*

I. INTRODUCTION

Health is a common theme in most cultures. All communities have their concept of health, as part of their culture. In some cultures, health and harmony are considered equivalent, harmony being defined as "being at peace with the self, the community, god and cosmos." The ancient

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 [ISSN 2581-5369]

Indians and Greeks shared this concept and attributed disease to disturbances in bodily equilibrium of what they called "humors". During the past few decades, there has been a reawakening that health is a fundamental human right and a worldwide social goal, that is essential to the satisfaction of basic human needs and to an improved quality of life, and that it is to be attained by all people. Health has evolved over the centuries as a concept from an individual to a worldwide social goal and encompasses the whole quality of life. However, health is not perceived the same way by all members of a community, including various professional groups like biomedical scientists, social science specialists, health administrators, ecologists, etc; thereby giving rise to confusion about the concept of health. In a world of continuous change, new concepts are bound to emerge based on new patterns of thought. Therefore, an understanding of health as the basis of all health care is necessary.

II. CHANGING CONCEPTS OF HEALTH

Traditionally, health has been viewed as an "absence of disease" and if a person was free from disease then that person was considered healthy. This concept known as the "biomedical concept" has the basis in the "germ theory of disease" which dominated medical thought at the turn of the 20th century. From the ecological point of view, health is viewed as a concept that is having a dynamic equilibrium between man and his environment and disease

a maladjustment of the human organism to environment. The ecological concept of health raises two issues namely – imperfect man and imperfect environment. However, with the improvement of human adaptation to natural environments has resulted in longer life expectancies and a better quality of life for the people even in the absence of modern health delivery services. Contemporary developments in social sciences revealed that health is not only a biomedical phenomena but one which is influenced by social, psychological, cultural, economic and political factors of the people concerned. These factors must be taken into consideration in defining and measuring health. Thus it can be seen that health is both a biological and social phenomena. The holistic concept of health recognizes the strength of social, economic, political and environmental influences on health. It has been variously described as a unified or multidimensional process involving the well-being of the whole person in the context of his environment. This view corresponds to the view held from the ancient times that health implies a sound mind, in a sound body, in a sound family, in a sound environment. The holistic approach to health implies that all sectors of society have an effect on health, in particular, agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors. The emphasis of holistic concept of health is on the

 [ISSN 2581-5369]

promotion and protection of health.

(A) Definition of health

"Health" is one of those terms which is difficult to define even although its meaning is understood. Therefore, many definitions of health have been offered from time to time. The most widely accepted definition of health, which is given by the World Health Organisation (1948) in the preamble to its constitution, which is as follows:- "Health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity." In recent years, this statement has been amplified to include the ability to lead a "socially and economically productive life." The concept of health as defined by WHO is broad and positive in its implications, that is, it sets out the standard, the standard of "positive" health. It symbolizes the aspirations of people and represents an overall objective or goal towards which nations should strive. However, the WHO definition of health has been criticized as being too broad. The critics argue that health cannot be defined as a "state" at all but it must be seen as a process of continuous adjustment to the changing demands of living and of the changing meanings given to live. It is a dynamic concept. It helps people to live well, work well and enjoy themselves.

(B) New philosophy of health

In the recent years, a new philosophy of health has gained importance which may be stated as follows:-

- Health is a fundamental human right.
- Health is the essence of productive life, and not the result of ever increasing expenditure on medical care.
- Health is inter-sectoral.
- Health is an integral part of development.
- Health is central to the concept of quality of life.
- Health involves individuals, state and international responsibility.
- Health and its maintenance is a major social investment.
- Health is a worldwide social goal.

