



States' Obligation In Guaranteeing Health Care Service In United Kingdom And India: A Comparative Study.¹

Basana Manna

Research Scholar,

University of Calcutta

Introduction

"We must take care of our body, it is the only place where we have to live", the quote admits itself the quintessential need to have good health. We must understand that the greatest wealth one can have is his good health and so does a Nation. With the emergence of the concept of welfare State, it becomes the fundamental obligation of every State to ensure good health to all its citizens. After devastating effect of World War, United Nations was formed and thereafter International Bill of Rights was framed. It recognises Right to Health as basic Human right.² Thereafter in the year 1966, International Covenant in Economic Social Rights was framed for further protection. It obliges each State authority to ensure right to health to all its citizens. In the year 1978, In Alma Ata Declaration, the main focus was given on primary healthcare. Finally World Health Organisation declared *Health for all* as the primary goal needed to be achieved by each member nation. India was one among the participating members of the Conference in Kazakhstan. Again in 2005, the 58th World Health Assembly adopted a resolution encouraging countries to plan the transition to Universal Health Coverage in their health systems. In 2010, the WHO devoted its World Health Report to a discussion of health care financing alternatives for achieving universal coverage.³ The need was a health policy to be framed by each State which would ensure health services to each and every individual. In the later years it came up in the names of Universal health Coverage. The concept of Universal Health Coverage began to evolve in Europe with reforms introduced by Bismarck in Germany in the 19th century and the introduction of the National Health Service in the United Kingdom in 1946.⁴ The Constitution of World Health Organisation framed in the year 1948 and the Alma-Ata Declaration in 1978 both indirectly stressed Universal Health Coverage as an important tool to achieve *Health for All*.⁵

¹ Basana Manna, Research Scholar, Dept. of Law, University of Calcutta.

² Universal Declaration of Human Rights, art. 25.

³ Ursula Giedion, Eduardo Andrés Alfonso and Yadira Díaz, "The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence Public Disclosure Authorized," *The World Bank* 1 (2013).

⁴ M.R. Mathur, D.M. Williams, K.S. Reddy and R.G. Watt, "Universal Health Coverage: A Unique Policy Opportunity for Oral Health," 94(3) *JDR Clinical Research Supplement* 35 (2015).

⁵ M.R. Mathur, D.M. Williams, K.S. Reddy and R.G. Watt, "Universal Health Coverage: A Unique Policy Opportunity for Oral Health," 94(3) *JDR Clinical Research Supplement Op. Cit. at 35*.

To understand Universal Health Coverage (UHC), it is defined as all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services.⁶ Again the Planning Commission of India, Universal Health Coverage means ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services.⁷ The main principles of Universal Health Coverage are Universality for broader coverage all around. Equity for Service for one who needs it. It also states about comprehensive care which includes all aspects of care. It also includes financial Protection and patient's rights. It also ensures consolidated and strengthened public health provision. It mentions about accountability and transparency along with community participation.

However, it is only in the past decade that the concept has received much greater recognition. However looking into the financial constraints of the developing and under developed states like India, this scheme is hard to be implemented. UHC was firmly endorsed by the World Health Assembly in 2005 and further supported it, since World Health Report 2010 proposed improved financing for health care to achieve this goal⁸ and since then more than seventy countries have requested policy support and technical advice for UHC reform from the World Health Organization (WHO). In response, WHO developed a plan of action that included providing guidance on how countries can manage the central issues of fairness and equity that arise on the path to UHC. The WHO Consultative Group on Equity and Universal Health Coverage was set up to develop this guidance⁹ The current movement in promoting UHC has been accompanied by other key actors in the field of global health such as the World Bank, the United Nations Children's Fund (UNICEF), the United States Agency for International Development (USAID), the Inter-American Development Bank, the Rockefeller Foundation, and the Bill and Melinda Gates Foundation, among others. They have contributed in many different ways that include financing and accompanying reforms, supporting initiatives, and publishing research and literature on the subject.¹⁰ Therefore, the present paper explores the need to have a uniform health policy with the sole object to ensure healthcare for all. That the State is duty-bound to provide accessibility, affordability, quality, availability of all forms of healthcare facility. Indian legal framework that puts obligation on State to ensure healthcare to everyone will also be discussed along with a comparative study with the healthcare structure of United kingdom will also help to analyse the scenario in India. The study will be concluded by some suggestion.

Indian legal framework States' obligation in providing healthcare

The Constitution of India envisages the establishment of a new social order based on equality¹¹, freedom¹², justice and the dignity of the individual¹³. It aims at the elimination of poverty which may be a reason of ill-health and directs the State to 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, securing the health and strength of workers,

⁶ World Health Organization, Final report of the WHO Consultative Group on Equity and Universal Health Coverage making fair choices on the path to universal health coverage(2014).

⁷ The Planning Commission of India New Delhi, Report High Level Expert Group Report on Universal Health Coverage for India, (November,2011).

⁸ Supra note 5.

⁹ Supra note 6.

¹⁰ Ursula Giedion, Eduardo Andrés Alfonso, and Yadira Díaz, "The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence Public Disclosure Authorized," 25 *UNICO* 1 (2013).

¹¹ Constitution of India, art. 14

¹² *Id.*, art. 19

¹³ *Id.*, art. 21.

men and women, specially ensuring that children are given opportunities and facilities to develop in a healthy manner¹⁴.

Although India has a rich, centuries-old heritage of medical and health sciences. In recent days almost one-third of the total deaths occur among children below the age of 5 years and infant mortality is around 129 per thousand live births.¹⁵ An effective well-structured health policy becomes the need of the day. The National Health Policy of 1983 and the National Health Policy of 2002 have served well in guiding the approach for the health sector in the Five-Year Plans.¹⁶ When the main focus was on primary health such as water supply and sanitation, control of malaria, rural health units, services for mothers and children, health education and training, self-sufficiency in drugs and population control. However in the last few decades, health care has got additional focus in government planning through health specific programmes such as the National Health Policy and National Rural Health Mission (NRHM), which have focused on the expansion of primary health care in rural areas ahead the implementation of disease control programmes of the member on. It was then that the concept of health coverage in the form of insurance grew up. India began its health insurance journey almost 70 years back with employer health insurance programmes such as the Employees' State Insurance (ESI) and Central Government Health Scheme (CGHS) retail commercial health insurance was introduced in India by the government-owned general insurers. The National Health Policy of 2017 envisages as its goal the attainment of the highest possible level of health and wellbeing for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence.¹⁷ Even as health insurance shows a steep growth, the majority of the health insurance members in India are still covered under employer programmes or welfare schemes. Employers in both the public and private sector offer employer-based health insurance schemes for reimbursement of employee's health expenditure. To address health coverage for the common citizen, the Rashtriya Swasthya Bima Yojana (RSBY or the National Health Insurance Scheme) was launched in 2008, as a Central government initiative. RSBY provides health cover to below the poverty line (BPL) households, with beneficiaries entitled to secondary level inpatient care up for a range of diseases, even pre-existing conditions of up to five members in a family are covered. Additionally, to address rural and below poverty population, the government provide social health coverage through the NRHM and at the state level through health insurance schemes. While NRHM attempts to ensure universal coverage through government funding from tax sources, the RSBY and the State health insurance schemes provide health coverage through insurance mechanisms. Currently, only 32% (or 380 million) of the total population of India is covered under the various health insurance schemes, with the majority covered under either government or employer programmes, with commercial private health insurance having around 6% penetration of the country's population.¹⁸ Even with this additional thrust, Government spending on healthcare continues to be quite low. Health expenditures is estimated to contribute to 3.6% and 2.9% of rural and urban poverty, respectively. Annually, an estimated 60 to 80 million people in India either falls into poverty or get deeper into poverty (if already below poverty line) due to health-related expenditures.¹⁹ India has a very low public health spending with only 0.94% of the GDP. The government contribution of the total health spending is only 22% with 78% of private health spending.²⁰ In spite of such initiatives around 42% of India's population is below poverty line (BPL)²¹ and that despite health being a key government ministry, majority

¹⁴ Constitution of India, art. 39.

¹⁵ Government of India, *National Health Policy 1983*, (Ministry Of Health It Family Welfare New Delhi, 1983).