(C) Health for all

In May 1977, the 30th World Health Assembly decided that the main social target of the governments and WHO in the coming decades should be – "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and

 [ISSN 2581-5369]

economically productive life." This culminated in the international objective of "HEALTH FOR ALL" by the year 2000 as the social goal of all governments. "Health for All" means that health is to be brought within the reach of every one in a given community. It implies that removal of obstacles to health, that is to say, the elimination of malnutrition, ignorance, disease, contaminated water supply, unhygienic housing etc. It depends on continued progress in medicine and public health. The attainment of Health for All by 2000 AD was the central issue and official target of WHO and its member countries. It symbolized the determination of the countries of the world to provide an acceptable level of health to all people. Health for All has been described as a revolutionary concept and a historic movement that is, a movement in terms of its own evolutionary process. With the adoption of health as an integral part of socio-economic development by the United Nations in 1979, health has also become a major instrument of overall socio-economic development and the creation of a new social order.

III. MILLENNIUM DEVELOPMENT GOALS

In September 2000, representatives from 189 countries met all the Millennium Summit in New York to adopt the United Nations Millennium Declaration. The leaders made specific commitments in seven areas: peace, security and disarmament; development and poverty eradication; protecting our common environment, human rights, democracy and good governance; protecting the vulnerable; meeting the special needs of Africa and strengthening the United Nations. The Road Map established goals and targets to be reached by the year 2015 in each of seven areas. The goals in the area of development and poverty eradication are now widely referred to as "Millennium Development Goals".

The Millennium Development Goals, place health at the heart of development and represent commitments by governments throughout the world to do more to reduce poverty and hunger and to tackle ill health, gender inequality, lack of education, access to clean water and environmental degradation. Three of the eight goals are directly health related and all of other goals have important indirect effects on health. Three of the 8 goals, 8 of the 18 targets required to achieve these goals, and 18 of the 480 indicators of progress are health related.

IV. SUSTAINABLE DEVELOPMENT GOALS

In September 2015, the United Nations General Assembly adopted the new development agenda, "Transforming our World; the 2030 Agenda for Sustainable Development", comprising of 17 Sustainable Development Goals (SDGs). The 2030 Agenda integrates all three dimensions of sustainable development (economic, social and environmental) around the themes of people, planet, prosperity, peace and partnership. The SDGs recognize that eradicating poverty and

 [ISSN 2581-5369]

inequality, creating economic growth and preserving the plant are inextricably linked, not only to each other, but also to population health.

Health is centrally positioned within the 2030 Agenda with one comprehensive goal – SDG3: "Ensure healthy lives and promote well-being for all at all ages;" and explicit links to many of the other goals. SDGs includes 13 targets covering all major health priorities including four targets on the unfinished and expanded Millennium Development Goals agenda; four targets to address non-communicable diseases, mental health, injuries and environmental issues, and four "means of implementation" targets. The target for universal health coverage is key to the achievement of all other targets and the development of strong resilient health system. It will require an integrated approach to the provision of health services that minimize the fragmentation.

V. CONCEPT OF THE RIGHT TO HEALTH AND HEALTHCARE

Health has been acknowledged as a fundamental right of the people. This has been echoed in international conventions on human rights. The recognition of health as a human right presupposes that governments bear certain responsibility for the health of the population. Governments have to provide for a health infrastructure and create conditions under which the availability, accessibility, and quality of health services are guaranteed.

(A) International Perspectives On Right To Health

The WHO's constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease." Article 25 of the Universal Declaration of Human Rights, 1948 recognizes the right to health. Article 25(1) states that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood in circumstances beyond his control." Article 25(2) further states that: "Motherhood and childhood are entitled to special care and assistance. All children whether born in or out of wedlock, shall enjoy the same social protection." Article 12 of the International Convention on Economic, Social and Cultural Rights, 1976 deals with the obligation of the state to realize right to health. Article 12 states that: The state parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the state parties to the present covenant to achieve the full realization of this right shall include those necessary for:

 [ISSN 2581-5369]

a) The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child;

b) The improvement of all aspects of environmental and industrial hygiene;

c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

d) The creation of conditions which would assure to all medical services and medical attention in the event of sickness.

The article does not contain a definition of health, but it interprets it as a broad concept and emphasizes environmental hygiene, preventive health care and occupational diseases. Other international conventions also contain provisions for the protection and advancement of health. Specific reference can be made to provisions contained in the following international conventions:-

i. Articles 11(1) (f), 11(2), 12 and 14(2) (b) of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW);

ii. the Convention of the Right of the Child (CRC); and

iii. Article 3(3), 23(3), 23(4) and 24 of the Convention on the Rights of the Elimination of all Forms of Radical Discrimination (ICERD).