¹⁶ Government of India, *National Health Policy 2017*. (Ministry Of Health and Family Welfare New Delhi, 2017).

¹⁷ *Id.*, at 2.

¹⁸ Thomas K Thomas, "Role of health insurance in enabling universal health coverage in India: A critical review," 29(4) *Health Services Management Research* 106,101 (2016).

¹⁹ Mudasir Maqbool, Mohamad Amin Dar, Shafiq Rasool, Imran Gani, Mohammad Ishaq Geer "Universal Health Coverage Policy and Practice Framework in India: A Review," 12(8) *Research J. Pharm. and Tech* 4051, 4045 (2019).

²⁰ Government of India, *National health accounts of India 2004-05* (Ministry of Health and Family Welfare, Government of India, 2009)

²¹ Sriram Shyamkumar Sriram, "Critical evaluation of two approaches to achieve universal health coverage in India," 5(8) *IJCPH* 3163, 3160(2018).

of India's health infrastructure is in the private sector and more than 70% of health care expenses are met by consumers and not the government. Given that medical costs are unaffordable for a majority of India's population, having a wide spread health insurance net is critical in ensuring equitable health care for all.

The Scheme of Ayushman Bharat

India is embarking on an ambitious target of achieving Universal Health Coverage for all during 12th Plan period. Everybody will be entitled for comprehensive health security in the State. The State will be responsible for ensuring and guaranteeing UHC for its citizens²². The initiatives are as follows:-

(i) Health and Wellness Centre - The National Health Policy, 2017 has envisioned Health and Wellness Centres as the foundation of India's health system. Under this 1.5 lakh Centres will bring health care system closer to the homes of people. These Centres will provide comprehensive health care, including for non-communicable diseases and maternal and child health services. These Centres will also provide free essential drugs and diagnostic services. Contribution of private sector through Corporate Social Responsibility and philanthropic institutions in adopting these centres is also envisaged.

(ii) National Health Protection Scheme - The second flagship programme under Ayushman Bharat is National Health Protection Scheme, which will cover over 10 crore poor and vulnerable families (approximately 50 crore beneficiaries) providing coverage upto 5 lakh rupees per family per year for secondary and tertiary care hospitalization. This will be the world's largest government funded health care programme. Adequate funds will be provided for smooth implementation of this programme.²³

The Scheme is implemented at the national level to manage, an Ayushman Bharat National Health Protection Mission Agency would be put in place. States/ Union Territories would be advised to implement the scheme by a dedicated entity called State Health Agency. They can either use an existing Trust/ Society/ Not for Profit Company/ State Nodal Agency or set up a new entity to implement the scheme. However States and Union Territories can decide to implement the scheme through an insurance company or directly through the Trust/ Society or use an integrated model.²⁴

The Centre have already allocated approximately E127 million towards the Ayushman Bharat scheme for the fiscal year 2018-19. Around 29 million health insurance cards have been issued, approximately 1.8 million beneficiaries have been admitted and around 15,291 hospitals have been empaneled under National Health Protection Scheme.²⁵ However, there is no data available validating the usage of the health services yet. Few Indian states are yet to implement the Ayushman Bharat Scheme. Moreover, Ayushman Bharat i.e National Health Protection Mission will have major impact on reduction of out-of-Pocket expenditure on ground of increased benefit cover to nearly 40% of the population, (the poorest & the vulnerable) Covering almost all secondary and many tertiary hospitalizations and 5 lakh for each family. This will lead to increased access to quality health and medication. In addition, the unmet needs of the population which remained hidden due to lack of financial resources. This will lead to timely treatments, improvements in health outcomes, patient satisfaction, improvement in productivity and efficiency, job creation thus leading to improvement in quality of life.

Recently, 20 States have already signed up to administer the scheme in their states. States with existing schemes of their own will have either to converge their schemes into AB-NHPM or subsume the scheme

²² Government of India, *Universal Health Coverage* (Ministry Of Health and Family Welfare New Delhi, 2016).

²³ Government of India, *National health protection Scheme to provide Hospitalisation cover to over 10 Crore poor and vulnerable families* (Ministry of Finance, 2018)

²⁴ National Informatics Centre, *Ayushman Bharat - National Health Protection Mission* (Ministry of Electronics & Information Technology).

²⁵ Lakshmi Balraj L Balraj and H Brand, "Living long in India- India's progress towards Universal Health Coverage," 29(4) *European Journal of Public Health*, November, 79 (2019).

afresh.²⁶ West Bengal, Karnataka, Orissa have kept out of the scheme and plan to have their scheme. What is common among these States is the party at the Centre does not rule these States. Going forward there is a possibility of opposition parties winning in other States and rejecting this scheme. This will hamper the success of the programme.²⁷ Again inadequate funds allocated for setting up Health and Wellness Centres. This scheme envisages setting up and upgrading 1.5 lakh HWC's Centres to cater to the medical treatment need of its Centres. The amount is grossly inadequate for the number of Centres it seeks to establish. Out of pocket expenditure out of total expenditure done by citizens themselves in India is nearly 70%, which is very high in comparison with countries world over product (GDP) in 2004–05 is among the lowest in the world and the reason for private expenditures accounting for 78% of total health spending in the country, resulting in serious inequities in health.²⁸

National Health Service of United Kingdom

The United Kingdom, located off the northwest coast of the European mainland, comprises Great Britain (England, Scotland and Wales) and Northern Ireland. It has a population of around 64 million, 80% of whom live in England.²⁹ The government of the United Kingdom guarantees the right to health care access to all citizens through its program called the National Health Service (NHS). It is made up of multiple subsystems divided by each of the 4 countries. The NHS, however, is essentially one system, one organization that provides health care access to the citizens and residents of the United Kingdom. This fully comprehensive system includes health care facilities, staff, technology, pharmaceuticals, financing, coverage and delivery. The National Health Service (NHS) in the United Kingdom came into operation in 1948 following the provisions of the NHS Act of 1946. The NHS is the largest employer in the United Kingdom. For the first time, a UK government assumed responsibility for the provision of a comprehensive preventive and curative service for the whole population.³⁰

Before this, healthcare in the UK was generally available only to the wealthy people, unless one was able to obtain free treatment through charity or teaching hospitals. In 1911, David Lloyd George introduced the National Insurance Act, in which a small amount was deducted from an employee's wage and in return they were entitled to free healthcare. However, this scheme only gave healthcare entitlement to employed individuals. After the Second World War, an endeavour was undertaken to launch a public healthcare system in which services were provided free at the point of need, services were financed from Central taxation and everyone was eligible for care. A basic tripartite system was formed splitting the service into hospital services, primary care and Community Services. By 1974 concerns over problems caused by the separation of the three primary areas of care had grown, so a drastic reorganization effort was made which allowed local authorities to support all three areas of care.

The Secretary of State for Health has overall financial control and oversight of all NHS delivery and performance. The Department of Health is the Central Government body principally responsible for setting policy for the health and social care system in England. Health care and health policy for England is the responsibility of the Central Government, whereas in Scotland, Wales and Northern Ireland it is the responsibility of the respective devolved governments. In each of the UK countries the NHS has its own

²⁶ Government of India, Cabinet approves Ayushman Bharat – National Health Protection Mission (Union Cabinet, 2018).

²⁷ Manoj Pareek, "Ayushman Bharat-National Health Protection Mission a way towards Universal Health Cover by reaching the bottom of the pyramid to be a game changer or non-starter," 7(7) *IJAIR* 6, 10 (2018).

²⁸ AKS Kumar, LC Chen, M Choudhury, S Ganju, V Mahajan, A Sinha, "Financing health care for all: challenges and opportunities" 377 *Lancet*. 668,668 (2011).

²⁹ Cylus J, Richardson E, Findley L, Longley M, O'Neill C, D. Steel, ". Health Systems in Transition" 17(5) *United Kingdom: Health system review* 125, 1 (2015).