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW), adopted in 1990 emphasizes equal access to medical care of migrant workers. The Conventions of the International Labour Organisastion (ILO) also contain numerous references to a specific area of health – namely, occupational health. The right of indigenous and tribal people to health is explicitly recognized in the Article 25 of ILO Convention 169 which was adopted in 1989. The standard minimum rules for the treatment of Prisoners (adopted in 1957) lays down a number of principles for the treatment of sick prisoners.

(B) Committee On Economic, Social And Cultural Rights

The Committee on Economic, Social and Cultural Rights has adopted a broader definition of health which includes access to safe water and food, adequate nutrition and housing, healthy environmental conditions, access to health related education and information.[4] In its paragraph 12, General Comment 14 enumerates a set of principles, namely –

[4]. Committee on Economic, Social and Cultural Rights (2000) general comment No. 14, The Right to the Highest Attainable Standard of Health <http://www.umn.edu/humanrts/gencomm/escgencom.14.htm. accessed. 01 November 2023.

(1) Availability;

(2) Accessibility;

(3) Acceptability;

(4) Quality.

1. Availability: Availability requires that "functioning public health and health-care facilities, goods and services, as well as programmes, are available in sufficient quantity within the state party."

2. Accessibility: According to the General Comment, accessibility has four overlapping dimensions:

a) Non-discrimination: "health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds";

b) Physical Accessibility: "health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS."

c) Economic Accessibility (Affordability): "health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinations of health, has to be based on the principles of equality, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups"; and

d) Information accessibility: "the right to seek, receive and impart information and ideas concerning health issues."

3. Acceptability: Acceptability requires that "all health facilities, goods and services are respectful of medical ethics and culturally appropriate, ie. respectful of the culture of individuals, minorities, peoples and communities sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned."

4. Quality: Quality implies that "health facilities, goods and services are scientifically and medically appropriate and of good quality." This requires inter alia, "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."

 [ISSN 2581-5369]

The General Comment 14 further elaborates the distinction among the three types of state obligations. According to the General Comment, the right to health, like all human rights, imposes three types or level of obligations on state parties: the obligations = "to respect", "to protect" and "to fulfill". The obligation to respect is a negative state obligation and requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health. Examples of violations of this obligation are – denying or limiting equal access to health services, enforcing discriminatory practices as a state policy, or unlawfully polluting air, water and soil through industrial waste, from state-owned facilities or through using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health.[5] The obligations to protect and fulfill are positive state obligations, requiring states to take measures that prevent third parties from interfering with this right and to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures towards the full realization of the right to health. Violations of the obligation to protect may occur, for example, when states decline to adopt legislation or to take other measures ensuring equal access to healthcare and health related services provided by third parties, or when states decline to ensure that harmful social or traditional practices do not interfere with access to pre-natal and post-natal care and family planning. General Comment 14 emphasizes that government must ensure that the privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability, and quality of health facilities, goods and services. It also requires that these services whether privately or publicly provided, be affordable for all, including socially disadvantaged groups.

Monitoring right to health takes place primarily within the framework of reporting procedures by several treaties at the international and regional levels. In addition, United Nations special rapporteur generates information on the right to health. Furthermore, the WHO has designated health and human rights as a crosscutting activity within its organisation. Finally, NGOs play an important role in the monitoring of the right to health. A possible way to monitor the right to health is through the use of indicators and benchmarks. Indicators are tools to indicate the present situation – for example, the maternal mortality rate, Benchmarks are self-imposed goals or targets to be reached at some future date – for example, reduction of the maternal mortality rate by half by 2020.[6]

[5] . Ibid

[6] . Bright Tobes, 'Right to Health and Healthcare in David. P. Forsythe (Ed), Encyclopedia of Human Rights (2009).