³⁰ Peter Greengross, Ke- 30n Grant and Elizabeth Collini, *The history and development of the UK National Health Service 1948 – 1999* 5 (DFID Health Systems Resource Centre 2nd edn., 1999)

distinct structure and organisation.³¹ The vast majority of NHS funding ultimately derives from Central (UK) taxation. Within the block grant allocated to each devolved administration each country is free to decide how much to spend on the NHS. The NHS can also raise income from patient charges, sometimes known as ‘co-payments’. Devolved administrations have control over the level at which these were set.³² Following the 2012 Health and Social Care Act, the specific roles and responsibilities of the Department have changed, away from direct responsibility for the delivery of the NHS to one that provides strategic direction and acts as steward for the health and care system, develops national policies and provides leadership. Responsibility for the delivery of the NHS and care services has shifted to a newly established organization, NHS England. NHS England is an executive non-departmental body, it has a wide range of statutory duties and is accountable to the Secretary of State and the public. It oversees the delivery of NHS services and is responsible for the contracting and purchasing of primary care health services, as well as some nation based functions previously undertaken by the Department of Health.³³ It became a mandated public health service in 2013. Local authorities are now responsible for offering an NHS Health.³⁴

This publicly funded system is currently under criticism owing to the huge incurred expenditure and the long waiting time for the patients before they can avail of the services. It leaves citizen no choice to choose the physician or treatment that they wanted. In general, government-provided care is somehow not as good as private health care providers. In 2013, there were more nurses per person in the United Kingdom than the EU average, with 870 per 100 000 (above the EU average of 850), despite a sharp fall in nursing numbers since the financial crisis. The number of doctors remains below the EU average of 347 per 100 000, however, at 278 per 100 000, the number of acute hospital beds is one of the lowest in the EU at 229 per 100 000 in 2013 (well below the EU average of 356 per 100 000).despite steady increases in recent decades.³⁵ Life expectancy for English men and women was 79.4 years and 83.1 years in the year 2003-05. The number of patients waiting longer than a year for treatment declined from 20,097 in September 2011 to 214 in November 2013, before increasing again. In April 2017 the number stood at 1,573. Over the past three years, the number waiting more than 26 weeks has increased from 60,402 in April 2014 to 136,030 in April 2017.³⁶ The universal health care system is not rewarding from the point of view of nurses and doctors as the government employees as they receive low wages. Since the government runs the universal health care; there are bureaucracy hurdles and lots of red tapes which result in poor service and long-time wait. There is an acute shortage of both primary care providers and specialists has led with quality care, particularly for the elderly who require 24x7 care. NHS has very few mechanisms to identify and respond to serious failures in health care. Thus, improvements in the organizational mechanism and its reporting systems are necessary for the NHS to take an active role in addressing its weaknesses. The NHS has never consistently and systematically measured changes in its patients’ health. It is difficult to measure the efficiency of the NHS as a health care system.³⁷ According to the British Medical Journal, health inequalities in Britain are greater currently than they were during the post-World War I slump and the Great Depression. Though health outcomes across all segments of the population have improved over the last decade, the disparity of health outcomes between the wealthiest and the poorest has widened over the past 20 years.³⁸

³¹ Konstantina Grosios, Peter B. Gahan, and Jane Burbidge, “Overview of healthcare in the UK” 1(4) *EPMA J* 529,534 (2010)

³² Rachael Harker, “NHS Funding and Expenditure” 5 *Commons Library Briefing* 11 (2019).

³³ National Audit Office *Departmental Overview, October 2018* (Department of Health & Social Care, 2018).

³⁴ Juliet A Usher-Smith, Emma Harte, Calum MacLure, Adam Martin, Catherine L Saunders, Catherine Meads, Fiona M Walter, Simon J Griffin and Jonathan Mant, “Patient experience of NHS health checks: a systematic review and qualitative synthesis” 7 *BMJ Open* (2017).

³⁵ Supra note 26 at XX.

³⁶ Janmejyay Senapati, Dr. Ranjan Dash, Bhabani Shankar Dash and Ryan Singh, “Finding healthcare Solution for India: A comparative study with USA and UK” 4(3) *IJARIIIT* 2145, 2139 (2018).

³⁷ Dennis Campbell, “NHS Failing in Basic Care of Some Elderly Patients, Warns Watchdog,” *The Guardian*, May 26, 2011.