 [ISSN 2581-5369]

VI. CONCEPT OF THE RIGHT TO HEALTHCARE IN INTERNATIONAL DOCUMENTS

UN: Universal Declaration of Human Rights (1948) – Article 25 Part I states that - "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." European Social Charter (1961, 1996 revised) Article II Part I states that - "Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable."

International Convent on Economic, Social and Cultural Rights (1996): Article 12 Part I states that: "The state parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Convention on the Elimination of All Forms of Discrimination Against Women (1979): Article II Part I paragraph f states that: "The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction." Convention on the Rights of the Child (1989). Article 24 Part I states that - "States parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilitates for the treatment of illness and rehabilitation of health. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services." European Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (1997): "Parties, taking into account of health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access of health care of appropriate quality."

Treaty on the functioning of the European Union (1957, 2010): Article 168 states that - "A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities. Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their courses, their transmission and prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health. The Union shall complement the member states action in reducing drugs – related health damages, including information and prevention."

The provisions of the aforementioned legal acts prove that the right of a person to health care evolved in the treaties and declarations from a conservative consolidation of health as the major

 [ISSN 2581-5369]

human value and to the independent right of healthcare. This can be seen from the constantly increasing number of various specific measures that are adopted by the various international bodies that comprise of factors which are of significant importance to the state of health. By analyzing the major provisions of these international documents, it is seen that these documents emphasises upon the consolidation of right to health and healthcare as a human right. The provisions of these documents ensure that the present status of the human right and its content creates the preconditions for the development of human right to healthcare on a national level and transfer of its provisions into national legal acts.

VII. ORGANISATIONAL PERSPECTIVES OF RIGHT TO HEALTH IN INDIA

Health has been regarded as a fundamental right of the people. This has been emphasized in various international conventions on human rights. The World Health Organisation (WHO) as an organ of the United Nations in doing its job of upgrading the quality of human life around the globe. As far as the Indians are concerned, the most important constitutional provision pertaining to health of the Indian citizens is Article 21 of the Constitution of India. Article 21 states that: "No person shall be deprived of his life or personal liberty except according to procedure established by law." This article aims to protect the life and personal liberty of the citizens. Apart from this, Part IV of the Constitution of India which deals with Directive Principles of state policy has several provisions that touch on the subject of health. Articles 39(e), 39(f), 42 and 47. Article 39(e) states: "that the health and strength of workers, men and women and the tender age of children are not abused and that citizens are not forced by economic necessity to enter vocations unsuited to their age or strength." Article 39(f) states: "that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedoms and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment." Article 42 states that: "The state shall make provision for securing just and humane conditions of work and for maternity relief." This provision provides for just and humane conditions of work and maternity relief. Article 47 states that: "The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, as in particular, the state shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health." This provisions directs the state to raise the level of living and to improve public health of its citizens.

VIII. JUDICIAL PRONOUNCEMENTS RELATING TO HEALTH AND HEALTHCARE

The courts in India through its pronouncements in a wide array of health issues have provided

reliefs to benefit the aggrieved citizens of India. Few notable decisions of the Hon'ble Supreme Court are discussed below:

In Paramand Katara V. Union of India,[7] the Supreme Court was confronted with a situation where hospitals were refusing to admit accident victims and were directing them to specific hospitals designated to admit 'medico-legal cases'. The court ruled that while the medical authorities were free to draw up administrative rules to tackle cases based on practical considerations, no medical authority could refuse immediate medical attention to a patient in need. The court relied on clauses 10 (obligations to the sick) and 13 (the patient must not be neglected) of the code of Medical Ethics to conclude that such a refusal amounted to a violation of universally accepted notion of medical ethics. It is observed that such measures violated the 'protection of life and liberty' guaranteed under Article 21 and hence created a right to emergency medical treatment.

In Murali Deora V. Union of India,[8] the Supreme Court prohibited smoking in public places in the entire country on the grounds that smoking is injurious to health of passive smokers and issued directions to the Union of India, State Governments as well as Union Territories to take effective steps to ensure prohibiting smoking in all public places such as auditoriums, hospital buildings, health institutions, educational institutions, libraries, courts, public offices and public conveyances, including railways.

In Consumer Education and Research Centre V. Union of India,[9] occupational health hazards and diseases of the workmen employed in the asbestos industries came up before the Supreme Court for consideration. The court directed the asbestos industries to take several measures for ensuring the health of workers engaged in the manufacture of asbestos or its ancillary products. The court also directed that in case of the positive finding that all or any of the workers are suffering from the occupational health hazards, then each such worker shall be entitled to compensation of a sum of Rupees one lakh payable by the factory or industry or establishment concerned within a period of three moths from the date of certification by National Institute of Occupational Health.

In Rama Murthy V. State of Karnataka,[10] the right to health of prisoners came for consideration before the Supreme Court. The apex court observed that prison system afflicted by nine major problems viz. overcrowding, delay in trial, torture and ill-treatment, neglect of health and

[7] . AIR 1989 SC 2039. Paramand Katara V. Union of India
[8] . (2001) 8 SCC 165. Murali Deora V. Union of India
[9] . (1995) 3 SCC 42. Consumer Education and Research Centre V. Union of India
[10] . AIR 1997 SC 1739. Rama Murthy V. State of Karnataka

 [ISSN 2581-5369]

hygiene, in substantial food and inadequate clothing, prison vices, deficiency in communication, streamlining of jail visits and management of open-air prisons. Society has an obligation towards prisoners' health for two reasons. First, the prisoners do not enjoy the access to medical expertise that free citizens have. Their incarcerations places limitations on such access; no physician of choice, no second opinions, and few, if any, specialists. Secondly, because of the conditions of their incarceration, inmates are exposed to more health hazards than free citizens. Prisoners therefore, suffer from a double handicap.

IX. LESSONS FROM KERALA STATE

Kerala is the southern-most state of India. With a population of 34.8 million, a population density of 859 per sq.km, the state of Kerala is extremely crowded, perhaps more than Bangladesh. Its annual per capita income of Rs.233,000 (FY 2022) is more than the national average of Rs.172,000 (for the year 2022-23). Kerala has surpassed all Indian states in certain important measures of health and social developments like literacy and life expectancy rates, infant mortality rates, birth and death rates etc. The efforts in the health field in Kerala were simultaneously reinforced by the developments in other key sectors. Literacy among women has played a key role in improving the health situation. This has in fact led to the high rate of utilization of health facilities. Long-standing programmes directed at social welfare raised not only educational levels of the population but also developed a social infrastructure, including a transport network which provided easy access to services. An effective programme of land reforms had given poor people access to land resources for food production at the household level. Kerala has demonstrated that good health at low cost is attainable by poor countries, but requires major political and social commitments. In a democratic system with a strong political commitment to equitable socio-economic development, high levels of health can be achieved even on modest levels of income. Kerala can therefore be considered a yardstick for judging health status in the country.

(A) The Kerala Model Of Healthcare

From the inception of Kerala state in 1956, every state government irrespective of their political affiliations, had placed primary education and primary healthcare as their two top most priorities. This has led to a steady growth of healthcare capacity and facilities in Kerala up to the grama Panchayath level over a span of seventy years. The health gains made in Kerala can be attributed to several factors, including the strong emphasis of the state government on public health and primary healthcare, health infrastructure, decentralized governance, financial planning, education of girls, community participation in development programmes and above

 [ISSN 2581-5369]

all a willingness to improve systems in response to the identified gaps. From the beginning after achieving statehood, Kerala has invested in infrastructure to create a multilayered health system designed to provide a first contact access for basic services at the community level and gradually expanded the integrated primary healthcare coverage to achieve access to a range of preventive and curative services. Moreover, Kerala has rapidly expanded the number of medical facilities, hospital beds, and doctors. From 1960 to 2010, the number of doctors increased from 1200 to 36,000 and the number of primary health care facilities increased from 369 to 1356 between 1960 and 2004. This increase in the number of PHC centres and doctors allowed for the provision of the right care in the right place, reduced the cost of patient care and lowered the burden on the secondary and tertiary care facilities. Successive state governments had succeeded in creating medical colleges in almost every district in the state and have also sanctioned self-financing private medical colleges at an impressive average of more than one college per district. This has been the principal reason for Kerala having 1.5 doctors per 1000 people. This is far above the national average of 0.62 and is ahead of the WHO mandated 1 for 1000 people. The Kerala model of development is acclaimed for the investment in education, healthcare, social infrastructure which improved health outcomes like high life expectancy, low infant mortality and low birth rate. Investment in the health sector has traditionally remained a priority area for governments in Kerala since the formation of the state.