³⁸ Nick Triggle, “Health gap ‘wider than in Great Depression’,” *BBC News*, July 24, 2010

A Comparative Study

We must begin with comparing with the current statuses of the 2 countries. Firstly, United Kingdom with a population of 66 million spends nearly 9% of the GDP (government funding being 7.6 which roughly equals £140 billion, whereas a developing country like India with a population of 1.34 billion spends only 4% of the GDP on healthcare, of which the government funds only 1.4% (equivalent of approx. £4 billion)³⁹. Secondly, with respect to manpower, India being the world's 2nd most populated Country in the world has a doctor to patient ratio of 1:1000⁴⁰, while the same in the UK is nearly thrice, approximated at 2.8 per 1000⁴¹. A physician's salary in India, on an average is approximately Rs. 50,000 per month (AIIMS), which just meets the bare minimum requirements of the World Health Organisation (WHO), whereas the average salary of a physician in the UK is projected to be ≤103,000 pounds/year or Rs. 7.75 lacs a month. These salaries seem fairly inadequate in India with the cost of living for a family of 4 being nearly Rs. 84,000/month with a cost of living index of 27.70, while in London it is nearly Rs. 2,58,327.70 with a cost of living index of 83.54.⁴² It can be understood from these numbers that there is sufficient amount of money to save at the end of the month for a doctor in the UK, as compared to an Indian doctor that they would not have opted for private practice. Thirdly, the major causes of health issues in the UK comprise non-infectious diseases like cardiovascular diseases, cancer, hypertension and diabetes. On the other hand, infectious diseases like tuberculosis, malaria, tetanus, rabies still pose a significant burden on the Indian healthcare system apart from being the diabetes capital in the world.⁴³ A less healthy population like India with limited resources is in desperate need of a solution, with 88% of people having access to a basic water source and 98.9% of people having access to basic sanitation while in the UK 100% of people have access to an improved water source and improved sanitation.⁴⁴

The NHS is a way more organised healthcare system as compared to the Indian healthcare system. Not only does every patient have his own patient-profile which is readily available and accessible to every healthcare professional working in the NHS but there is also nearly perfect documentation. Each patient is given sufficient time for grievance redressal along with social and moral support is provided to patients who need it most. Besides the fact that the rehabilitation services are brilliant, there is also a thorough respect for a sound referral system

There are a lot of challenges in the path to achieve the dream here in India. The population of this nation deserves a budget that focuses on healthcare more than defence. As per the 2017 rankings of health systems in 11 developed countries, in the Commonwealth fund health think-tank, the NHS was adjudged as the best when it came to affordability and safety.⁴⁵

Thus we can concluded that 75 of 194 countries met the first legislative criterion but, of these, only 58 met the access criteria. Several things were striking. First, many countries had achieved UHC when they were still

³⁹ Suvansh R Nirula, Mayuresh Naik and Srishti R Gupta, "NHS vs Modicare: The Indian Healthcare v2.0. Are we ready to build the healthier India that we envisage?" 8(6) *J Family Med Prim Car* 1835, 1837 (2019).

⁴⁰ Raman Kumar & Ranabir Pal, "India achieves WHO recommended doctor population ratio: A call for paradigm shift in public health discourse," 7(5) *J Family Med Prim Care* 841-844 (2018).

⁴¹ Tom Moberly, "UK has fewer doctors per person than most other OECD countries," *BMJ Publishing Group Ltd*, June 20, 2017.

⁴² *Supra* note 36.

⁴³ Suvansh Nirula, Mayuresh Naik, R Srishti Gupta, "NHS vs Modicare: The Indian Healthcare v2.0. Are we ready to build the healthier India that we envisage?" 8(6) *Journal of Family Medicine and Primary Care* 1837, 1837 (2019).

⁴⁴ Suvansh R. Nirula, Mayuresh Naik, Srishti R. Gupta, "NHS vs Modicare: The Indian Healthcare v2.0. Are we ready to build the healthier India that we envisage?" *Op. Cit.* at 1837.

⁴⁵ World Health Organization's Ranking of the World's Health Systems, *available at*: <http://thepatientfactor.com/canadian-health-care-information/world-health-organizations-ranking-of-the-worlds-healthsystems/> (Last visited on 10th Mar 2023).

quite poor. For example, the United Kingdom did so in 1948 when gross domestic product, in real 2005 US \$, was under US \$5000 per capita.⁴⁶

Concluding remark and a way forward

A general visit in the state-aided hospitals will bring forth the real scenario of the healthcare system in India. The over populated state like India with limited resources and infrastructure is overburdened. Likewise leading to increasing number of deaths, mistreatment, maltreatment, neglect, abuse etc. The never-ending problem of limited number of beds, limited number of doctors and specialised diagnostics machines in state aided hospitals has resulted in mistrust in the minds of the healthcare seekers. People are afraid to take a serious patient in Government hospital because there is a big question as to their level of care and service for a general citizen. The only option left for one is to go for private hospitals which at least ensures immediate action and care. These leads to the unnecessary out of pocket expenditure a family has to incur for undergoing medical treatment. This is where the system lacks, the State lacks to provide proper healthcare to its citizen. An over populated country like India must spend most of its resources in healthcare rather than in defence. In the era of Covid 19, people were dying in street there was acute medical emergency in state and it failed miserably to provide healthcare services. The mechanism of Ayushman Bharat is still not applicable in most part of the country. Even if it is applicable it called 'a Poor man's insurance'. Private hospitals treats these people in a very different way. They are categorised as government insurance holder starting from mineral water to every single things are differentiated and they are deprived of quality care. Even most of the private hospitals do not recognised this insurance cards. One has to complain in a proper forum then if steps are taken then the patient can get the facility of treatment however it leads to delay in treatment and people do not want to take any risk to have unwholesome terms with the hospitals. Thus the present system in India is not about how much a government spend its GDP in healthcare, of course it is a very important point to be noted, but still one must take initiative to establish an active grievance forum where one might get immediate relief. The present healthcare system need to be upgraded to a great extend in order to match up with NHS. It is far reaching aim for the Indian system. Some of its challenging factors are its population, mostly poor populations, limited expenditures, limited doctors, nurses, infrastructure and finally the system itself. Despite several system-level obstacles, in India, big data research in health care can improve the status quo, whether in terms of patient outcomes or scientific discovery. Collaboration between India and the United Kingdom can result in mutual benefits to academic and health care delivery organisations in both countries and can serve as examples to other countries embracing the promises and the pitfalls of health care research in the digital era.⁴⁷ There are a lot of challenges in the path to achieve the dream here in India. The population of this nation deserves a budget that focuses on healthcare more than defence. As per the 2017 rankings of health systems in 11 developed countries, in the Commonwealth fund health think-tank, the NHS was adjudged as the best when it came to affordability and safety. India would to change and India would have to adapt. Considering the successful clinical, operational and cost parameters that the NHS itself is known for, it would be our vested personal interests if we could ensure the implementation and functional success of a near-perfect healthcare insurance system in one of the largest democracies in the world.

The proposed health legislation goes beyond delivery of health-care services to endorsing health-care rights of every individual. It brings about a change towards a realisation that individuals have an equitable right to health and wellbeing. The draft of the proposed National Health Bill is different from all other health legislations because it is based on the understanding that health care and sound public health are public goods.

⁴⁶ Martin McKee, Dina Balabanova, Sanjay Basu, Walter Ricciardi and David Stuckler, "Universal Health Coverage: A Quest for All Countries But under Threat in Some" 16 *Value In Health* S39,S45 (2013).

⁴⁷ Souvik Bandopadhyay, Gudlavalleti Venkata Satyanarayana Murthy, Dorairaj Prabhakara, Paul Taylor and Amitava Banerjee, "India and the United Kingdom-What big data health research can do for a country" *Learn Health Sys.* 1,5 (2018).

It encompasses all the tenets of health and health care, including the determinants, and aspires to the goal of health for all. This proposed legislation delineates all rights of an individual with respect to health and health care, while regulating the services provided by health institutions and health-care providers through adequate health-care information and systems for redress. It gives emphasis to the Panchayati Raj institutions and local organisations. The bill addresses the needs of people in society who are marginalised and vulnerable through not just health care but by also addressing the determinants of health. It mandates an assessment of the effect on health of every proposed law, policy, programme, project, technology, or a potentially damaging activity, in relation to health, before decisions. The bill envisions protecting the right to affordable, inclusive, and portable health care that is accessible, available, acceptable, good quality, and delivered in a non-discriminatory way through transparent and accountable processes by government and private institutions.