(B) Aardram Mission

In the year 2016, the Government of Kerala through the Aardram Mission, introduced a series of reforms in the health sector of the state with the support of Local Self Governments (LSGs). Primary Health Centres were slated for transformation into Family Health Centres (FHCs), with extended hours of operation as well as improved quality and range of services.

(C) Primary Healthcare in Kerala

Kerala had sought to operationalise the constitutional obligation to decentralize power; as early as in the year 1995. The state had transferred funds to the health department for the development of healthcare infrastructure. A typical PHC in Kerala has one Medical Officer (MO) who provides clinical services and also supervises the public health team in the PHC. Every PHC has five to six subcentres roughly catering five thousand population. The public health team consists of a Health Inspector (HI), who supervises the Junior Health Inspector (JHI) in implementing communicable and non-communicable disease control activities. The Public Health Nurse (PHN) supervises a team of five to six Junior Public Health Nurses (JPHN) to provide a range of services to the population in their catchment area. They are supported by

 [ISSN 2581-5369]

Community Health Workers (CHW) named ASHA workers. Each ASHA worker is assigned about a thousand individuals to support and connect with the health system.

LSGs have a controlling stake in PHCs and support them with additional human resources, maintenance funds, medicines and consumables. The present FHC program has upgraded the existing resource pattern to three MOs and four staff nurses in the FHCs as well as the introduction of newer services at the primary level like Chronic Obstructive Pulmonary Disease Management (COPD), diabetic retinopathy and depression screening. The FHC program in Kerala under the Aardram Mission was the largest investment made by the state in the recent years to improve healthcare infrastructure, with over 5,289 posts of hospital workers created and also doubling of the plan investment in the Health Sector of the state.

X. PUBLIC HEALTH POLICY IN INDIA

Public health is a state subject in India. The Indian health policy reflects primary health care and universal health coverage as its key priorities which is in line with the Astana declaration of 2022, which reaffirmed primary healthcare as the cornerstone for achieving Universal Health Coverage and investments in improving the PHC system as the most efficient and inclusive approach to attain health-related United Nations Sustainable Development Goal 3 (SDG-3) by the year 2030. The Government of India, as early as in the year 2015, rolled out the Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) with a component to provide universal access to PHC services to all its people.

XI. CONCLUSION

Kerala has attracted international attention for its outstanding achievements in the healthcare sector despite its economic backwardness. The 'Kerala Model of Development' has now became an ideal model of development for many poor income countries in the world. The healthcare system in the state is considered to be the principal factor responsible for attaining the high level of health status in Kerala. From the formation of the state, healthcare provision was one of the government's top priorities and the system was developed in such a way that it incorporated both the western and traditional systems of medicine in view of the service of care was accessible to the people. The healthcare facilities in Kerala are divided into three categories in view of the service of care, namely – allopathy, (western medicine), ayurveda and homoeopathy. In view of the ownership, it is divided into three categories – namely, public, private and co-operative sectors. The state of Kerala has revamped its existing Primary Health Centres (PHCs) into people-friendly Family Health Centres (FHCs) in order to provide comprehensive primary care as part of 'Aardram' mission initiative. The implementation and

 [ISSN 2581-5369]

operation of this mission made use of the decentralized governance in primary health care which has greatly influenced its reorganization. Kerala provides an example of an approach that can provide vastly improved healthcare at a rapid rate. It is noteworthy that, Kerala has maintained low infant and maternal mortality rates and higher literacy rate when compared to the national average. This is mainly due to the forward thinking health policy planning by the successive state governments irrespective of their political ideologies.

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 [ISSN 2581-5369]

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